

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

## The Perspectives of Foster Carers and Birth Parents: A Qualitative Analysis

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

REPORT NO. 4

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

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

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

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

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

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

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

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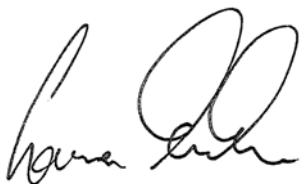
## FOREWORD

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

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

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

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



*Cormac Quinlan*  
*Director of Policy and Strategy*

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# INTRODUCTION

## by the Head of the HSE Crisis Pregnancy Programme

The *Sexual Health and Sexual Education Needs Assessment of Young People in Care in Ireland (SENYPIC)* programme of research was commissioned in late 2011 by the HSE Crisis Pregnancy Programme, in partnership with the Child and Family Agency (Tusla).<sup>1</sup> This is the fourth report in the programme, '*Report No. 4: The Perspectives of Foster Carers and Birth Parents; A Qualitative Perspective*'. The report presents findings gathered by way of in-depth interviews with nineteen foster carers and five birth parents of YPIC.

The report finds that fostering was largely a positive experience for foster carers, although experiences varied according to the young people involved. Foster carers were very aware that many YPIC had additional needs relating to emotional and social skills, and to address these needs they reported using family norms and household boundaries as a method of imparting social skills.

The majority of foster carers engaged in a variety of approaches to RSE, and some reported use of covert references to sexual behaviour and use of humour when telling young people about the importance of safer-sex. What is particularly interesting about this report is that the indirect approaches to RSE delivered by foster carers mirrored those reported by parents of teenagers (not in care) who were interviewed for the 2009 research project '*Parents' Approaches to Educating their Pre-adolescent and Adolescent Children about Sexuality*'.<sup>2</sup> What is clear from both reports is that parents and foster carers have additional supports and resource needs to support them in delivering RSE effectively to young people at-home, as current strategies were often indirect and not always effective.

In contrast, the birth parents of YPIC who were interviewed did not see any role for themselves in delivering RSE to their children and tended to be of the view that schools had the main role in its delivery. The CPP is currently re-developing resources for parents to help them to talk to their children about relationships and sexuality, to support the provision of RSE at home. The aim is to ensure that parents are aware of the broader benefits and protective impacts of discussing age appropriate relationships and sexuality information with their children. The CPP will work with the Child and Family Agency and other key stakeholders to ensure vulnerable parents have access to these resources at local levels and are provided with skills to support in delivering the messages.

I would like to thank the foster carers and the parents of YPIC who took the time to talk to the research team about their lives.

1 Formerly HSE Child and Family Social Services

2 Hyde et al. (2009). Crisis Pregnancy Agency.

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I would like to thank the researchers from the School of Nursing, Midwifery and Health Systems, University College Dublin; the School of Nursing and Midwifery, Queen's University Belfast; the School of Sociology, Social Policy and Social Work also at Queen's University; and Insights Health and Social Research, Derry. The Principal Investigator for this project was Professor Abbey Hyde, School of Nursing, Midwifery and Health Systems, UCD.

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

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

*Helen Deely*

*Head of the HSE Crisis Pregnancy Programme*

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## About the Authors

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

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.

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



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The authors wish to convey their sincere gratitude to all of the foster carers and birth parents of the young people in care who gave their time voluntarily to be interviewed for the study, and without whose support the study could not have been conducted. The SENYPIC programme of research was supported by a Steering Group and an Advisory Group who provided invaluable expertise throughout. The authors express their sincere thanks to these groups, and to the HSE Crisis Pregnancy Programme in conjunction with the Child and Family Agency (Tusla, formerly the HSE Children and Family Services) for funding the research. In addition, we are grateful to Jenny Bulbulia, Barrister-at-Law, and to Suzanne Phelan, Child Welfare Consultant, for reviewing components of this report.

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

## Abbreviations used in this report

CIC	Children in Care
CPP	Crisis Pregnancy Programme
HSE	Health Service Executive
LGBT	Lesbian Gay Bisexual Transgender
RSE	Relationships and Sexuality Education
SENYPIC	Sexual Health and Sexuality Education Needs Assessment of Young People in Care in Ireland
YPIC	Young People in Care (used in the Republic of Ireland)
YPIFC	Young People in Foster Care

## Terminology used in the report\*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Introduction

This report focuses on a qualitative analysis of the sexual health and sexuality education needs of young people in care (YPIC) from the perspective of foster carers and birth parents of YPIC. It is the fourth in a series of reports (Fullerton *et al.* 2015a, 2015b; Hyde *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 (SENYPIC). The findings of all five reports are amalgamated in a composite report of the findings that outlines each phase of the study and synthesises the overall results (Hyde *et al.* 2015c).

## **‘Sexual health’ and ‘sexuality education’: A note on terminology**

One of the challenges in undertaking a needs assessment of sexual health and sexuality education for any group is defining what is meant by the terms ‘sexual health’ and ‘sexuality education’. Before moving on to Section 1, a brief note to clarify these terms is required. Sexuality has been variously defined in the literature, and in this report, invoking the definition given by Jackson and Scott (1996, p. 2), it is considered to ‘encompass erotic desires, practices and identities’ and includes ‘aspects of personal and social life that have erotic significance’. The term ‘sexual healthcare’ is used throughout the report to refer to the broad spectrum of sexual health provision as well as relationship and sexuality education.

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 transferred to the development of what is referred to as ‘sexual competence’ or ‘sexual readiness’ (Hawes *et al.* 2010). This concept of sexual competence

used earlier in the UK National Survey of Sexual Attitudes and Lifestyle (NATSAL study) (Wellings *et al.* 2001), is operationalized by four indicators: contraceptive protection; autonomy in decision-making (not influenced by alcohol or peer pressure); non-abusiveness (both partners equally willing); and absence of regret (the timing being viewed as appropriate for the person) (Hawes *et al.* 2010). While biological knowledge (understanding how pregnancy arises and STIs are transmitted) is clearly important, having the confidence, social skills and emotional maturity to choose to engage in or abstain from sexual encounters and the sensitivity to read the psychosocial cues of another, strongly mediates sexual competence. The building blocks for sexual readiness thus lie in social skills' learning beyond sex education in its narrow sense; while scientific sex education is essential for sexual competence, it is not sufficient.

Appreciating the relevance to sexual health of wider teaching and learning about relationships is important, and is borne out by a growing body of evidence that the sexual health of young people rests beyond sex education in its narrow sense (Wight & Fullerton 2013). In a recent review of reviews by Wight and Fullerton (2013) on the influence of family on the sexual health of young people, four distinct aspects of family life were identified as being important: family structure, family connectedness, parental monitoring, and parents' attitudes and values about sex. For the purposes of the present study, a considerable amount of space is justifiably devoted to participants' accounts of teaching about relationships and embedding this teaching in family life. Given that the aim of this study was to identify the sexual health and RSE needs of YPIC, it was deemed important to investigate the ways in which participants sought to promote positive social interactions.

## Structure of the report

This report is structured around 11 sections. In Section 1, the focus is on the current status of knowledge in relation to the following:

- the context of foster care in Ireland
- empirical evidence of foster carers' and birth parents' role in sexual healthcare provision to young people in foster care.

Also in Section 1, the aim and objectives of this report are set out and the methodology employed is described.

In Section 2, the participants' fostering experiences are described. Their experiences of various placement types and with different young people shaped the foster carers' perspectives on the RSE and sexual health needs of YPIC. In Section 3, the extent to which participants viewed sexual health and RSE as a legitimate aspect of the fostering role is explored, as are their perspectives on the role of birth parents and service-providers in this regard. In Section 4, data analysis moves on to participants' views on the sexual attitudes and behaviour of YPIC based on their experiences of having fostered. Section 5 builds on the previous sections and attempts

to capture what participants consider to be the sexual health and RSE needs of YPIC, but at a fairly broad and abstract level, considering YPIC as a category of young people. In Sections 6 and 7, the emphasis shifts from this broad level to the more specific level of what participants actually said they do or have done with young people in their care as far as RSE is concerned. Section 6 focuses on the 'R' of RSE – relationships' education – and how this is transmitted to the young people through enabling social and emotional skills' learning in a way that is embedded in everyday routines. Section 7, by contrast, reports on participants' accounts of more direct RSE delivery with young people, the type that is more conventionally recognised as sex education. Since this study is specifically on the needs of YPIC, it is important to identify what is different and what is similar in terms of what is known about RSE delivery to young people in general. While comparisons are drawn as appropriate throughout this report, it is in Section 8 that the strongest sense of the specific challenges foster carers face with a young person in care is captured. The emphasis in Section 9 is on how participants managed the known sexual activity and behaviour of foster teens and is thus more concerned with sexual health and accessing the sexual health services rather than RSE *per se*. The final data section, Section 10, focuses on RSE and sexual health with regard to foster fathers, whose experiences on these matters in relation to foster children was reportedly considerably different to that with birth children. Section 11 summarises the report's findings and draws conclusions from them.

# Section 1

## Background, literature review and methodology

### Background and literature review

In order to contextualise the findings of the present study, this section begins with an account of the social and legal context of foster care in Ireland. This is followed by a review of literature pertinent to the current study of foster carers' and birth parents' perspectives on the sexual health and RSE needs of YPIC. Since literature that directly addresses the focus of the present study is very limited, the review is extended to related literature in order to determine what is known already about the topic, both in Ireland and internationally.

#### *The social and legal context of foster care in Ireland*

Foster care is enacted when The Child and Family Agency delegates the responsibility for the care of a minor (under 18 years) to 'a person . . . who is taking care of the child on behalf of a health board' (*Child Care (Placement of Children in Foster Care) Regulations 1995*). Of 6,490 children in care in 2014, 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 (Tusla 2014). Of the 6,014 in foster care, a sizeable minority (31%) were in foster care with relatives, with the remainder (69%) in general foster care. Placements are mainly represented by three time scales which reflect the Care Orders issued under the 1991 *Childcare Act*, that is, Emergency and Short Term, Interim and Long Term. Irrespective of the duration of the placement, it can be on a voluntary basis or by a court order. The duration of the placement is cross-cut by the type of care, either voluntary or involuntary, a distinction that will be explained a little further on. In 2011, at the time when SENYPIC programme of research was commissioned, the majority of children in care (CIC), 62% approximately, were admitted to care on a voluntary basis (Health Service Executive 2012b).

Foster care in Ireland is governed by a number of pieces of legislation, namely, the *Child Care Act 1991*, the *Child Care (Placement of Children in Foster Care) Regulations 1995*, the *Child Care (Placement of Children with Relatives) Regulations 1995* and the *Children Act 2001*.

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 with social workers 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 Child and Family Agency 'control over the child as if it were his parent'.

Section 39 of the *Child Care Act 1991* allowed the Minister for Health to make regulations governing foster care, which he did, as set out in two statutory instruments that entered the statute books in 1995, namely, the *Child Care (Placement of Children in Foster Care) Regulations 1995* and, to govern relative fostering, *Child Care (Placement of Children with Relatives) Regulations 1995*. A range of issues governing fostering are set out in the 1995 Regulations, and while foster carers' role in sexual health provision to children in their care is not specifically mentioned, the duties of foster carers include taking 'all reasonable measures to promote the child's health, development and welfare' (Section 16:1).

The *Children Act 2001* is a piece of legislation governing children in general, including fostered children, Section 268 of which determines that children under the care of the health board pursuant to the provisions of the Act 'have the like control over the child as if it were his or her parent do what is reasonable . . . in all the circumstances of the case for the purpose of safeguarding or promoting the child's health, development or welfare'.

Based on this legislation, consultation with stakeholders, and best-practice in the field, a document entitled *National Standards for Foster Care* (Department of Health and Children 2003) was published in 2003. The objective of these National Standards was to enhance the quality of foster care nationally. Rippling through this report was the discourse of children's rights, advocating dignity, respect and choice regarding the care of children in care. This is especially prominent in Chapter 3 of the document, 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. Elsewhere in the document, while references are made to respecting the sexual identity of the young person, sexual health is not directly referred to except where the responsibilities of link workers are concerned. Each young person in foster care or relative care is required to have an allocated social worker responsible for coordinating the care plan ensuring decisions are implemented and that the young person and his or her parents are consulted about the plan (Department of Health and Children 2003). The Placement Plan is the agreement around which the day to day care of the young person is carried out and is agreed between the foster carer, the allocated social worker and the fostering link worker and could incorporate issues such as sexual health. Link workers (social workers assigned to the foster family) are required to ensure that foster carers 'receive all relevant information and advice about the children including: background history, health, education, cultural, ethnic, religious, and sexual development issues . . .' (Department of Health and Children 2003, p. 35).

Overall, in all cases where a child is in care, even where the HSE delegates the day-to-day duties for the health and welfare of the child to a foster carer, it still retains its position as corporate parent. This occurs with the consent of the birth parents in the case of voluntary care and without their consent in the case of involuntary care. This potentially has implications for the freedom of foster carers to parent compared to birth parents in normative situations and something that we revisit later in the report.

What had been published in the year preceding data collection for this report (Report No. 4) was the document *Children First: National Guidance for the Protection and Welfare of Children* (Department of Children and Youth Affairs 2011). This document is a revised version of the earlier guidance set out in 1999 (Department of Health and Children 1999). In it, how child abuse is defined and recognised is outlined, as is the basis for reporting concerns, standard reporting procedures, as well as protocols in managing suspected abuse or neglect. The Children First Act, 2015, was enacted after the data for this study were collected. The majority of its provisions await commencement.

#### ***Empirical evidence of foster carers' and birth parents' role in sexual healthcare***

Foster carers' and birth parents' perspectives on the RSE and sexual health needs of YPIFC have not been the subject of previous research in Ireland. While this reflects the dearth of knowledge of the sexual health of YPIC in Ireland in general, internationally, research that addresses specifically the issue of foster carers and the sexual health of YPIC is very limited. A UK study commissioned by the Department of Health sought (among a range of aims) to capture the input of foster carers to the RSE and support needs of YPIC who were parenting (Chase *et al.* 2006; Knight *et al.* 2006). Sixty-three young people were interviewed for the study, as were an unspecified number of foster carers. Findings indicted considerable difficulties among YPIC in discussing sex and relationships with foster carers (Chase *et al.* 2006). The basis for these difficulties rested in a number of factors such as strong religious beliefs of the carers, their disapproval of early sexual activity, their lack of knowledge, and concerns that raising issues about sex might imply that sexual activity was occurring. It was also reported that carers were unclear about their roles and responsibilities. The study advocated a more comprehensive training for foster carers to prepare them for RSE with young people. In a separate article from the same study, Knight *et al.* (2006) reported that in two instances, foster carers had facilitated their foster teen to access contraception. While this UK study identified some issues pertaining to the role of foster carers in the sexual healthcare of their foster teens, it is limited in terms of depth in analysis because data from young people, professionals, and carers were combined in the reporting of the study.

There is circumstantial evidence that YPIC in Ireland are at higher risk of teenage pregnancy than are young people who are not in care (Keilthy & Morris 2011), and there is a consistent body of evidence in this regard from other industrially-developed countries (Mooney *et al.* 2009; Dworsky & Courtney 2010; Boonstra 2011; Manlove *et al.* 2011). There is also evidence that among YPIC, risk behaviours tend to cluster (Jones *et al.* 2011), and there is an

association between risk behaviours such as alcohol and drug abuse and early sexual initiation (Carpenter *et al.* 2001; Manlove *et al.* 2011), as well as unprotected sexual activity (Dale 2009; Dale *et al.* 2011; Manlove *et al.* 2011). While research into YPIC has grown in relation to a range of areas, the absence of studies that focus specifically on fostering and sexual health make it necessary to turn to the broader literature for indirect information as to how fostering as a practice is related to the sexual health of YPIC.

Across the broad category of YPIC, we know that generally those in foster care tend to fare better than those in residential care (Dregan & Gulliford 2012), including on sexual health outcomes such as age at sexual initiation (Carpenter *et al.* 2001). This may be accounted for by two factors: firstly, young people in residential care have more complex problems – this make them difficult to place with foster families and they are therefore more vulnerable and challenging than those placed in foster care. Secondly, living in a foster family may have a protective effect on sexual health compared to living in residential care. It is difficult to determine which of these possibilities carries greater weight owing to the complexity of measuring the influence of each. However, the protective effect of family may well play a significant role by virtue of the fact that foster situations tend to expose the young person to the patterns and cohesion of stable family life that young people in residential care do not experience. While research into the impact of family structure and processes on health is derived from research into families in general rather than foster families, it does offer insights that may have relevance for foster children.

As indicated in the Introduction, there is evidence that family structure and family connectedness offer protections to the sexual health of young people. (For a review, see Wight & Fullerton 2013). Where a young person lives with both biological parents, sexual initiation has been found to be delayed, both for young women and young men (Wight *et al.* 2006). The impact of family structure, however, needs to be viewed with reference to family processes (Wight & Fullerton 2013). Important process factors include parental aspirations for their children and their engagement in the children's education. Manlove (1997, 1998), for example, found that teenage girls whose parents were involved and interested in their education were at lower risk for teenage motherhood. The monitoring of young people's behaviour has also been found to be an important family process, with several studies finding that young people whose activities are monitored by their parents are less likely to engage in risk activities including unprotected or early sexual activity (DiClemente *et al.* 2001; Resnick *et al.* 1998; Romer *et al.* 1999; Wight *et al.* 2006).

Fathers' involvement in young people's lives appears to have an effect on the sexual health of adolescents. Katz and van der Kloet (2010) found that paternal emotional responsiveness enhanced daughters' refusals of unwanted sex and increased their resilience to male dominance. A longitudinal randomised trial of a school sex education programme in Scotland (Wight *et al.* 2006) found that a significant predictor of teenage girls always using condoms was their comfort in talking to their fathers about sex.

A knowledge base has been developed nationally and internationally with regard to parents (in general) and sex education. It is not intended to review this here; however, at points in this report reference is made to a previous Irish study funded by the Crisis Pregnancy Agency (now the HSE Crisis Pregnancy Programme) entitled *Parents' Approaches to Educating their Pre-adolescent and Adolescent Children about Sexuality* (Hyde *et al.* 2009). For convenience, this research is abbreviated to The Parents' Study in this report.

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

Fostering in Ireland is regulated by legislation, standards and guidelines. The HSE becomes the corporate parent for children in care and delegates responsibility for the day-to-day parenting to foster carers in the case of children placed in families.

Identifying the sexual health needs of YPIC from the perspective of foster carers and birth parents has not been studied previously nationally, and only to a very limited degree internationally. There is evidence that young people in foster care fare better than their counterparts in residential care in terms of a range of health outcomes, suggesting that foster placements have a protective effect on the health of YPIC.

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

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

### Methodology

The methodology for this study focusing on foster carers and birth parents 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. Foster carers were deemed to be particularly useful

<sup>3</sup> 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).

informants for the study by virtue of their key position in dealing with the daily routines of the young people they fostered. Birth parents were also included because of their potential to contribute to the overall picture of the sexual health and RSE needs of YPIC.

### *Ethical considerations*

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

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. Informed consent was obtained from each participant. Participants were guaranteed that they would not be identified in any written reports of the study. In the case of telephone interviews, participants were provided with information about the study in advance of the telephone call, and were advised as to the approximate time when the interviewer would telephone. Audio recording of interviews occurred only where a participant was explicitly in agreement with this. All audio recordings were destroyed following the submission of the report to the funding body.

In this report, there were revelations in participant accounts of underage sexual activity among YPIC. The principal investigator, also the designated person (DP) responsible for reporting child protection concerns, was satisfied that there were no specific incidences that required follow-up. As indicated later in this report, foster carers indicated feeling obliged to interface with the HSE where they suspected that a foster child was sexually active.

### *Eligibility and recruitment*

The eligibility criterion for the study was having experience of fostering a young person aged thirteen years and older (either currently or in the previous year); for birth parents, the criterion was having a birth child aged 13 or older in foster care on a voluntary basis. Foster carers were recruited through the HSE Children and Family Services (now Tusla, the Child and Family Agency) and via support organisations, namely, the Irish Foster Care Association (IFCA), and private fostering agencies. Birth parents were recruited via a family advocacy group in the west of Ireland that provides support to birth parents whose child is in care. Potential participants were furnished with information about the study in the form of an information sheet.

### *Description of the sample*

The sample was comprised of nineteen foster carers and five birth parents.

While it was initially proposed to recruit just 12 foster carers, it became clear after the first few interviews that the contribution of this group was very important. As the complexity of the

sexual health needs YPIC began to emerge during the interviews with the foster carers, it was decided to expand the sample size.

The experience of fostering among these participants ranged from two to thirty years. All had fostered more than one child; many reported that the first child that they fostered was on a short-term basis. Some had experience of a wide spectrum of placement types and ages of children; others specifically opted to foster teenagers in view of work commitments that impacted on raising younger children. Some of the short-term placements were for respite purposes. These ranged from a single weekend to a few months. Longer-term placements sometimes spanned virtually the entire childhood of the young person. All apart from three participants also had birth children, and in approximately a quarter of cases their own birth children had reached adulthood. Just two participants were foster carers involved in relative fostering. One was a woman fostering her granddaughter, and the other was fostering the children of her husband's brother. A range of socio-economic groups was represented. One female foster carer participant was a member of the Traveller community. The gender breakdown of foster carer participants was thirteen females and six males. The age range of participants was 42-63 years.

With regard to birth parents, a sample size of five was proposed. This relatively small number was proposed because it was expected that data from these participants would be supplementary to the data from foster carers. It also helped to ensure a manageable quantity of data in the overall SENYPIC programme of research. The criterion for participation was that each birth parent had at least one child in voluntary care. The length of the placement at the time of the interviews ranged from ten months to four years. The gender breakdown of the birth parents was four females and one male. Their ages ranged from 31-47 years. One of the female birth parents identified herself as being a member of the Traveller community.

### **Data collection**

#### **(1) Foster carer participants**

Data were gathered from foster carer participants by 15 in-depth individual interviews, along with two sets of paired interviews where a fostering couple were interviewed together. (Paired interviews arose because the couples in question expressed a preference to be interviewed jointly). An interview (topic) guide (see Appendix 1) was used to structure interviews, developed from existing literature and from knowledge gleaned at earlier phases of the SENYPIC programme of research). The length of the interviews ranged from 20-95 minutes, with the average being 55 minutes. Interviews were conducted in a variety of locations that were deemed to be most convenient for participants; locations included their own homes, cafes and hotel lobbies. All interviews were audio recorded, apart from one where the participant expressed her discomfort about being recorded. In this case, extensive notes were made by the interviewer. Audio recordings were transcribed in preparation for analysis.

## **(2) Birth parent participants**

Data from five birth parents were gathered by telephone interviews. The interviews with the birth parents were shorter than those with foster carers, lasting from 18-25 minutes. Many of these participants had limited contact with their child which meant that there were gaps in their knowledge about the child's sexual health. An interview (topic) guide (see Appendix 2) was used to structure interviews. This was similar to the one used with foster carers but modified specifically for birth parents. All apart from one of the telephone interviews was audio recorded. (In one case the participant chose for notes to be made by the interviewer in preference to the call being recorded).

## **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. 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.

## Section 2

# The context: experiences of fostering

### Introduction

It is important to get a sense of participants' wider experiences of fostering, as a background within which to frame the sexual health and RSE needs of YPIC from the perspective of foster carers and birth parents. For this reason, more general but related contextual issues capturing participants' diverse experiences of fostering are considered here. In this section, the spectrum of fostering experiences is explored; this includes both positive experiences and the challenges of fostering. This general overview of participants' experiences of fostering is not unrelated to the sexual health and RSE needs of YPIC that are explored in later sections. As indicated in the literature review, positive family connectedness offers protections to the sexual health of young people (Wight & Fullerton 2013). There is evidence that foster care may offer protections over and above residential care in terms of early initiation of sexual activity (Carpenter *et al.* 2001). In this section the positive regard for foster children that some participants described is highlighted. Participants' reports of risk behaviours of foster children are also considered because, as indicated in the literature review, risk behaviours tend to cluster, and there is an association between risk behaviours (such as alcohol and drug abuse) and early sexual initiation.

### Diversity in experiences of fostering

A variety of placement types were described by participants. This variety gave rise to a diversity of experiences with individual young people as far as understanding their sexual behaviour was concerned. Some participants had up to 30 years' experience in fostering. They believed that the variety of scenarios that they experienced may partly be accorded to shifting sexual and behavioural norms and social influences (particularly social media) on young people over time. In view of changing discourses and practices associated with adolescent sexuality over generations, one participant with 22 years' experience of fostering teenagers noted that she continued to be on a learning curve in relation to it.

There were examples of what appeared to be highly successful placements, where foster carers who had come through the teenage years with foster children proudly relayed the young



people's progress in adulthood with their jobs, subsequent relationships and continued high levels of contact and engagement with them:

*Our experience of the children that we have had here for a good while and that have left us, they have fulfilling lives. Okay, it's difficult with the economy, but they are functioning, they are holding their own in society . . . The first two we ever had, they are out there, they work, they travel, they have families. One of them hasn't babies but a clatter of pets! . . . They are happy out. I am fascinated by the resilience for the most part. You see them making their way in life. They may go through episodes but they are in the mainstream.*

There were also those still in the midst of parenting teenagers, some of whom reportedly displayed challenging behaviour, who nonetheless foregrounded the positive dimensions of fostering in their narratives. Several participants spoke very warmly about the teenagers whom they currently fostered. A few expressed their wish that the young person would stay in the family home after the age of 18 years in view of the progress they had already made in developing social and emotional skills, and because of their bonds of affection for him or her. In the first example, the participant's 16-year-old foster son had experienced multiple unsuccessful placements and was described as having been 'destined for residential care' when he arrived at her home. His foster mother gave the following account of his character and progress:

*Behind it all he is a very honest child. He is a fabulous kid and that has helped him come to where he is today. He is a fabulous kid, and I feel he has learnt so much in this house but he has a decision to make. He can go home, and he has to decide. He could stay till he finished his education, but for us, we would have him forever.*

In another case, a 17-year-old young man who had previously dropped out of school had been successfully re-integrated into the education system under the guidance of his foster carers. His foster mother described his qualities and her hope that he would remain in the family home beyond the age of 18 years as follows:

*He's a lovely kid. I hope he'll stay after he finishes school. We're hoping to hold onto him that bit longer while he starts college and gets himself established . . . He's naturally affectionate.*

However, there were also accounts of what might be described as unsuccessful placements, where the challenging behaviour of the young person could not be managed or where the young person chose to terminate relations. In some such examples, the breakdown was accepted by both parties in the context of disharmony and conflict. While most of these unsuccessful placements pertained to relatively short-term arrangements with children with a history of multiple placements, sometimes breakdown was reported after a lengthy period of time (one after 12 years).

Overall, irrespective of whether placements remained stable or terminated, participants' accounts were heavily peppered with references to their foster children's risky and challenging behaviours. Many foster carers referred to the challenges of dealing with practices such as alcohol consumption and illicit drug use during the teenage years. While they acknowledged that these practices were a source of worry in the case of both birth children and fostered young people, the latter were believed to be more likely to be at risk. For example, one participant recounted how the placement with her foster daughter whom she and her partner had fostered since the girl was 20 months old had broken down, after the girl had become unacceptably abusive and violent in the early teenage years. The participant relayed that, following the placement breakdown, the young woman had chosen not to maintain contact with her and had experienced several subsequent short-term placements. The participant later learned that the teenager had become pregnant when she was 16 years old. In another case, a young man returned to his birth family when he was 14 at his request, having arrived at the foster family aged 19 months. His behaviour had become increasingly difficult to manage and involved alcohol abuse.

Challenging behaviour did not always signal placement breakdown. There were many reports of the foster carers managing difficult behaviours and accepting that there would be demands with which they would have to deal. Examples of challenges arising in placements that were current at the time of the interview included the case of a young woman who was reportedly having difficulty managing anger, observing curfews and attending school regularly (that girl had a history of several unsuccessful placements prior to being placed with the current family at the age of 15 years). Expulsion from school owing to using an illegal substance presented difficulties for another foster mother; her concerns were compounded when her foster son's education had to be completed at another educational centre where he would regularly engage with other teenagers with challenging behaviours whom she believed might influence him. Another participant's 17-year-old foster son had been involved in a traffic accident while intoxicated with alcohol in the week preceding the interview, and he had sustained substantial injuries.

It was not unusual for the same participant to describe having experienced both 'unsuccessful' and 'successful' placements. An unsuccessful placement with one child did not at all predict similar difficulties with another child. Indeed, very successful placements were reported following previously unsuccessful ones.

While later sections of this report focus specifically on the issue of sexual health and RSE with young people in foster care, the link between challenging risk behaviours and sexual behaviour was made explicit in the following account from a foster mother with 30 years' experience of fostering whose 17-year-old-foster daughter was engaging in prostitution (which had been brought to the attention of the HSE).

*Drink and drugs have an awful lot to do with it. And a lot of kids are on the game younger than 18 . . . Money has to come from somewhere and for girls in particular, being on the game is a very likely thing.*

It should be noted that the above assertions about young people and prostitution relate to the experiences of that particular foster carer and did not feature across the sample as a whole.

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

- Participants reported diverse experiences in relation to fostering, ranging from placements that were very stable and unproblematic to those that were very challenging.
- In spite of the difficulties that fostering often brought, participants were positively disposed to it.
- While several participants had experienced placements that had broken down, placement stability was widely reported, even in cases where a young person's behaviour required special attention.

## Section 3

# RSE and sexual health as an aspect of the fostering role

### Introduction

Before identifying what foster carers perceived to be the RSE needs of young people in their care, it is important to consider the extent to which participants viewed RSE and sexual health as a legitimate aspect of the fostering role. As will become clear as this section unfolds, most viewed it as an important aspect of their role, for reasons that we analyse here. The perspectives of foster carers as to how much of an input birth parents' ought to have is also explored, as are the views of birth parents themselves in this regard. Finally, the degree to which service-providers were reportedly involved in RSE with fostered children is also considered.

### The extent to which RSE was viewed as part of the fostering role

The extent to which foster carers viewed RSE with foster children as part of their role varied. Some indicated that they did not consciously engage in any RSE with foster teenagers because they did not see this as part of their role. Rather, they viewed RSE as the role of both the HSE and schools. This view tended to be confined to a small number of cases – but by no means all – where YPIFC arrived at the placement during the teenage years. Nonetheless, even in such cases, participants sometimes went on to describe dialogues with their foster teen that involved messages about relationships and suggestions about appropriate sexual behaviour. Moreover, they often went on to describe their engagement in developing the social skills and emotional sensitivity that are widely acknowledged to underpin the development of sexual competence (Hawes *et al.* 2010) although participants did not tend to explicitly make the connection. Indeed, in all of the narratives, to varying degrees, foster carers described having created a learning environment for sociability in its wider sense, much of the time embedded in everyday interactions in the home. This amounts to relationships' education in its wider sense. (Participants' role in emotional and social skills' development is considered in Section 6). It should also be noted that even in cases where a participant believed that the role of RSE was beyond their remit, they nonetheless engaged with the HSE in managing sexual health provision, such as in securing contraception, in cases where this arose. An example follows of a foster mother who, in response to a direct question about sex education, indicated that she did not engage in much sex education *per se*, yet did support her foster teenagers in

accessing a health clinic where they would receive sex education. It is also noteworthy that she reported having passed on messages about the consequences of sexual activity and attendant responsibilities.

*Interviewer: Do you take on a sex education role with the teenagers?*

*Participant: Not hugely. I can't get them to flush the toilet or to blow their nose, so I think the chances of me getting through to them aren't great. I'd send them to a sexual health clinic where they might feel more free to talk about it but I couldn't claim to be giving sex education. I would talk about having children and the responsibility when it comes up in other conversations - when someone is pregnant I'd be saying, 'God that's a big expense', trying to make it real, but I can't say I would give them the details of sex.*

In another case, a foster mother from the Traveller community (fostering Traveller teenagers who were from her husband's extended family) indicated that she did not undertake any sex education with either her birth children or foster children, as she believed it to be well understood among the Traveller community that virginity was expected until marriage. Indeed, that participant relayed that her birth daughter actually reprimanded her (the participant) for not preparing her (the daughter) for what to expect on her wedding night nor informing her about 'babies and pregnancy'. This participant also revealed that her second daughter, whose marriage was imminent at the time of the interview, would be too embarrassed to discuss sex with her. It was the perspective of that participant that there was no need to discuss sex (including contraception) with young people because the Traveller cultural practice of celibacy until marriage obviated any adverse consequences such as non-marital pregnancy. However, parents and foster carers were believed to have a role in 'basic' education, such as how to manage menstruation. Thus, as a foster mother, she felt that she had no role in sex education with her foster children.

### **Sexual healthcare and RSE as a central dimension of the fostering role**

In the majority of instances, participants viewed RSE explicitly as part of their role, and some saw it very much as part of their role. For example, one foster mother presented a strong argument that sex education was an essential component of empowering YPIC and therefore an essential part of the role of being a foster carer. Moreover, in her estimation, providing text-based information about sex was no substitute for openly discussing sexuality which was a basic dimension of a child's education.

*You need to empower . . . I don't think people talk enough. I'm not saying that my way is perfect, but some kids get given a book and there's no discussion. I think that people need to have it explained to them that this is an important part of foster carers' role in educating and as important as going to school and learning to tie your shoelaces. . . . I think as a responsible parent you have got to make the effort.*

In another instance, a participant who reported that discussions about sexual health embarrassed her 15-year-old foster son, nonetheless was upfront with him about her responsibility as his foster mother to equip him with skills that would enable him to maintain sexual health. His sensibility about the delicate matter of sex did not supersede her sense of duty as a foster carer.

*I always tell him fostering is a job for me as well. I say, as much as I love being your mum, part of my job is to teach you to cook, teach you to go out in the world and teach life skills and one of those life skills is to be able to behave yourself sexually and all that. I have done that from the beginning.*

That participant described how she insisted on providing sex education, even where the teenager was reluctant to engage with it. Her strategy was to allow him a little leeway with the timing, but to ensure that it was done.

*Sometimes he is reluctant – I'll say, 'I'm going to have the embarrassing conversation again, - Are we ready?' [Laughs] There have been one or two times he would say, 'Do we have to talk about that now?' So I would say, 'No, we don't have to talk about it now, but we will have to talk about it'. . . . And he knows that he does have a time limit of a couple of days and he has to get it over with.*

Another also suggested that her sense of responsibility to undertake the role took precedence over her foster son's temporary sensibilities.

*I would say to [name] now, I'm sorry that I have to tell you this chat, but unfortunately it's something that parents have to tell their children, because afterwards it's no good if something happens and they said, 'You never explained this to me'.*

Another participant revealed that she herself was sometimes uncomfortable in undertaking sex education and had to push herself to do so, because sex education was seen as a key part of her role.

*Oh there's parts of you that doesn't want to do it [sex education]! Parts of you say, 'I'm not in the humour today, maybe I'll do it tomorrow', but you do need to do it, but you have to do it. I think so. It all has to come out in the wash.*

One of the issues raised by a foster mother was the difficulty in undertaking sex education (in its narrow sense) with young people on short-term foster placements because the bonds of trust and familiarity may not be developed sufficiently. Another participant noted that while 'at the end of the day it's down to you to show what's appropriate', young people get 'proper' sex education at school. Indeed, many participants viewed schools as having the strongest role in RSE. A participant who had completed a Train the Trainers course with the Irish Foster Care

Association reported that her exposure to the course had increased her awareness about the vulnerability of YPIC to sexual health problems and unanticipated pregnancy as well as the psychological impact of being in care on their emotional health. She would not have otherwise been aware of the importance of sex education, she revealed, and indicated that she had only become confident in engaging in sex education since completing the course.

### Birth parents' role in RSE

Information about the role of birth parents in relation to RSE and sexual health was gleaned from both foster carer participants and the five birth parents who participated. For the most part, there was a high degree of consistency between the accounts of each group insofar as virtually all foster carers believed that birth parents did not deliver any RSE to the young people, and birth parents themselves largely confirmed this. It should be noted that a wide variety of contact arrangements between birth parents and their foster teenagers were reported by foster carers, including no contact at all with either birth parent, supervised contact in the presence of a social worker, and regular weekly visits. All five birth parents interviewed had regular contact with their birth teenager of at least once a month.

All birth parent participants expressed their uncertainty as to how much RSE was being delivered by the foster carers as it had never been discussed between the two parties.

*I don't know, to be honest with you. It never came up and, well, nobody ever mentioned it, to be honest.*

Birth parents also reported that they believed that RSE was being delivered at school and two mentioned the possibility that social workers might engage in it. The general vagueness about RSE delivery on the part of birth parents is captured as follows:

*Well no, I haven't covered any of that. The schools do that anyway. I haven't a clue about the foster mother if she does any. Or maybe it's the social worker. I don't do it anyway.*

It should be noted that none of the birth parents interviewed objected to RSE being covered by either foster carers or school. When asked if they had a view on the content of the RSE, again, none had strong views about this; rather, it was evident from the narratives that these birth parents were positively disposed to RSE being covered. This was the case also for the birth mother interviewee from the Traveller community. This participant expressed strong views that sex should occur only within marriage, yet she approved of comprehensive sex education being offered to her daughter.

As well as their belief that RSE was being conducted by others, two of the participants indicated that the level of contact they had with their birth teenager and/or structured visits of a fixed duration were not conducive to discussing sexuality.

*You see, I just see them on a Sunday and you don't, well you can't really say anything then. They're not with me all the time. That would be different.*

*We wouldn't talk about that [sexual issues], no. I wouldn't want to. It's a short time with them and schools are doing everything like that now.*

In just one case, in an interview with a foster mother, there was a reference to some communication between herself and the birth mother about an RSE issue. The participant described having informed the birth mother of what she had covered with the girl (who was 11 years at the time) in relation to menstruation and invited the birth mother to make her contribution to the girl's knowledge.

*Now the birth mother might say [re daughters] 'They're at the stage where they might be getting their periods should I say something?', and I'd say, 'This is what I've said, and you can add your bit if you want to'. Most of her visits were supervised so she would have said it in front of a social worker.*

To summarise, it seems that the birth parents interviewed had almost no role in the RSE of their birth child. When asked if they were satisfied with the current arrangements for RSE delivery, all five birth parents indicated that they were, and none believed that additional supports were required to help them engage with the role.

### **Service-providers' role in RSE**

The extent to which service-providers, that is, those with a professional role in providing social, health and educational services, were reportedly involved in RSE with fostered children varied widely - from accounts of fairly heavy involvement to a perception that there was no involvement at all. Several participants were of the view that RSE was implicitly left to the foster carers and they accepted this. A few others spoke of relaying back to social workers the thrust of the RSE that they had delivered, but, as is noted in the following quotation, the RSE appeared to be at the discretion of foster carers, who themselves took on this role voluntarily.

*Participant: When I'm speaking to the social worker I will say that I've had this conversation [with foster child], but nobody has asked me to have this conversation.*

*Interviewer: Would it have been on the care plan that it's been discussed?*

*Participant: No, it wouldn't, no.*

Another participant who similarly found that social workers left RSE to the foster carers reported that there appeared to be a good degree of communication between foster carers and social workers during annual case reviews as to the substance of the RSE the young person had experienced.



*It comes up in reviews, yes: You are meeting your milestones, what kind of programmes have you done with them, have they done this in school or that in school. They know about them, what you are doing.*

That participant also shared an experience that is peripherally-related to professional involvement in sexual health, namely, the complexity that bureaucracy created when his foster daughter was to receive her vaccination under the National Human Papillomavirus Vaccination Programme: Because the form for her vaccination could not be signed by one of her foster carers, she was unable to receive her jab on the same day as the rest of her classmates.

Another participant reported that the RSE needs of his foster daughter had been discussed among the young person, the foster mother and the social worker, and the social worker appeared to have a checklist of issues to cover. This foster father was very positive about the engagement of the social worker in the foster child's care, including attending to her sexual health. The dialogue with the social worker was two-way, he explained. The social worker supported him and his wife in keeping them aware of issues, and they had raised concerns about the young woman's sexual health with the social worker as appropriate.

*We would have very good experiences of the social worker. And part of it is we would have a very frequent dialogue . . . We are not afraid to call the social worker and leave messages. Because, again, we don't want to be in the situation where they feel they are not informed of changes that are happening for the child.*

A few referred to other health professionals who interface with YPIC having a role in RSE. One participant indicated that her foster teenagers had been referred to a health clinic by a social worker. Her perspective was that this was a preferable way for RSE to be delivered than for her to deliver it herself.

*They [foster teens] have been to the clinic where they might feel more free and got all their information there and they have done courses on it, because I just feel they wouldn't listen to me.*

When asked if they would like additional support from professional service-providers in undertaking their RSE role, most participants struggled to identify what would help.

Virtually all participants, both foster and birth parents, viewed schools as having a major role in RSE delivery. Some foster carers who were heavily engaged in the life of the school were familiar with the content of RSE at school. Others who were less engaged with schools reported receiving information about RSE from parents meetings and communication from the school. However, most foster carers, in keeping with findings from the Parents' Study (Hyde et al. 2009) of parents in general, reported that they were not familiar with the substance of the RSE being taught at school, but they assumed that it was being undertaken in depth.

### Key points: Section 3

- The degree to which foster carers perceived themselves as having a role in delivering RSE to foster children varied, with the majority viewing it as part of their role.
- Those foster carers who did not see RSE as part of their role viewed it as the responsibility of both the HSE and schools.
- Where participants declared that RSE with foster children was not part of their role, they nonetheless described scenarios and situations involving foster children where social skills and emotional literacy - essential foundations for sexual health - were facilitated.
- Some foster mothers indicated that they insisted on undertaking RSE with foster children, even where the young person signalled a reluctance to engage with it.
- The birth parents interviewed indicated that they did not engage in RSE with their birth child.
- Professional involvement in the sexual health of foster children reportedly varied from a high level of engagement to very little. Several participants contended that RSE was implicitly relegated to foster carers and they accepted this.
- A strong and consistent theme was that schools were viewed as having a major role in RSE delivery.

## Section 4:

# Perspectives on the sexual attitudes and behaviour of YPIC

### Introduction

What participants constructed to be the RSE needs of YPIC tended to be derived from their own experiences with foster preteens and teenagers in the course of current and past placements. In order to explore participants' views on what young people in foster care need as far as sexual health and RSE are concerned, it is thus important to draw on their experiential knowledge of the sexual attitudes and behaviour of YPIC whom they had encountered. Indeed, it was this experiential knowledge that enabled participants to identify the sexual health and RSE needs of YPIC, which is the focus of this entire report, and considered intensively in Section 5. In this section, in addition to foster carers' perspectives on the sexual attitudes, demeanour and behaviour of fostered teenagers, we also identify how participants learnt about the sexual activity of young women in their care. (Their knowledge about the sexual activity of young men was notably absent in the narratives.) It should be noted that there is no claim being made here that participants' views amount to an objective measure of the attitudes and behaviours of the young people; rather they provide rich data on the impressions and experiences of these foster carers, many of whom were highly experienced in the fostering role. Though no participant had directly experienced a teenager in their care becoming pregnant, we close the section with their perspectives on pregnancy among foster teenagers after the placement in their care had ended.

### Foster carers' perspectives on the sexual attitudes and behaviour of fostered teenagers

With regard to matters of sexuality, individual foster carers reported different experiences depending on the individual teenager; notwithstanding this diversity, there was a general acknowledgement that fostered teens tended to present more challenges than did birth children when it came to overseeing sexual health. The different experiences of the same foster carer are captured in the following quotation in which the participant described one foster daughter as not posing any particular challenges in terms of her sexual health, while the other was found to be very demanding in this regard.

*I have had two very different experiences with girls. One was very sexualised, and I would say very damaged by the time she came to us at 11 . . . Another had a very tough past, but she was resilient and actually, apart from a few storms here and there with us, got on the right track and was quite biddable really. She didn't carry on in the same way and had the one fellow for a good while.*

Most of the concerns and challenges reported by participants were related to their experiences of foster daughters (rather than sons), who tended to be viewed as more sexualised in their demeanour than birth daughters. In response to a question as to whether he found fostered daughters different to birth daughters, a foster father responded in the affirmative as follows:

*Way more sexualised than my natural<sup>4</sup> daughters. Oh, way more. She [foster daughter] was fairly immature but was sending off these signals by her attitude.*

Describing a thirteen-year-old girl whom she and her husband has previously fostered for eight months, one participant spoke of her concerns regarding the young woman's sexualised dress practices, which, she reported, were different to those of her slightly older birth daughter. As the quotation indicates, the young woman's self-presentation in the presence of males was interpreted as sexually precocious and inappropriate.

*Participant: When she was with us, her dress was an issue. She liked to wear very low tops . . . we obviously had to say something. Now if there was any males around, you would see a difference – she was more sexualised – she seemed old, more like mid-teens than 13.*

*Interviewer: In what way?*

*Participant: How would you say? It's hard to describe, but sort of [pause] suggestive, or well, trying to act sexy – it wasn't good.*

Several other participants who had experience with adolescent foster girls also made reference to the manner in which they believed the latter dressed and presented themselves in a culturally-defined sexually suggestive way. That the demeanour of young fostered women in particular was identified as problematic compared to that of young men may reflect continuities in how teenage girls in general are perceived by parents; Hyde *et al.* (2012) found the same pattern with parents among participants of The Parents' Study (Hyde *et al.* 2009). However, the finding that fostered girls were viewed as more sexualised than birth daughters is an important one.

### **Foster carers' perspectives on sexual activity among their fostered teens**

Turning to foster carers' perspectives on sexual activity among their fostered teens, a dominant feature of data was a tendency to believe that their teenage foster daughters in

4 Some participants used the term 'natural' when referring to birth children. This term tends not to be used in social care scholarship because of its potential to cast children other than birth children as 'unnatural'.

particular, were, or at least may be, sexually active by their mid-teens. This was particularly so where the young woman had arrived at the placement in her preteen years or where the placement was short-term.

*Participant: Her issue would be she is very sexual - very. She would have to have sex three to four times a month at 15 years of age.*

*Interviewer: And is she still having sex regularly [girl is now 17 years]?*

*Participant: She finds it very hard lately to get boyfriends.*

*Participant: She has been too much around – she's been with all the boys locally in [small rural area], and there's nobody left.*

*Interviewer: Would you say she's has sex yet [16-year-old foster daughter]?*

*Participant: Well, definitely I'd say she's had something, maybe oral, that's what they do nowadays, but you know, I'd say she could have, it wouldn't surprise me.*

Foster daughters' dress and attitude sometimes sent signals that they might be sexually active. There were also cases where foster carers believed that a foster daughter was not sexually active, their rationale being based on the fact that the young woman was too young (as an early teen) or that opportunities were limited by virtue of evening curfews and house rules, or that the family home was in a rural area and not conducive to peer liaisons. However, participants who were most experienced in fostering teenagers tended to be more likely to believe that these factors would not deter young people (male or female) from being sexually active. They reported that sexual activity among foster teens, particular those coming to foster placements later in their childhood, was happening from very early teen years and in a range of locations and not confined to evening or night times. Responding to a question as to whether she believed that foster teens in her care were sexually active, a woman with 30 years' experience responded as follows:

*Yes, I do. I wouldn't put my head in the sand, and when you are fostering you tend to get real, you don't pretend.*

When participants were asked about foster sons, and whether they had concerns about their sexual behaviour, in general foster carers had greater concerns about risky behaviours such as alcohol and illicit drug use over and above sexual behaviour. One participant suspected that his foster son was using cannabis and had spoken to the social worker about this. Another had experienced a foster son receiving a Garda caution for anti-social behaviour. Smoking cigarettes was commonplace across the sample for both boys and girls, something which many foster carers seemed to accept as a lesser transgression than other behaviours, even though a few registered their sense of disgust at the practice. Ensuring that his foster son attended school regularly was a concern for one participant. A few participants had experienced concerns about the company their foster sons were keeping. In one case the

participant believed that his foster son was being influenced by peers he associated with prior to the placement. Although a range of possible risk behaviours dominated the interviews in relation to young men, sexual behaviour and early fatherhood did feature, albeit to a lesser extent than was the case with young women. These will be considered in Section 7.

Compared to the findings from the Parents' Study (Hyde *et al.* 2009), where most parents believed their teenagers were not sexually active before the age of 18 years, participants in the current study were more likely to report that their foster teen was or might well be sexually active.

### **Foster carers' sources of information about the sexual conduct of foster daughters in their care**

How foster carers came by information that their foster teen was sexually active varied and they tended to be far more conscious of sexual activity among foster girls compared to boys. In a couple of instances, the foster mothers indirectly broached the subject after piecing together clues that alerted them to possible signs of sexual activity. Dress, demeanour, and attitude sometimes sent signals that the young woman might be sexually active.

*I had it at the back of my head that she [aged 15 years] needed to be watched. There was something about the way she dressed, and I had a feeling that she was keeping stuff from me - sure they all do - so I said, 'Would you like to talk to [names social worker]? It's very easy for a girl to get pregnant', and all this sort of thing. I was picking my words, so she kind of fuffed some answer, so I said it to the social worker who said okay, she'd talk to her.*

In the above case, the participant subsequently gleaned from the social worker that the young woman was indeed sexually active, and contraception was accessed via the social worker's liaison with the birth mother. Another foster mother similarly described non-specific clues that alerted her to the possibility that the young woman (aged 16 years) might be sexually active. It was on this basis that she broached the subject with the girl. As in the previous case, the social workers intervened. At a later point in the interview the participant reported that she had no further discussion with her foster daughter about the issue once access to contraception was put in train.

*This girl [16 years] was very sexual, and I got the impression that she didn't have boundaries - awful really. So I actually asked her would she like to go to the clinic for contraception, that's all I said, and she didn't say no, so I got on to the social worker. I was sure that she would become pregnant on my watch.*

In the case of another participant, a friend of hers who also fostered teenagers 'tipped her off' that her 14-year-old foster daughter was mixing in a group where sexual activity among group

members was suspected. That participant told the social worker of her suspicions, who in turn spoke to the young woman.

In another instance, a participant was alerted to the fact that her 16-year-old foster daughter had had unprotected sex with her boyfriend at his home, unknown to both her and the boy's parents. The matter came to the fore on foot of a family house rule specifying that if one member was aware that another was 'in trouble or at risk', then the foster carers ought to be told about it. That participant explained that she had emphasised to all of her foster children that revelations intended to keep another family member safe did not amount to 'squealing' or 'tell-taling' but rather should be interpreted as protective. This is exactly what reportedly transpired: One foster daughter, aware of her foster sister's sexual liaison with the young man, informed her foster mother.

There were also cases where the foster teen was reportedly completely uninhibited in acknowledging that she was sexually active. According to one participant, her foster daughter (who arrived at the placement aged 15 years) openly discussed her sexual experiences with a range of local young men, rating her estimation of their sexual prowess.

An aspect of the personal experience of another participant was that a 17-year-old foster child of hers had been exchanging sex for money with older men, an issue that emerged during group counselling for a drug addiction that the young person had developed. In the course of the group counselling, it was revealed that several other young people, including those not in care, had had the same experience: prostituting themselves in order to feed their drug habit.

*Participant: When I went to rehab with one child a lot of the kids in rehab, not necessarily in care, had been on the game.*

*Interviewer: How do you know?*

*Participant: It was discussed openly in a group. When you go with your child it's discussed in group work. Being on the game is particularly common in [names city] Most of the girls seemed to be doing that.*

In a different case, a foster mother gleaned information from her 16-year-old foster daughter that she may be sexually active though something that she had said a few months previously that made sense in the context of new information.

In almost all instances where foster daughters were deemed to be sexually active, the matter was dealt with by the foster mother rather than the foster father, for reasons expanded upon in Section 10. In these cases, professionals were made aware of the sexual activity. Participants' experiences in dealing with service-providers in relation to the sexual health of a foster teen are considered in Section 9.

### Foster carers' experiences of teenage pregnancy among YPIC

A few participants among the sample considered here made reference to foster children who became pregnant after the placement ended. One participant referred to two teenagers whom she previously fostered who were currently pregnant (at the time of the interview), one who was 17 and the other 18 years old. In the following quotation, a foster father gives his view on why his foster daughter had become pregnant on leaving care, citing both his assessment of her low maturity level and a family history of being in care.

*As it turned out she became pregnant when she left us. I'd imagine it was purely because of the fact of her immaturity . . . She had the baby at 16, no, 17. I think she has two kids by now. She was in a bad place. All her brothers and sisters had been in care. Her mother had been in care. Totally and utterly a cycle.*

Another participant contended that the fear, stigma and social exclusion that motivated her generation to proactively avoid pregnancy had no impact whatsoever in the current period. She felt that this - coupled with a lack of opportunity and the need to be loved - created a cocktail that propelled YPIC towards early pregnancy.

### Key points: Section 4

- Although individual differences in attitudes and demeanour of foster teenagers in relation to sexuality were reported, there was a shared recognition that fostered teens tended to present more challenges than did birth teenagers in terms of sexual health.
- Teenage girls who were fostered were believed to be more sexualised than those not in care.
- In many cases, foster carers acknowledged that their foster teen was or might well be sexually active, even by mid-adolescence.
- Foster carers expressed greater concerns about the sexual behaviour of teenage fostered girls compared to boys; risky behaviours such as alcohol and illicit drug use were dominant concerns with fostered boys.
- Foster carers reported becoming aware that a foster teen was sexually active in a variety of ways, ranging from implicit acknowledgement to open admission by the young person.



## Section 5:

# Perspectives on the sexual health and RSE needs of YPIC

### Introduction

In this section, participants' perspectives on the sexual health and RSE needs of YPIC are analysed. To clarify, the focus here is not so much on how participants approached or delivered RSE and sexual healthcare (this is the substance of Section 7), but rather on what they believed YPIC need as far as sexual health and RSE are concerned. The emphasis in this section is therefore on participants' macro or general perspectives on the sexual health and RSE needs of YPIC. We begin by considering participants' views on how much and what kind of sexuality-focused education and information-giving YPIC need. The focus then shifts to their perspectives on the wider needs of YPIC, such as the need for social and emotional security that impact on sexual health.

### Sexuality-focused education and information-giving

The extent to which sexuality-focused education, that is, imparting knowledge of reproductive science (anatomy and physiology) and safer sex was seen to be important to address with YPIC varied across the sample. A number of participants made a point of conveying that deficits in education with a direct focus on sex were not the main challenge or barrier to good sexual health for this group, since this information was already widely available.

*Participant: Sure, they have all the education. In our day there was no education but now there is, there is plenty of education.*

*Interviewer: And do you think that people have the knowledge - the children in care, do you think they have the knowledge of how you get pregnant, how to use a condom or buy a condom, all that kind of scientific and practical knowledge?*

*Participant: They have. They are getting that in school as well.*

*Interviewer: And practical knowledge?*

*Participant: They have.*

Another participant described her 17-year-old foster daughter, who was found to have been engaging in prostitution, as not being 'short of information' in the sense of knowledge about contraception. Another participant, who believed that she had invested a great deal of time and effort into educating her foster daughter about ovulation, menstruation and conception, revealed that she was 'devastated' when she learned that the young woman had become pregnant within a short space of time following the breakdown of the placement. Her conclusion was that since the young woman was well-equipped with knowledge of sex and conception, the pregnancy was planned.

*I was devastated when she became pregnant, because I would have felt that I had taught her more than to do that. So it was planned, I think so.*

In the accounts of several other participants it was also suggested that sex education in the narrow sense of conveying facts of conception was not the main need. Motivation to prevent a pregnancy was seen as a greater need, as is proposed in the following account where the participant contended that the prospect of a pregnancy in the face of limited options might be welcomed by young people.

*I don't honestly think that it's a lack of sexual education . . . And I do think that a lot of kids that are not from great backgrounds would love to have a baby.*

A consistent and strong theme was that the cycle of disadvantage for YPIC should be stopped as a priority and that factual education should focus on the consequences of having a baby. Across the sample, there was far less emphasis on the need to equip YPIC with factual knowledge to protect themselves against STIs than on the need for education on the implications of a pregnancy. When prompted, though, participants agreed that young people were also vulnerable to STIs. Virtually all participants made some reference to pregnancy, and it was the main focus of a few of the narratives, with some participants revisiting it at various points during the interview. The quotation that follows was from a participant who was extremely strong in her position (and emphasised it several times during the course of the interview) that the biggest consequence for any individual 'far greater than any STI' was that of having a baby, irrespective of one's circumstances.

*My concern would be, I think they know the facts, like how you could get pregnant and things like that, but I think we as a nation aren't good about consequences anyway, and I think kids in general wouldn't be that good about consequences. Like, boys would have no intention of raising a child just because the girl happened to get pregnant. Outside of sex education in the narrow sense is the education of consequence, like that there is a child. Okay, the diseases and other possibilities. Because I think that that is often missed in the mix – they are talking about, you might get a disease, and you might get this and that, but you might get a baby, which is a much bigger consequence than any of the others.*

She clarified that she did not 'begrudge' teenagers the pleasure of sexual intimacies in the case of non-abusive peer sex, provided that safer sex was consistently and responsibly practised. However, she - and indeed several others across the sample - believed that actively teaching the responsibilities involved in caring for a child should be a priority, as pregnancy without social readiness had such far-reaching personal and societal consequences. Her perspective was that in the case of YPIC, their parents did not take responsibility for them 'and their parents have other children by other partners all over the place'. In her experience of 30 years' fostering, she found that many YPIC did not have a developed sense of 'the concept of an adult caring for a child'. (In this regard, limited emotional connectedness is seen as underpinning their lack of appreciation of the responsibilities of parenting. The participant's account of the need for emotional learning on the part of YPIC is considered in the next section). She went on to describe the challenges for YPIC in grasping the scale of parenting responsibilities because their repertoire of understanding was restricted by their own experiences. For her, enlightenment on the consequence of a pregnancy was the most prominent sex education need for YPIC.

*The biggest message in any sex education - school, home, whatever - is the consequences of having a child. Are you able to take care of it? Will you have your own home? . . . They [YPIC] don't have the idea that the child is their own and they have to start their own home and being a parent - it's not as clear - you are the parents financially and in every other way. . . And this is where the thing repeats itself, because you have one mother who has five children and none of those five children are aware that you should look after children, and they have five more and it explodes.*

It was the view of another foster mother that the responsibilities of caring for a child should be part of the school curriculum. In her account, she alluded to the structural inequality that underpins the cycle of disadvantage, yet what she proposed as a means to address this was individual behavioural change through pregnancy prevention rather than societal reform to reduce inequalities.

*There should be an exercise in school - what does it cost to feed a baby? What does it cost for nappies a week? But you see, for people who aren't well off, they see themselves as having a flat and having a grand life, whereas otherwise how are they going to get a flat? That's the only thing they know. They wouldn't be planning on having a job because there wouldn't be a history of it. They are likely to have addictive personalities because both their parents are addicts before them.*

Another participant who held a similar view expressed this as follows:

*But the training I think has to come in - that they will have babies, they have to be reared, they have to be minded from 0 to 90, as we all know if you have children. They are always your children - even when they are adults they are still your children. That's where the*

*focus should be: give them a baby or a – you know these fake things – to mind, that will cry and not give you a minute . . . Then there would be no babies for the State to mind.*

That participant, at a different point in the interview, also acknowledged that the problems experienced by YPIC were created by societal factors such as poverty, inequality, and a lack of opportunity that lay in wider society and not in the individual. Nonetheless, she tended to be of the view that the most immediate priority was to stop the cycle of disadvantage through pregnancy prevention.

*These kids are not to blame for their situation. Actually, they are easy targets for blame, seen as having babies willy nilly, no responsibility, welfare spongers and all the rest, drugs, what have you. But they didn't ask for their situation. That said, the first step is to break the cycle and empower them. It's harder to empower yourself if your life is taken up with a child. And if that means the bar [contraceptive implant] or whatever, bring it on . . . They need to know the importance of that.*

Another participant identified the need for young men to be made aware of the consequences of their sexual actions to a greater extent. Her contention was that 'The boys need the message more than the girls because the girls make some effort at raising their children'. Her view was that rather than focusing on young women, whom she believed were too readily castigated for early pregnancies, wider societal changes that would act as a deterrents to fathers who shirked their parental responsibilities were required. Among her suggestions were the need for absent fathers to pay maintenance from their social welfare in situations where this was their income source in order to 'make them think twice than having children willy nilly'. (This already happens in the UK).

When participants were asked whether YPIFC had specific information needs around lesbian, gay, bisexual and transgender (LGBT) issues, there was largely a sense of uncertainty expressed about what these needs might be. This appeared to be because none of the participants reported having encountered issues around LGBT with a foster teenager. Several expressed the view that they would not respond adversely were a foster teenager to express an LGBT identity, and there was a general sense of acceptance that this was a matter for the individual young person.

Before closing this section, it should also be noted that, while factual knowledge about sex in the narrow sense was not deemed to be the greatest need for YPIC (as has been illustrated above), it was not universally dismissed either. It should also be noted that in spite of the fact that a number of participants were of the view that YPIC receive factual RSE from other sources, international studies have found that YPIC display gaps in their knowledge about safer sex and how to access sexual health or contraceptive services (Scott & Hill 2006; Dale 2009; Dale *et al.* 2011). Also, in spite of anecdotal reports that young people in general have never historically had more information available to them about sexuality, 'large swathes of

ignorance about reproductive physiology' were found among a general sample of secondary school children in Ireland (Drennan *et al.* 2009, p. 249). Because YPIC are more likely to have gaps in their education and to have missed lessons at school, their needs in this regard may be greater than those not in care.

Some participants went on to describe undertaking focused sex education with their foster child, an issue that is developed in Section 7.

### **The need for emotional security and social skills' learning**

Embedded in the narrative of virtually every participant was some reference to the need for emotional security and emotional stability among YPIC. As indicated in the literature review, emotional security manifested in family connectedness plays a major protective role in sexual health (Wight & Fullerton 2013), so participants' prioritising of this has good support in scholarly literature.

One foster mother contended that, in her extensive experience of fostering, very often children who come into care 'are on their own' and not 'watched over', leading to emotional insecurity. Another recalled the day that her two foster daughters arrived at the placement, describing the scene as they sat in her living-room. They had just been moved from the family home in which they had witnessed domestic violence with their possessions in refuse sacks, described by the participant as having 'their whole lives in black plastic bags'.

A lack of trust was also identified as a difficulty for YPIC. This was experienced by a participant whose foster son had recurrent experiences of being rejected, including in a previous placement where he was reportedly under the impression that he was going to be adopted. Another described YPIC as lacking a level of permanency and consistency ordinarily enjoyed by children in stable families. Her view was that the insecurity often experienced by YPIC stays with them, even in foster care, because of the possibility that any transgressions on their part might result in the breakdown of the placement, an insecurity not shared by children living with their birth family.

*It is different for children in care because of the responsibilities parents have regarding statutory requirements, and if things get out of hand, it could result in breakdown. For birth children that doesn't happen. They might hit you and they'll think they will be put out. Your own could hit you and they won't be.*

Her view was that feelings of insecurity lend themselves to a lack of confidence, poor self-esteem, and low self-worth. There was a need, she proposed, to build up the young person's confidence in a realistic way by identifying their strengths.

*Children in care feel somewhat powerless. They don't have the level of permanency and consistency. I haven't met a [foster] child yet who doesn't have issues with confidence, self-esteem or self-worth, and you need to build them up in confidence but realistically. If they are not good at football it's about trying to put something else in.*

Both she and a number of others were of the view that building confidence and emotional security were rooted in the commitment of the foster carers, and the young person's belief in that commitment. One participant described the incremental development of this security over time.

*My big thing for foster children is that they have to believe that you are committed to them. They don't believe that you'll stick with them and it's only over time that they see that you really will.*

A component of emotional development raised by some participants was the need for YPIC to learn social skills. Virtually all accounts by participants in the study relating to social skills teaching were associated with their direct experiences with their own foster children. This issue of social skills' teaching is considered in depth in Section 6.

### ***Emotional insecurity linked to sexual behaviour***

Many foster carers directly linked risky behaviours, including sexual behaviours and relationship difficulties, to emotional insecurity. The impact of these unmet needs on establishing and maintaining relationships later in life was recognised, even in children who were placed for foster care in infancy.

*People say it's easier when you get them younger, but they will still have to deal with the issue of rejection. Their mum or dad didn't stick with them and that stays with them, it never leaves them.*

*You see, you don't know what life was like for them during the baby months. I hear all that stuff about attachment and the first year is the most important and if you grow up with damage done in that first year, it stays with you and follows you throughout your life in your later relationships.*

*You often have to stick with relationships and work on them, but if you feel you've been rejected, or it's somewhere at the back of your head already that you are a failure, so all of this emotional stuff comes to the fore - more so for foster children.*

While heavy alcohol and drug use was perceived to be part of contemporary youth culture, the vulnerability of YPIC to engaging in unhealthy practices and relationships was associated with their sense of emotional disconnectedness by the following foster mother.

*And they are getting so drunk when they are out that they are anyone's. It is the culture now of drinking, drugging and sexing. It is very sad - very, very sad. And a lot of these children, from what I can see myself, they are lonely - they really have nobody. So they can latch onto anybody for any reason.*

Another described a foster daughter whom she found to be demanding as childish and emotionally immature in her mannerisms; however, she believed this immaturity led the girl to be excessively sexually experienced for her years. A different foster mother suggested that the reason for high levels of promiscuity among YPIC was because they were in competition with each other about image and attempted to out-perform each other in terms of risky behaviours. This arose, she contended, because of emotional insecurity. It was noted by several other participants that where emotional needs had not been met, YPIC substituted their need for love and security with sex.

*I see the way in which they are acting all the big man or girl, whatever, and think that they can find people easily to have sex with, and 'this will show everyone' kind of thing, but all that is is grasping at something to fill the void of being loved, or not being loved, I mean.*

*It's hard enough if you are the actual child, the natural child, when you're a teenager and all the insecurities that's normal in teen years, but without that solid someone who loves you - now there might be war in the house with your own, but deep down they know you love them. They don't have the same issues as foster children who may have doubts and go after any relationship to fill the emotional gap and are sexually promiscuous.*

The emotional vulnerability of foster children was also recognised by a male participant whose 12-year-old foster daughter had thus far negotiated the preteen transition admirably. Yet, because of her friendly and outgoing personality, he intimated concerns about her capacity to discriminate between acceptable situations and risky ones as she moved further into her teens.

*The foster child has been with us for a long time and she flipped from primary to secondary and we thought that was going to be a big jump, but actually she has blossomed in there; she is really enjoying it and she is very friendly, very outgoing, but . . . you know, is that going to bring her into a risky situation? Will she even know she is in a risky situation? She is in the youth club as well so she is mad to go to all the discos and stuff like that and you are thinking, okay there is a bit of a journey there.*

There were several examples of current and former foster teens engaging in relationships that the foster carers deemed to be dysfunctional. In one case a woman described a situation where a foster daughter, after leaving care, had persistently been assaulted by the father of her baby. As far as young men were concerned, two participants stressed the importance of

the need to teach young men to feel responsible for their sexual behaviour and the outcome of this behaviour.

To summarise, in terms of what participants believed that YPIC needed as far as sexual health and RSE is concerned, it was clear that a central need was for emotional security and stability as a prerequisite to good intimate relationships. That participants placed so much weight on this issue is consistent with the emphasis on the significance of emotional security and social skills in scholarly literature in relation to YPIC. Low self-esteem, loneliness, mistrust of others, lack of assertiveness and lack of perceived choices and opportunities have all been found to influence risk behaviours among YPIC (Haydon 2006; Berrington *et al.* 2005).

### Key points: Section 5

- Science-based information about sexuality was not largely seen as a priority for YPIFC since the belief was that this was already available to them.
- Some foster carers strongly believed that factual RSE should include information on the demands of childrearing.
- No participants reported having encountered LGBT issues with foster teenagers, and thus did not identify any particular needs for YPIC in relation to sexual orientation.
- There was widespread agreement that YPIC need to learn social skills as a basis for good sexual health.
- There was overwhelming agreement that, against a background of instability and inconsistency in parenting, YPIFC need emotional security and stability as a prerequisite to good intimate relationships.
- Building confidence and strengthening self-esteem and self-worth were considered to be key needs to underpin good sexual health.



## Section 6:

# Imparting social skills and facilitating emotional learning

### Introduction

The previous section focused on what YPIC need as far as RSE and sexual health are concerned from the perspective of foster carers. In this section we move on to what participants said they did with their foster children when it came to imparting social skills and facilitating emotional learning. It is well established in the literature that competence to negotiate sexual relations is influenced by social and emotional skills. It is, of course, difficult to isolate relationships' education related to sexuality from promoting competency in wider social engagement. This is because all human interactions involve relationships of some sort, and the acquisition of social skills for one component in life (e.g. non-sexual) may well be transferable to another realm (the sexual). In this section, the manner in which participants reportedly helped the young people in their care to develop emotional and social skills is considered. Much of this 'teaching' by foster carers was described as occurring informally, in everyday situations such as during the family meal. The opportunities for social and emotional learning in other routine daily encounters will also be explored, as will participants' experiences in prescribing acceptable boundaries and expectations.

### Imparting and developing social and emotional skills

A consistent theme throughout the narratives was the importance of transmitting social skills to foster children. Many participants did this indirectly, implicitly transmitting messages through family routines and norms. Rather than speaking in terms of 'teaching' social skills, participants tended to describe how an environment had been created within the home so that the foster child would absorb the habits, practices and culture of the home.

#### *Social learning and the family meal*

The most frequently occurring reference in terms of social engagement was to the centrality of family meals. In most cases, family members were obliged to be in attendance.

*My 15-year-old [foster child] is a very fussy eater and won't eat dinners, but is obliged to sit at the table and has no choice. This is what we do here.*

Attendance at the family meal was not just a rule for its own sake, but was used as an opportunity to engage with others, learn communication skills of turn-taking and listening, and feel part of a wider group.

*But as a family we sit down around the table to have our dinner. We are all talking and everyone gets a chance to get things out. That helps a lot. They all have a bit of banter, everyone has a chance to have their say. They are free to bring things up.*

It was also described as an opportunity to allow family members, including the foster child, to feel that their contribution mattered and was of interest to others, and allowed the foster carers to covertly monitor the young people's movements.

*Dinner could last an hour, an hour-and-a-half. It's my favourite part of the day – 'How was your day? Any craic [news]? What's been happening?'*

A few participants described the progress that had been made though insisting on the young person engaging in family routines, and several reported considerable success in a relatively short space of time.

*He came in first, he had no social skills - it was what he wanted when he wanted. He wouldn't eat for us when he first came. It took months, but now we've got him to eat what we eat.*

Rees *et al.* (2012), based on a UK study of parenting styles in relation to food in families where a child was fostered, argued that family meals served to define the foster child as an 'insider'. Other roles that mealtimes served were to show care and acceptance, as well as to monitor behaviour, which most children interpreted as benign and necessary. The authors' conclusion was as follows: 'The data from this study suggest that food practices played a positive role in these placements . . . [and] . . . revealed something more of food and meal-taking as both a medium and constituent of a caring relationship' (p. 111). There is also evidence in the literature that family meals as an indicator of parental engagement have a positive impact on development, social competencies and a positive identity (Fulkerson *et al.* 2006). Of relevance to the current study, Fulkerson *et al.* (2006) found that the frequency of family dinners was inversely related to a range of high-risk behaviours in young people, including sexual activity. To return to the present study, the centrality of the family meal for many participants suggests that this practice may have a positive, indirect spin-off in terms of sexual health.

#### **Everyday boundaries, expectations and advice**

Some participants described the concrete teaching of social skills, where they consciously made the foster child aware of house rules, particularly about boundaries and privacy. One participant described how she deliberately and overtly taught her foster children basic rules around privacy, building up an understanding incrementally.

*You are addressing the privacy issue first . . . Then you are setting the boundaries: like, you are in your bedroom, nobody else should be in there except yourself, knocking and so on. Then we talk about bathrooms - If the door is closed don't barge in. So you start with the very basics. Then with the girls, we talk about leaving the underwear on the floor, the sanitary pads, the privacy around that.*

Another described imparting social skills in a similar way:

*They know that when our bedroom door is closed you knock. You don't just walk into our bedroom. I've said, 'You're welcome to any area of the house, but when my bedroom door is closed please knock first, because I could be having a bath, I could be undressing'*

Talking to foster children about normal family routines was also very important for another participant. She pointed out that established everyday practices that give shape to the lives of children in stable families often do not have meaning for foster children. As an example, she referred to the stable routines that invariably occurred in her own home at Christmas, which were possibly similar to those of other local families, yet to foster children, these were entirely new. Being explicit about these was important, in her view.

*We talk to them, because I think you have to talk to them. I think that children in foster care need to be spoken to about things more . . . When children come into foster care, they just don't know, like, 'What do we do on Christmas Day?' You take for granted that they know because your children know, so you have to communicate everything with them.*

Another dimension of social skills education embedded in everyday interactions was managing challenging behaviour and emotions. In the quotation that follows, the participant describes how making her foster son aware of the needs of others and the importance of taking into account others' needs was part of his socialisation within the family. In the extract she also describes a technique of 'time out', where she allowed him time to release anger before advising him to apologise for unacceptable behaviour. His progress in developing social skills was also noted.

*He [16-year-old foster son] actually was a very difficult child when he first came - extremely difficult. We got plenty of flare-ups in the beginning. He was constantly telling us to F-off. He was a child who was destined for residential care. When he came first he had no social skills whatsoever - he would think that it was his automatic right to turn on the television. So now - and it has taken a lot of time for him to realise there are others here too - now he would say, 'I'd like to watch this [TV programme] at 4 o' clock, is that okay with everyone? It's only now he's realising it's not all about what he wants: there's give and take. When he came he had a lot of problems and he wouldn't discuss things. And he'd give a few expletives, and I'd go and say, 'But you need to apologise', and I'd*

*leave him then and he'd come back to me. And he'd come back then and apologise, so you'd say, 'You have to man up and apologise', and as a rule now we don't really have any problems.*

Giving time and space to process and vent anger and deal with emotional outbursts was also favoured by another participant who was fostering her husband's son. Her advice was to 'never force an issue when they are angry as it just makes things worse'.

Another participant referred to embedding what she described as 'basic manners' into daily routines in her interactions with her foster son (aged 14), which included offering him praise for courteous behaviour. This, she noted, would allow him to feel good and 'that someone appreciated him'.

*They actually then realise that someone respects them, and okay, it's not cool to be all polite and that if you are 14, and you might get a grunt or a mumble in response, but that level of manners will eventually get through. They'll at least learn that not every discussion is an argument with them. That normally being pleasant as a matter of course makes for a more positive life and better relationships with the folk around you.*

Exposing her foster children to positive warmth in her relationship with her husband was another way in which social skills were taught by a different participant. Here, there was no deliberate effort made to teach social skills, but rather displaying them in the presence of the foster children allowed the latter to imbibe ways of engaging socially that were respectful and emotionally connected.

*They see how we get on with each other, that we are happy together and kind to each other . . . The girl who was here before, she saw my husband bringing flowers for me on Christmas Eve. They see him give me a peck on the cheek. Small things like that that are normal for us.*

Another aspect of social skills' learning to which a few referred to was contract-making and honouring and respecting agreements. This involved making informal contracts with their foster child so that expectations of the foster carers would be observed. For example, one participant allowed her foster son out on condition that he would always be contactable and would only socialise in locations that had been mutually agreed.

*I have said, 'You must answer the phone when you're out. If I ring [friend's] house you better be there', and in fairness he's very honest and he wouldn't lie.*

In another case, a participant relayed how her foster son arrived at the placement at 16 years of age, with a history of a previous difficult placement that involved him not observing curfews. She described how she shifted the responsibility for ignoring curfews back to the young man

so that he would have to deal with the consequences. Her strategy appears to have been successful in giving him a sense of where the boundaries lay:

*He would go drinking [on his previous placement] and ring his foster carer and say, 'Come and get me', and when he came here first he said something about going out and said that he'd be in this place, and I said, 'You know if you are out 'til 11 and you ring us and say "Come and get me" it's not going to happen. You'll have to get a taxi back and pay for it yourself', putting the responsibility back to him. Putting boundaries in place, telling him exactly where he stood. Careful here now not to upset this apple cart, so he didn't go. Then he got more into local people and he stopped hanging round with that particular gang. Now he talks to them occasionally because we had the summer holidays. Now he met up with them over the summer and he was to be back here at eight, and my nerves, but he was back at half seven. Now we had to give him the chance to see what he was going to do.*

In some cases, the young person had moved school or location (sometimes more than once in a short space of time) and had few friends locally. One participant attempted to build her foster son's confidence by encouraging him to invite friends home. She relayed that on one occasion, her foster son was invited to the home of a friend, but was embarrassed when he learned that the friend's mother was already acquainted with his foster carers and would be aware that he was fostered. That participant described the process of building the young man's self-esteem and confidence before he finally took the step to accept the invitation:

*He was embarrassed about being fostered and that the fellow he wanted to stay over in his house would know. And I said, 'Does it matter to you that the friend is [names nationality]?' he said 'No'. 'Does it matter that he lives with his mammy and not his daddy?' He said, 'No'. 'Does it matter that he's an only child?' So he was saying, 'Why are you asking me these silly questions?' And I said, 'When his parents ask about you, what do you think they are going to answer?' I said, 'You like them because they're your friend and they like you because you're their friend, it doesn't matter how many are in the house', and he said, 'I think you're right'. Now he didn't go [on the sleepover] that time, but they invited him again and he did go, and it was fine, but it took a lot of steps to get to that.*

She also went on to explain that at the start of the placement, the young man was constantly under the impression that he might be sent to 'respite', or temporary care, until she and her husband regularly reassured him that unless he chose to go to respite, then they wanted him to remain with their family.

In terms of building confidence, one participant expressed the view that consistency in the relationship between the young person and the foster carers was very important. She noted that children whom she had previously fostered and were now adults nonetheless felt that

they could rely on her and her husband for advice about everyday matters. Irrespective of what grievances had occurred in the teenage years, the long-term benefits were appreciated by both parties.

*One of my older girls [now an adult] would say, 'I was really nasty to you, but you stuck with me' and I'd say, 'Yes, but you stuck with me too'.*

A further manifestation of how foster carers facilitated emotional development was to advocate for the young person. Acknowledging that her own foster son, who arrived at the placement aged 13 years and with considerable behavioural difficulties, and was still (3 years on) 'no angel' at school but making good progress, one participant recounted how she and her husband negotiated with the school principal over appropriate reprimands for him. This was to allow some leeway while the young man continued to develop emotionally. Another example of advocacy from a foster carer designed to protect the young person's fragile self-esteem and to build her confidence was a decision by a foster mother to change GP after he had apparently remarked to her foster daughter on being introduced, 'Oh you're the foster child'.

While participants did not generally tend to make the link explicitly between social skills and negotiating sexual encounters safely and mutually, one participant did comment on the centrality of learning social skills for sexual health and positive relationships.

*Participant: Before you ever get to sex education and what they should and shouldn't do, a lot has to do with basic courtesy and being aware of others. Like simple things like knocking on a door before going into the bathroom or someone's bedroom, not having music blaring if someone is sleeping, asking if it's okay to go out. We try and teach them to have that bit of respect, and we will give them the same respect back. That way, they learn that being nice makes people nice back. We can't always do what we want and neither can others.*

*Interviewer: Do you think, then, that this will help with, say, relationship boundaries when they are out?*

*Participant: Exactly yeah, they learn to respect other people's boundaries.*

Another reported a technique for teaching assertiveness and responsibility through reflecting on social situations where an alternative course of action was possible. In this way, the participant described how she transmitted a sense that the young person has within his or her gift the capacity to make choices and to decide between alternative behaviours. This technique, she conveyed, could be applied in a sexual encounter.

*You need to say to them, 'What could you have done different, what would the outcome be if you had stopped at this point?' You need to be the leader in stopping things with the people you are with. You need to learn to be the one to say 'Stop!' in any situation, sexual*

*or otherwise. Of course that's not always possible because teenagers act on impulse, so it is a problem, and sexuality is something that's going to occur on impulse as well, but this could apply with regards to anything.*

### **Key points: Section 6**

- Social skills are considered to be an important prerequisite to sexual competence and the negotiation of sexual relationships.
- A strong feature of data were references to the manner in which social skills embedded in everyday routines were transmitted to YPIFC.
- Family meals provided an opportunity for facilitating the learning of social and emotional skills.
- Social skills were also sometimes taught in more concrete ways such as clarifying the house rules and expected patterns of behaviour for the young person.
- A few participants referred to the skills of contract-making and honouring and respecting agreements, which are fundamental to facilitating mutuality in relationships.
- Participants reported using various techniques to build their foster child's confidence and social competence including role modelling of desirable behaviour and advocating on their behalf.

## Section 7:

# Engaging in 'direct' relationships and sexuality education

### Introduction

In this section, we turn to the issue of direct and deliberate RSE reportedly conducted with YPIFC by foster and birth parents. Beginning with an overview of general trends in how and/or when RSE was delivered, we then move on to consider participants' experiences regarding factual information-giving about sex and relationships. The substance of the content of relationships and sexuality messages that participants described is then explored, and an analysis is presented of the two broad forms that characterised RSE messages, namely, consequence-orientated messages and values-orientated messages. The discussion then shifts to consider the strategies reportedly used by foster carers to promote sexual health and deliver RSE. Finally, the reported responses of young people to RSE by foster carers are explored.

### Overview: engaging in 'direct' RSE with foster children

On the whole, in situations where the young person entered the foster placement as a young child and grew up in the family with participants' birth children, the more the pattern of preteen sexuality education that they reportedly received resembled that provided to birth children. (Three participants who did not have birth children had no reference point by which to make comparisons). There were also participants who though in principle felt that no difference should be made in how foster or birth children were raised, nonetheless went on to describe some differences in how sexual health issues were managed according to the young person's needs as he or she progressed through the teenage years. (The issue of differences between RSE delivered to birth and foster children is covered in Section 8). Participants reported that each child was different, and that RSE needed to be tailored accordingly. There were trends, nonetheless, in RSE practices: Reproductive physiology, bodily changes and menstruation were topics that foster carers tended to talk about to preteen girls. With boys, the topics discussed tended to focus on bodily changes and differences between the sexes. Contraception was a topic that tended not to be raised at the preteen stage because it was believed that sexual protection (safer sex) was not yet relevant.



### Factual or instrumental communications focused on transmitting knowledge

In terms of doing RSE with foster children, factual communication - associated with sexuality, including biology, anatomy and physiology - was more heavily associated with the preteen years than the teenage years. Other types of factual information conveyed included practical information such as managing menstruation and hygiene requirements with the onset of puberty. The extent to which foster carers reportedly engaged in this varied, but where preteens (aged 10-12 years) were being fostered, most foster carers reported having imparted scientific knowledge about what changes in the body occur at puberty. Where the young person was in a long-term foster placement, the more this aspect of RSE resembled that reportedly given to birth children.

A few parents reported having used books when their foster children were in the preteen years, in many cases supplemented by verbal explanation.

*The older boy, when he was about 12, I sat down and went through everything with him and I gave him photocopies of a book that I thought would be relevant for him to know. Boys know about themselves, they can look at themselves, but you have to tell them about girls.*

Another foster mother attempted to provide 'catch-up' RSE where she deemed that her foster son had missed out on scientific aspects of RSE taught in 5th and 6th class. Gaps in his knowledge came to her attention when her daughter was excused from attending school in view of dysmenorrhea (painful periods). The usual family rule that any child not fit to attend school was to remain confined to bed for the day (as a deterrent to feigning illness) was waived in the case of the girl in this instance. Her 13-year-old foster brother, aware of the liberty given to his foster sister when she was supposed to be sick, was peeved about his sense that there was one rule for her and another for him. The foster mother relayed how she used this opportunity to teach him about periods, and in the course of her information-giving, realised that he had not received any of this information previously. The young man had experienced multiple placements prior to the current one.

### Consequence-focused messages

By far the most dominant RSE communications that foster carers reportedly imparted to their foster teens were consequence-focused messages; these took various forms. Some were at a fairly general level in which the foster carer reportedly emphasised that one had to accept responsibility for all of one's actions, including sexual behaviours. Others were straightforward messages informing the young person of less serious immediate outcomes; for example, two participants warned their foster teens of the high probability of transmitting common colds and sore throats through the practice of 'meeting' (indiscriminate kissing of multiple

partners practised in the early teen years). Additional consequence-focused messages related to the law on sexual behaviour, in which the perceived legal outcomes of underage sex were conveyed.

*I said it to my own and to my foster lad, if a girl is not 17 and if anything happened you're in serious trouble, doesn't matter if they agreed to it, the law is the law.*

Messages about legal consequences were sometimes overlaid by moral content, as is exemplified in the following quotation where the ethical reasoning behind the law – to mitigate against exploitation – was reportedly made transparent.

*I have explained that you might want to become sexually active, but you are underage, and she might want it too but her parents could go to the Guards [police] . . . I'd say the laws are there to protect because somebody might have more power than another.*

The two Traveller participants (one a foster mother, the other a birth parent) both made much of the impact on a young woman's reputation if she were viewed as sexually promiscuous. Interestingly, the issue of contaminating one's reputation hardly featured at all in any of the other narratives - by far the most common consequence-orientated messages related to the repercussions of an early pregnancy. This was reportedly sometimes raised with foster children fleetingly, and sometimes in depth. The consequence of a pregnancy featured in narratives about RSE directed at foster teens of both sexes.

One strategy used by foster carers in order to reinforce the message about the repercussions of a pregnancy was to spell out the responsibilities that a baby brings:

*I say to have a baby is an extremely unselfish cause you have to deny yourself to fulfil the baby's needs. So I say, 'Do not have a baby until you are prepared not to be out, not to be dressing up - nappy, cream and wipes are the priority - financially broke'. I say it that way. It's not heavy stuff, but you are naming the responsibilities . . . I have explained to him, 'What would you offer a baby? Look, only have a baby when you can offer them something'.*

*I have sort of said, you know, it's [childrearing] a lifetime commitment and it all falls to the mother. It looks different from the outside, but having a baby really limits you. You can't go off out with friends and all the things young ones do. A baby is a lifetime responsibility.*

Another consequence-based message directed at young men was that condoms should be used. For young women, foster mothers sometimes talked about how to access hormonal contraception, an issue we consider later in Section 9. As indicated earlier, STIs were far less frequently mentioned as an outcome of sexual behaviour. More examples of the heavy focus

on consequences are given when some of the strategies used by foster carers are described further on in the report.

The emphasis by foster carers on consequences within the present study is in contrast to the findings of the Parents' Study (Hyde *et al.* 2009). Here the reported dominant message of parents to teens was values-orientated - that sex should only occur in the context of a loving relationship.

### **Values-based communications encompassing moral perspectives on sexuality and sexual relations**

Many participants described RSE communications where they attempted to convey values such as respect, responsibility and dignity in the course of the dialogue. In these values-based communications, the emphasis was on considering the morality of possible actions in romantic encounters rather than on the consequences of actions, although, as indicated in the preceding sub-section, consequence-focused messages were foregrounded in participants' narratives.

One example of a sexuality message with a focus on the morality of the action was the case of the Traveller participant who reported that she did not engage explicitly in sex education because sex before marriage was morally wrong and this was sufficient information for young people to receive. However, the values around sexuality mediating Traveller culture should not be regarded as fixed and unchanging: the two Traveller participants (one a foster mother and the other a birth mother) from whom data were analysed for this report painted a fairly heterogeneous picture within Traveller culture regarding sexuality. While both participants shared the view that young people should recognise that sex outside of marriage was morally wrong, one participant contended that this was sufficient information for young people while the other was very open to young Travellers being exposed to knowledge about sex and contraception at school. The latter also was favourably disposed to individuals, irrespective of their culture, using contraception once married. Other information captured in the interviews with the two Traveller women also points to cultural heterogeneity among Travellers in terms of values around intimate relations.

To return to the data more widely, one concept that mediated morality messages was the need to demonstrate respect for others. This was referred to particularly in relation to young men needing to respect young women. In the following quotation, the message to boys was reportedly a deliberately gendered message, with differences between boys and girls highlighted and used as a basis for conveying the need for boys to respect girls. In the scenario described below, a foster father relayed the kind of communications he had experienced with his foster son and the latter's friends prior to the group of youngsters congregating for a night out.

*We say to a group of them, 'You are going out tonight; you need to have respect. They are girls, they are completely different from boys, you need to be respectful towards them'. . . Even in the car going to the disco last night, I said to the lads in the car, 'You've got to respect the girls, it's not about all this meeting [indiscriminate kissing of others] carry on'.*

At another point in the interview with the above participant and his wife (the couple were interviewed together), the foster mother revealed how she conveyed a moral message about appropriate and ethical conduct to both her birth and foster children, by asking them to consider the impact of their behaviour on others.

*We would talk to them about respect and respect for others: you know, don't do something unto others that you don't want done unto yourself.*

In another example, similar values were also at the forefront of the message being transmitted, where a participant described her attempts to facilitate feelings of empathy in her foster son by asking him to consider how girls he had been 'meeting' (indiscriminately kissing) might feel about such a brief and fleeting intimacy, devoid of mutual feelings. Her account also included advice as to how to revise his behaviour to become more humanly sensitive.

*There have been occasions where he would have been rude to girls and you'd have to say, 'You know, they're a person too and you have to respect them'. . . Because he went out to a disco and he was boasting then to his friends that he was after meeting eight girls. And I said, 'That's not really very nice and you can boast, but that's eight girls that you kissed and walked away from'. . . I said, 'You kind of have to think about what you are doing. You have to talk to them. Give them the time of day, don't just go up to them and kiss them and walk away from them'.*

Values-based messages to foster teens were not confined to communications about showing respect for others, but also included cultivating an awareness of the need to be respected by the other party in an intimate relationship. One participant recounted how her foster daughter had become romantically involved with a man from a different culture, a relationship of which she (the participant) disapproved on the grounds that he did not treat her well. When the foster daughter suggested that her disapproval was because she was racially prejudiced, the mother defended her position and reinforced her contention that the relationship should discontinue because the young man's disposition towards her was disrespectful (and by implication, was wrong). In this sense, the participant's focus was primarily on the ethics of the relationship rather than on any consequences that might ensue, and she challenged her daughter's acceptance of this situation.

*Now she would see my input as being prejudiced. But I would say, 'It's not that, I have a problem with how he's treating you. He is not respectful to you and I have a problem that you think that's good enough'.*

Another values-based message that emerged in participants' accounts of communicating sex education messages to foster children was that sexual engagement should be underpinned by freedom from coercion. As indicated in the Introduction to this report, this is a central concept in sexual readiness or competence. Again, the focus of these messages is the morality intrinsic to the action or behaviour, and the duty to oneself and others, rather than the consequences of the action.

*I would talk about sex openly in context, as in sex should be about love, not forced.*

*If you enter an intimacy with somebody it has to be something that you want - nobody should force you.*

Another aspect of values that that participant reportedly transmitted to her foster children regarding intimate encounters was to freely choose a course of action and to resist being influenced by others to act according to group norms.

*I would say, [re 'meeting'] 'You're not in competition for numbers'. They'd say 'I wouldn't do that'. I'd say, 'I know, but your peers might be, and you're not in competition. You get to make that choice. You don't just do what someone else is doing'. And I say that around not just sexual behaviour, but drinking or smoking or anything else that's offered.*

A further component of RSE with her foster children described by that participant was outlining the moral context of an intimate relationship.

*We do say about what is appropriate in becoming intimate, like it's not good to be intimate with someone on the first date, that if they are intimate with someone it should be someone who is significant in their life, that there's also a friendship in it.*

She also clarified that she presented sexuality as having values-based boundaries rather than defining it as something prohibited. Her account also suggested that the values-based communication about the moral context of sex included messages about the need to protect oneself as well as to demonstrate respect for others.

A few other participants described what might be termed 'sex positive' messages as part of the value system that they reportedly imparted to their foster children.

*Everybody says to teenagers, 'Don't do it'. Everybody is on a negative. Even among themselves - girls get off with someone and get called a slut by the girls and easy by the boys. Nobody says it's ok to show affection to each other. The message that I try and get across is that it is okay to be nice and it is okay to be affectionate.*

In another example of a values-based message, a foster father reportedly corrected his foster son when the latter used the word 'slut' to describe girls or women.

Most narratives that described RSE communications were neither singularly values-focused nor consequence-focused. Most descriptions combined elements of each at different points of the interview, with (as indicated earlier) the former the more dominant when data as a whole are considered. RSE communications overall were reportedly imparted with varying degrees of clarity, ranging from fairly indirect to more open communication. The fusion of values-based messages that advocate postponement of sexual activity and consequence-focused messages is sometimes loosely described as 'abstinence-plus' sex education in the literature. An example of an abstinence-plus message is from a foster father who, a couple of years previously, had believed his (then 16-year old) foster son to be in a 'toxic' relationship with a girl who had herself experienced an unstable family environment.

*I had a conversation with him that if you are going to make that choice [to have sex] - and I would rather you didn't make that choice - but if you are going to make that choice make sure you are taking precautions as well.*

The 'abstinence' piece was conveyed to the young man by the foster father specifying his own value preference, yet the course of action was simultaneously presented as a choice that the young man was free to make; the 'plus' piece was that should the young man chose sexual activity, contraception ought to be used.

While the transmission of values-based messages was generally described as requiring some degree of explanation and instruction from the foster carer, in the following example, a participant described a more pragmatic approach than moral reasoning, namely, following the rules set by the foster carers.

*I find with children in care, and sometimes your own children, they don't always have the language. We're coming at it at the moment, like, of 'Follow the rules and you won't bring trouble on yourself'. It minimises the trouble.*

### **Strategies used by foster carers in promoting sexual health and delivering RSE**

Curtailling sexual activity by restricting the movements of the young person was mentioned by several participants as mechanisms to prevent early sexual activity of a foster teen. Several also relayed how internet access and remote (electronic) communications of the foster teen were monitored and regulated. With regard to the latter, many participants indicated that they had access to the young person's social media accounts, and in some cases the young person's entire electronic communication modes were monitored at regular intervals (often discretely). A few parents still registered concerns about the impact of social media on their foster child

and felt that it was impossible for them to control this completely. Concerns about access to pornography scarcely featured at all in the narratives of these foster carers.

Just as the substance of the RSE messages reportedly delivered to foster teens varied in focus, as indicated in the previous sub-section, so too did the strategies used to deliver this message. Strategies employed included embedding safer sex communications in sex-positive messages, making covert references to sexual behaviour, invoking humour, and using opportunities that arose from everyday life.

### **Encouraging sexual safety embedded in a sex-positive message**

One method reported to transmit RSE information was to focus on the positive aspects of sexuality while embedding a preventive message. One foster father described doing this in order to encourage his 17-year-old foster son to use condoms should the young man be sexually active. He explained that he was keen to convey a sex-positive message to the teenager – that sex was a healthy practice. He did so by inverting the traditional message about sex being 'bad' or sinful and redefining being sexually active as 'good'. At the same time, he described interspersing the sex-positive message with encouragement to use condoms. The manner by which he reportedly conveyed this to the young man was indirect, yet he believed that his foster son understood.

*I have this regular conversation where I say to him, he'd know exactly what I am saying, 'If you are going to be good, be very good'. In other words, take proper precautions and stuff like that, certainly don't be doing anything without.*

Another participant similarly reported a strategy of weaving a message about the consequences of sex into a sex-positive message.

*We have tried to get the message that it's good to show love, not that sex is bad like in the old days, but you do need to be aware of the consequences like statutory rape or pregnancy.*

### **Indirect mechanisms for transmitting safer sex messages**

Transmitting safer sex messages through indirect references and inferences about sexual behaviour was also reported by foster carers. Some participants described messages designed to raise awareness of the consequences of sexual behaviour imparted in advice about being 'careful' or to 'watch' themselves.

*Participant: I suppose you would say it: 'Be careful now out tonight'. I will always remember a woman long ago when I was working myself, and that is going back, she said, 'When you go out now tonight keep your two legs in the one sock'. And that would be my way of approaching it: to be careful. That would be my way of saying it.*

*Interviewer: And would that mean no sex?*

*Participant: Well, just to think about what they're doing really, to be aware.*

*Interviewer: So would that be 'Don't do it' or 'Use precautions'?*

*Participant: They could take it whatever way they want as long as they are not going in to it blind and they are not caught off-guard and find out through the consequences.*

*Participant: I would just say something like, 'Now watch yourself, you don't want to get into trouble or have to face a situation at a young age'.*

*Interviewer: Would you say what situation?*

*Participant: Well, I think they'd cop that they could get pregnant. I just want that message to get through.*

The practice of couching advice in innuendo found in the current study was a strategy also reported in interactions between parents and their children in the Parents' Study (Hyde *et al.* 2013). Several participants indicated that their foster children had been made aware that they (as foster carers) were open to answering any questions the young person had, and communicated this in such a way that the YPIFC would know that this openness also extended to queries about sexual health.

### **Using humour**

Humour was another mechanism through which RSE messages were reportedly channelled. The consequences' message was also reportedly sometimes delivered using humour.

*We have our own humour. I say, 'If there are any buggies in the hall they better be mine!' So you're not saying, 'Don't come home here pregnant', but you're putting your message out there.*

*I tell them him under no circumstances is he to make me a foster granny for another 10 years!*

### **Identifying opportunities to deliver RSE**

One participant described RSE as a 'continuous dialogue' undertaken regularly. The narratives of several other participants also suggested that foster carers seized on opportunities that occurred spontaneously and periodically in their cultural milieu or in the media to raise issues about sexuality with their foster children. It was also suggested in some narratives that as the young people moved into adolescence and engaged increasingly in the social world of teenagers, the RSE was adjusted accordingly.

*It's not a once-off with us, it's an open conversation. It started before the teen years, he had hands slipping into the pants while watching TV so I'd just tell him, when in public*



*what's appropriate, when in private it's okay. Now that he is older [15 years] and is meeting girls, the conversation has moved on how to approach them and treat them with respect that kind of thing.*

Others also delivered RSE according to when the timing was deemed to be most suitable.

*It also depends on time, if somebody is rushing out to [sports] training or to a meeting or what have you, you might have to defer the conversation, you might have to wait, use what you have around you, the TV, the radio, but the timing has to be right to bring it up.*

An example of news media being invoked to educate a foster teen was described by one participant. She reported drawing her foster son's attention to a case in the media where sexual intercourse between a consenting underage heterosexual couple resulted in a prosecution for statutory rape of the young man when the young woman's parents made a complaint to the Garda. Reference to that case opened the way for that foster mother to inform the young man about the legal age of consent and the fall-out of having a criminal record for a sex offence.

### **Moderating the intensity of one-to-one RSE**

Moderating the intensity of one-to-one RSE was a strategy described in various forms by participants. This was found to be relatively successful at engaging young people in dialogue about delicate issues. One form that this took was to avoid eye contact with the young person.

*The car is a great place to talk. You don't have to look at them, you don't have the eye signals.*

Another strategy for diluting the embarrassment and self-consciousness associated with sensitive aspects of RSE was to shift the emphasis away from a personal focus on the young person's own behaviour to more general messages about what was deemed to be right (from the perspective of the participant) at a societal level. One foster mother, for example, reported that she found it easier to focus on the consequences of unprotected sex than on sex per se, as her foster son was less likely to withdraw in the case of dialogue about the former.

*You mention about using protection and it's 'Fuck's sake' under his breath – but, if you say, 'You want things to be right before any person becomes a dad' and all that, and take the focus away from sex and away from him personally, and he's less negative, or at least doesn't hate the conversation as much.*

One way a participant tried to reduce the intensity of one-to-one RSE was to clarify that the young person was not being censured or castigated for his behaviour or suspected behaviour, but rather that the message was a general one at a more abstract level, but one that he was required to hear.

*We'd say this at dinner, and I would say, 'Nobody's giving out and nobody's saying you've done this, but we feel as parents we need to explain this so you know where you stand'.*

Another participant described a mechanism for mitigating the discomfort of sensitive conversations in advance of a youngsters' night out as follows: instead of directing messages individually to her foster son about how to conduct himself in the presence of young women, she gave general advice to both him and his peer group as they congregated before departing for their evening out. Her view was that the message may be more effective in positively influencing the behaviour of the whole group. (It should be noted that that participant also relayed having undertaken individually-tailored RSE to her foster children in parallel).

### Responses of young people to RSE by foster carers

Reported responses of foster teens to RSE from foster carers varied. One participant described her foster son's reactions as 'mainly positive', while others described embarrassment, disengagement from the interaction, and signs of disgruntlement that the issue was being raised. These reported responses from the young people mirror very closely those described in the Parents' Study (Hyde *et al.* 2009, 2010). A few found that young people in general failed to see the relevance of some of the information that parents or foster carers were attempting to transmit.

*I tell them about the legal age, and they get it I think, but at the same time they would be thinking 'Sure, what would I [mother] know?'*

*About the law - it doesn't matter. Kids don't realise how serious it is - it does not come into the picture at all.*

Fostered teenagers were reportedly more inclined than birth children to view foster carers' advice about dress and sexual behaviour as unwelcome regulation and curtailment of behaviour. In many cases, based on the narratives of foster carers, acceptable practices and boundaries about behaviour in general needed to be 'taught' to those who arrived at the placement relatively advanced in childhood, and required a far sharper learning curve than the incremental assimilation of rules by children raised in the home from early on. A couple of examples of this are as follows: One participant relayed that pointing out to her 14-year-old foster daughter the inappropriateness of doing handstands on the public green in a mini skirt with her underwear exposed was interpreted by the young woman as 'just another rule'. In another example, a foster daughter reportedly 'did not like being told' that her revealing neckline was inappropriate, viewing it as overly strict.

Young men's responses (where these were reported) to consequence-focused communications from foster carers about the possibility of a partner's pregnancy were varied. In one example, a foster father recalled a dialogue that he had with his foster son two years' previously

when the young man was 16 years old about the possibility of becoming a young father. In the description that follows, the participant conveyed his foster son's relaxed attitude to the prospect of becoming a father. The participant also described his own attempts to make sense of why the young man would choose to become a father when he had experienced such a poor connection to his own birth father.

*The young fellow that is 18, when he was 16 I remember having that conversation with him and he was like, 'Ah sure having a baby wouldn't be the worst thing in the world'. I said, 'Yes, but you have a long journey to go through before you'd be ready to have children and being able to care for them properly'. 'Oh sure it is grand'. 'You think so? You really think so?' Like he was sort of saying it wouldn't be the end of the world if.. It is very hard for me to put my finger on it. I thought that was strange coming from him, I really did because - him in particular - all the siblings in our care have the same mother but they all have different fathers. His particular father was very difficult to make connections with because he was in England and stuff but we did go over there and tried connecting but it just became a bad relationship . . . He thought it was okay to have a son, yet he is completely disconnected from his father . . . of all the kids in my care, he would have the most attachment issues and yet he thought it was okay to have a child.*

In a separate case, a foster mother's description of her foster son's stance on the possibility of becoming a young father was quite different, although he too apparently had experienced an estranged relationship with his birth father. His response was to shun fatherhood until he could engage with it.

*And he'd say, 'I'll never have a baby until I can offer him something', because he was rejected.*

### **Key points: Section 7**

- In the case of young people in long-term stable foster placements, preteen RSE was largely described as being similar to that provided to birth children.
- Science-focused RSE imparted to YPIFC was associated more heavily with the preteen rather than the teenage years.
- Participants' accounts indicated that consequence-focused messages were a dominant aspect of the RSE they delivered.
- Consequence-based messages reportedly varied in substance, from consciousness-raising about taking responsibility for the repercussions of one's actions in general, to specific information about the potential impact of particular sexual or relationship behaviours.

- Consequence-orientated RSE emphasising the impact of an early pregnancy was the most dominant type imparted, particularly to fostered girls.
- Values-orientated RSE was also reported with foster children that emphasised the morality of actions that crosscut intimate relationships.
- Participants tended to focus on preventing a teenage pregnancy over other sexual health concerns (e.g. STIs, sexual competence/readiness in relation to age of sexual consent) and to focus this concern towards foster daughters rather than foster sons (for example, by ensuring that the girls had knowledge of, and access to, contraception if they were sexually active). Dealing with specific challenges in relation to the sexual health needs of boys were, relatively speaking, overlooked.
- A variety of strategies were reported by foster carers to deliver RSE, including embedding safer sex communications in sex-positive messages, making covert references to sexual behaviour, invoking humour, and using opportunities that arose from everyday life.
- A diversity of responses from the young people were reported by foster carers including embarrassment and disengagement. However, an open recognition between foster carer and young person that sexual activity was occurring was reported in many instances.

## Section 8:

# Specific challenges in delivering RSE to foster children

### Introduction

When asked directly about what supports they would like to help them to provide RSE and sexual healthcare to foster children, virtually all participants struggled to identify particular interventions that might help. Nonetheless, they did articulate particular challenges in delivering RSE to their foster children, even if they were reticent in suggesting solutions to these. These challenges sometimes manifested themselves in the interviews when the foster carers made comparisons between their experiences in undertaking RSE with their foster and with their birth children. In this regard, both the continuities with and differences between the substance of RSE reportedly delivered to foster and birth children are explored. Several participants identified the issue of clashing values between themselves and the young person as a specific demand of fostering. This 'values-clash' often arose because the young person had been exposed to a different value-system prior to arriving at the placement. Since many of these values cross-cut RSE and sexuality, we consider them here. Finally, in describing the challenges that mediated the provision of RSE and the maintenance of sexual health of YPIFC, several participants spoke about the issue of children's rights. As indicated in Section 1, the concept of children's rights is embedded in the *National Standards for Foster Care*, which proposes that CIC are encouraged to exercise choice relating to a range of activities, and are made aware of the complaints' procedure should they wish to register a grievance about their care. We explore this concept of children's rights as participants interpreted it, and provide an account of why some participants found it problematic.

### Continuities and differences in the substance of RSE with foster and birth children

Some participants indicated that there were no differences in how birth and foster children were managed when it came to RSE and sexual health; many others signalled their consciousness that a different emphasis was required. As indicated earlier, much depended on the age at which the foster child arrived at the placement.

*Interviewer: Do you think sex ed is different between birth and foster children?*

*Participant: I think if you have the child from a very young age there's no difference. . .*

*You have to do exactly the same as if they were your own. And for my little one she's that long with us that she is like our own.*

As the teenage years progressed, differences in the needs of foster children sometimes became obvious. This tended to be so even in cases where participants' accounts indicated that they were keen to embrace a foster child as their own and to treat birth and foster children the same.

One participant commented on differences in the emotional connection between foster and birth children that cross-cut sex education in cases where the young person arrived at the placement in later childhood. In particular, she noted that because of the nature of short-term placements, familiarity and comfort that normally underpins familial relations was underdeveloped, creating difficulties for RSE delivery.

*There's not the same emotional connection, there can't be . . . If they came very early, yes . . . I think that due to the nature of foster placements in the short-term, you don't really know each other well, you're not comfortable, you are embarrassed and the child is embarrassed.*

Another participant described differences between RSE with foster and birth children by referring to 'instinct' in knowing birth children.

*You don't have that same instinct with your foster children so you have to fill in the gaps and they have to fill in the gaps. It is an instinct so when it comes to like education and stuff like that, it is easier for me to have a chat with my own son or my own children.*

The manner in which each family has its own culture was raised by another participant; unlike the situation for birth children who grow up to gradually absorb (and in turn create) family patterns and expectations, experiencing these as normal, foster children have to 'buy in' to these.

*With your own child you have your own house rules. You are not sitting down and making a big plan. It's a gradual education piece for life. Every family has their own language, whether they talk it or look it. For children coming in you have to buy in your piece, your domestic piece.*

A difference between foster and birth children that she highlighted was in their self-perception that led them to conceal aspects of their past.

*You try and treat them equally but they are not equal – they are dealing with their background, they are stigmatised, and it stays with them. And they say, 'Don't tell anyone my story'.*

It was pointed out by another that she attempted to impart the same core values to all her children, but because of their past experiences, foster children had different starting-points in relation to some issues that mediate sexual health.

*You try and hold the same core, but it is different, because children in care might have different boundaries around privacy to start with.*

A recurring theme across data was the challenge for foster carers in understanding aspects of the child's past, of which the foster carers sometimes had limited knowledge. One described her constant consciousness that foster children had different life experiences prior to being placed with her. Another explained how she approached RSE with her 16-year-old foster son cautiously because even after five years, they were 'still getting to know each other' and had to negotiate new roles; in his relationship with his birth mother, the young man was described as having been 'the adult in the relationship'. Another described how her knowledge that a 12-year-old foster child on a one-year placement had previously lived with her birth father only, prompted her to spend a degree of time imparting to the girl knowledge about menstruation and the science of bodily changes, as she doubted that the girl had received this information previously.

Foster daughters were deemed to be particularly challenging for foster carers, and because foster daughters often tended to be viewed (as indicated in an earlier section) as sexually precocious, they were deemed to be more in need of RSE than were birth daughters.

*Although I'd like to think there were no differences, I feel I was stronger with [foster daughter] because she was already showing just a little bit more sexual development – not physically, but in other ways – so I was more conscious.*

Another foster mother indicated that her younger foster daughter was protected from knowledge of the promiscuous behaviour of the older foster daughter lest she later become influenced by the behaviour of the former. In a separate case, part of the participant's rationale for regulating how her foster daughter dressed (which the foster mother deemed to be inappropriate) was so that her birth daughters would uphold her preferred standards.

### **Clashing values associated with sexuality**

As indicated in Section 7, some of the RSE messages delivered by foster carers were value-laden. One of the challenges of which several participants spoke was the potential clash between the foster family values and those to which the young person was previously exposed. Indeed, sometimes participants' accounts suggested that the foster family was not always aware of the values to which the young person had been exposed in the past. Most participants indicated that the birth family had currently little or no input into RSE with the young person, and this information was corroborated by the five birth parents who were interviewed. Again,

the age at which the child was fostered was considered important, as those fostered at an early age were more likely, it was believed, to adopt the values of the foster carers.

*We have raised foster children from younger and they know your values, but for children that have always lived on the streets it's a different kettle of fish.*

One participant noted that in delivering RSE to foster children, there were three factors to consider: The birth families' values, the foster carers' values and the values of the HSE. Managing the competing sets of values was described by her as follows:

*You bring your own values to it, whatever they are. And with the child, they have their own family values and their experiences with family life . . . If I am having a conversation with my foster daughter, there are loads of factors to consider. One is her understanding, two is her history, and three is the HSE . . . You are trying to equate with somebody else's expectations, so what we try and establish is an understanding of what our role is.*

She went on to highlight the complexity of dealing with a fostered teen's past, and the need to be sensitive to the fact that in extolling one's own values, one may simultaneously be denigrating those of another.

*You also can't trash their experiences before this. So if you say, 'We don't drink - we don't touch drink', you're actually putting down their family and they are sensitive to that, so you are always mindful: What would that mean for him or her? . . . You can't go around saying, 'This girl is pregnant, isn't that terrible?' That might be one from their history. It's different for your own children it's clearer because their history is with you.*

That participant went on to describe several instances of clashes in values around issues such as alcohol use and educational attainment, which are known to be linked to sexual health. One was related to using alcohol: Her 16 year-old foster son had become ill after being provided with alcohol by his birth father at a (birth) family celebration. That incident prompted the foster carers to talk to the birth father and convey their sense that the young man could not tolerate alcohol. Another example given by the participant related to her foster daughter, whom she encouraged to maximise her performance at school and to study for her examinations in order to increase her life chances. By contrast, the message from her birth mother was to dismiss the significance of examinations. This was at variance with the foster mother's contention that education offered choices and a way out of deprivation.

*My girl is doing exams, and I'm telling all the kids to put their utmost into them. Education is on the agenda because exams are on foot and I would say, 'Really give it your best shot, this is your future. It's about you, not social workers. What you put in you'll get out'. But the birth mother phones and says, 'Don't be worrying about them exams - there's too much emphasis placed on this or that'. Complete opposite of my*



*message, because I see her [foster-daughter's] way out through education and being self-sufficient, not repeating cycles, with no disrespect to what that cycle is, but that they don't have to automatically go into it; they have a choice, they have another option. I say to the foster kids, 'The more tools you get in the bag, and education is a tool, it gives you a choice and an option, and you are afforded the opportunity to fill that bag'. I don't even talk about a particular subject, just get all the tools you can and put them in the bag. 'It's something you'll have accomplished'.*

Another clash in values between the participant and the birth family related to the same foster daughter referred to in the last quotation who had a boyfriend whilst studying for examinations. Her foster carers were keen for her to focus on her examinations and limit the time and attention she gave to the relationship with her boyfriend until the examinations were over. Her birth family, on the other hand, made much of the relationship and encouraged it.

*We'd have relatives [birth family] ringing and saying, 'Oh lovely, boyfriend, were you out?' . . . So on the one hand I'm trying to keep it in the real world, I'm not going to say she can't have a boyfriend, that would be foolish, but at the same time, put forward her own piece, which is education at the moment. She can always come back to the boyfriend when the exams are done.*

Although this foster mother's stance in facilitating her foster daughter to see the value of education would not ordinarily be perceived as RSE *per se*, an internalisation of the importance of education by young people has a protective effect on sexual health. Young people who succeed academically tend to postpone sex until a later age (Furstenberg *et al.* 1987; Lammers *et al.* 2000; Schvaneveldt *et al.* 2001) and to use contraception more effectively when they subsequently become sexually active (Herceg-Baron *et al.* 1990). Moreover, academic success also reduces the likelihood of withdrawing from school, in turn reducing the chances of becoming a teenage parent (Manlove 1998). The importance of education for YPIC in Ireland and elsewhere has been emphasised by Daly and Gilligan (2005).

To return to the clashes in values between foster and birth families, the issue of Traveller culture also was raised by participants. In one case, a participant expressed her uncertainty as to how much information about sexuality she ought to be imparting to a teenager from the Traveller community. That participant relayed that she was aware that Traveller culture places a high value on virginity, but her own view was that the girl might be better prepared for life if she were given the message that the use of contraception was acceptable. She reported that she did not raise this with either the social worker or the birth parents as she would feel uncomfortable if it appeared that she was challenging cultural values, and so did not pursue it. The Traveller foster mother interviewed (with no connection to any of the other participants) noted how her foster children's birth mother – also a Traveller – had abandoned Traveller standards. This had impacted on the young woman being fostered, who apparently wanted to behave like settled girls and go out with boys. That (Traveller) foster mother explained how

she was challenged to channel the girl back into Traveller standards of behaviour, including making her aware of the importance of sexual purity to the reputation of Traveller women as a precursor to marriage.

The birth family were not the only contributors to shaping the young person's values: foster carers from previous placements were also found to influence a foster teen's values. One participant described the value-set that her 17-year-old foster son had been exposed to during his previous lengthy placement with a family in which religion was dominant, and which clashed with her own (the participant's) values. She described the previous family as having 'put the fear of god' into the young man and in her opinion, exposed him to very negative impressions of love and sex. Part of her role as a foster mother was to revise the young man's understanding of sexuality to one to which she and her partner subscribed (that non-abusive sex was a healthy expression of love).

### Children's rights and challenges to the foster carer role

A number of issues emerged in the interviews with foster carers that they believed undermined their role in delivering RSE to YPIFC, many of which related to the concept of 'children's rights'. The discourse of children's rights and the 'voice' of children turned out to be complex concepts in relation to how they were interpreted by participants. There was a general sense that YPIC were hard done by at a societal (macro) level and that their rights to resources, education and legal protections should be prioritised; however, there was also a view that the balance of power had tipped too heavily in favour of children at an individual (micro) level and this excessively undermined the role of parents, with detrimental consequences. Speaking of children in general, one foster father recalled how men of his generation were raised with very authoritarian fathers 'who trashed the lard out of them'. He reflected on the problems created when parental authority was disproportionately eroded.

*But we are now responsible for a lot of the problems in society because things have gone too far the other way. There's too much softy softy . . . You also have to do the parenting so that your children grow up with the respect, so that you engender this kind of respect in them.*

There was also a perception voiced by several participants that the increasing permissiveness accorded to young people impacted more heavily on foster carers than on birth parents. One participant who had been fostering for over two decades expressed the view that everyday routines and practices had become so regulated in recent times that her control as a foster carer was being eroded.

*Again, being at it [fostering] for so long, the adults are not in control. What do they say? The lunatics are running the asylum. Do you know what I mean? It has gone to that. We can't correct them [young people] any more.*

Specifically in relation to RSE, that participant reported that the increasing regulation over foster care by the state (an overview of this is given in Section 1) had impacted on her parenting of foster teens in a number of respects, including the provision of value-laden information. She described how over the years her freedom to advise about sexual health, particularly where this involved attempts to regulate teenage behaviour, had been curtailed through a fear that she might be held accountable for providing information deemed to be inappropriate.

*Participant: It has got to the stage where you can't open your mouth about anything now to children, sexual health or any other kind.*

*Interviewer: Why not? Do you mean it is out of bounds in terms of educating foster children?*

*Participant: Sure, everything is out of bounds. You could say the wrong thing as far as they are concerned and they could have you up for it.*

(To further reinforce her point about state regulation over fostering in general, that participant went on to recount her unease about allowing foster teens to smoke cigarettes in her yard, lest they later attempt to sue her for knowingly facilitating nicotine consumption).

One issue about which that participant was particularly aggrieved was that birth parents could overrule her judgement as a foster carer, and, in her view, birth parents tended to acquiesce to the demands of the young person in order to avoid conflict with him or her.

Another also indicated that she found that birth parents had greater freedom to maintain harmonious relations with the young person as they circumvented the boundary-setting and rule impositions of parenting that often lead to parent-teen conflict.

Challenges to the foster caring role were also reported in the case of the fostered teenager questioning the legitimacy of the foster carers' role as disciplinarians. For example, one participant indicated that on occasion her teenage foster son would point out that she was not his mother (implicitly challenging her authority). In another case, a foster daughter was reported to have informed the foster mother that the behavioural expectations in the foster home were at variance with those deemed acceptable to her birth mother; the foster mother reportedly suggested she would consult with the birth mother about these expectations, at which point the teenager rescinded and began to conform. Challenges to the fostering role and references to rights also came from outside sources: One participant recounted how a former foster teen, a 16-year-old young woman, had at the time of the placement a boyfriend who 'dictated' to her family the girl's legal and social rights. The young man had been in care himself and, according to the participant, had apparently been learning about her rights as a foster child. He used this knowledge in an attempt to exercise control over the foster carers' actions.

*He was reading all the law books and saying how much wrong we were doing and if she wanted to be collected at six, you collect her at six, not at five, not at seven. Dictating to us.*

In a further case, a participant relayed that at the point at which her foster daughter began to display challenging behaviour (after a ten-year placement that subsequently broke down) the girl would defiantly threaten to report to the social worker the foster mother's parenting decisions of which she did not approve. That participant explained that an aspect of the girl's undermining of her as a foster mother was to invoke a formal language and a knowledge of the system, referring to social workers by title such as 'the Principal Social Worker'. It should be noted that most participants were complementary about the input of social workers in fostering experiences, but one participant was strongly of the view that there was a tendency for social workers to take the side of the child where there was any issue of disagreement or conflict between foster carer and the young person.

While accounts here of challenges to the fostering role pertain to disagreements over conduct and behaviour in general and not just foster-parent conflict over sexual health issues, there are implications for foster carers' role in overseeing the sexual health of foster children. Challenges to the authority of foster carers over parenting decisions in general are likely to spill over into parental freedom to manage teenagers' behaviour around sexuality.

To tease out further the complexity of the concepts of the 'voice' of children and children's rights from the perspective of foster carers, examples that focus specifically on sexual health are considered: In one of these examples, the interview began with the participant asserting strongly the view that YPIC needed a voice.

*So my feeling is that they are a particular group that need a voice. In one sense their numbers might be small but they need to be included in what's necessary for them.*

At a later point in the interview, however, the same participant suggested that young people were not mature enough to know what they want and society needed to step in to protect them. She explained her stance as follows, when reminded of her earlier comments about children's rights:

*When I said they need a voice, I mean that society should wake up and look at how children are being treated, like with child prostitution, and they turn a blind eye. As for young people themselves, there's a difference between what they think they need and with what I think they ought to have. A bit like when they ask you for the five hundred euro phone or whatever, and you say, 'That's not what you need, it's what you want'... The difference between what they want and what I think they need... What they want is the freedom to have sex at whatever age they like, and to be quite honest I don't begrudge*

*them. The only thing I begrudge is that they don't produce children that they don't want or they don't intend to take care of or be able to take care of.*

To reinforce her point about the complexity of heeding children's perspectives, she recounted that when her foster daughter was engaging in prostitution, ostensibly this was with the foster daughter's own consent and as a willing party. Yet the participant held that a 15-year old was not in a position to determine whether or not she should engage in prostitution.

*Participant: It shouldn't be up to a 15-year-old child not to go on the game, it should be up to the adult to say that they would not have sex with a 15-years-old child and therefore the child would be safe because the adults wouldn't abuse it. And what children do among themselves would not be as abusive, I feel.*

*Interviewer: But there is a law.*

*Participant: They are not being enforced. It was known to the HSE and the guards what this girl was doing and nobody was ever charged. That's what I feel angry about – these kids are vulnerable. She had no interest in suing – she said she was well up for it – those were her exact words. But we shouldn't be leaving it to a 15-year-old to decide . . . We have to remember that when we are asking them what they want, they are still a child. Adults ought to be in charge. The thing I repeat rather a lot is that adults ought to be in charge – of any children . . . There's an awful lot going on with children. I say children because they are not 18 and we should make it such a crime to have sex with a child under 18 that a man would be afraid to do it, if we cared tuppence about children in this country, which basically I feel we don't.*

In this sense the notion of the young person having a voice is problematised: in taking a developmental approach (as this participant did), it is recognised that minors are not yet adults and do not have the maturity or repertoire of experience to be self-determining. However, it is clear from her narrative how particularly vexed she felt that as a society, so little emphasis is placed on taking children's needs seriously. Thus, she was entirely committed to addressing the needs of children, but through the lens of mature deliberation.

Another participant also registered concerns about the increasing dominance of the children's rights discourse. She expressed her fears that the powers that young people could exercise might place foster carers in a very vulnerable position and at greater risk of false allegations of sexual abuse. Referring to the November 2012 referendum<sup>5</sup> designed to afford to children a greater say over their lives, she raised concerns about how the voice of the young person might prevail in the case of allegations of sexual abuse, to the detriment of an innocent foster carer.

*Participant: Well I think with the new referendum when it comes into place it is going to cause more problems.*

*Interviewer: In what way, would you say?*

*Participant: Because they [young people] are going to be listened to and if you heard her [17-year-old foster daughter] speaking, if she was putting an allegation [falsely against participant's husband], she has this definite explanation and action of explaining, honestly, that is true. And she knows so much about men that she could describe every aspect of the body . . . She knows what everything looks like.*

(The issue of fear of false allegations against foster fathers will be dealt with detail in Section 10).

Another element of the move towards less authoritarian childrearing practices, which had the potential to impact on teenagers' sexual health, was the declining fear culture mediating contemporary childrearing. The participants who raised this issue expressed the view that without a fear of parents' reactions to an early pregnancy, a key deterrent to pregnancy had been undermined.

*Like, years ago there wasn't so much [contraception] available, but now there's loads but they just don't seem to bother . . . I suppose years ago we were afraid to, like. But they seem to take more chances nowadays. You couldn't come in pregnant years ago.*

The diminished ties to birth parents of YPIC were believed to make them particularly vulnerable to early pregnancy. The participant particularly drew attention to the preventive impact of formidable parenting as a motivation to prevent a pregnancy.

*For the kids in care, there's no-one to respond or at least no sense that you can't do that, or having a baby is a no-no. Okay, foster carers can react, but half the time their birth parents probably don't really see teenage pregnancy as a problem anyway . . . Your own learn that they have to aim for the college and all their friends are going to college and that's what they are expected to do, or there'd be hell from their mother and father if they got pregnant.*

Before closing this section, it is worth noting that a few participants gave examples of past foster teenagers with whom they had disagreements and conflicts, yet when these teenagers became adults, they expressed gratitude and appreciation of the strong influence of the foster carers in regulating their behaviour at the time.

5 A referendum was held in November 2012 to make changes to the Constitution of Ireland aimed at increasing the power that children have in determining their lives, and potentially affording them a say in judicial and custody proceedings that affect them (depending on their age and maturity). The proposed changes were carried, since they were approved by the majority of voters. A court challenge was brought to the validity of the referendum process which was ultimately dismissed by the Supreme Court. The changes to the referendum were signed into law on 28th April, 2015.

### Key points: Section 8

- Both continuities and differences in RSE were reported in foster carers' delivery of RSE to foster and birth children.
- The age at which a foster child arrived at a placement impacted on the extent to which foster children were deemed to have different RSE needs: the earlier in childhood that a foster child had been placed, the more the approach of the foster carers resembled that they took with their birth children.
- In some cases, even in long-term placements, specific needs of YPIC emerged during the teenage years.
- Foster daughters were deemed to be in greater need of RSE than birth daughters because they were believed to be more sexually precocious.
- A recurring theme across data was the challenge for foster carers in understanding aspects of a young person's past, of which the foster carers sometimes had limited knowledge.
- Differences in norms and expectations between the birth family and the foster family posed challenges for foster carers in matters relating to sexual health. Influences of previous placements on the young person were also reported to pose challenges.
- Several participants reported challenges in their foster carer role associated with the children's rights' discourse. While there was support for the notion of a societal shift towards recognising and meeting the needs of children at a macro (general) level, there was also a sense that at an individual level young people were still maturing and expressed wants rather than needs that were not always in their best interests.
- A few participants referred to threats to their role as foster carers arising from their diluted authority over parenting compared to the relative autonomy over parenting enjoyed by birth parents. This arose because others (birth parents, and social workers especially) had jurisdiction over their parenting role.

## Section 9:

# Dealing with sexual activity and sexual behaviour of foster teenagers

### Introduction

Given the findings presented in Sections 4 and 7 respectively that (i) there was a widespread acceptance that foster teens were or may be sexually active and (ii) that pregnancy prevention was a priority, some foster carers reported having interfaced with the sexual health services in relation to YPIFC. The experiences of these foster carers in engaging with service-providers about a foster teenager's sexual health are considered here, many of which involved accessing hormonal contraception for young women. We begin the section by exploring participants' perspectives on providing contraception for sexually active foster teens. We then move on to analyse how sexual activity, a private matter ordinarily dealt with within the family, becomes a 'public' one to a degree in the case of YPIFC, due to the obligations of foster carers to the social services (HSE).

### Perspectives on providing contraception for sexually active foster teens

The tendency was that where a foster teen was suspected of or had communicated being sexually active (as reported in Section 4), the focus was predominantly on pregnancy prevention. While some participants spoke of imparting moral messages to discourage sexual activity, facilitating safer sex through contraception tended to be reported to a greater extent and was prioritised. It was not that foster carers approved of early sexual activity – many clarified that they did not; rather, they appeared to be resigned to the fact that they had limited control over a foster teen's sexual behaviour and accepting the use of contraception was viewed as a pragmatic response.

*I was happier that she was on contraception because otherwise she was going to end up pregnant. Not happy as such, I don't think she should be having sex at that age, but what else could we do?*

*The [contraceptive implant] bar isn't the be all and end all, they need all the other education around that, but at least they are not bringing any more helpless babies into the world.... It wouldn't be what I want but they are doing it [having sex] anyway so they might as well have the protection.*



In one case, a participant reported having advised her 16-year-old foster daughter that she had a choice not to engage in sexual activity if she did not feel ready, yet as a precaution arranged an appointment with the doctor so that the young woman could access contraception. The participant conveyed that both she and her husband were very strong in discouraging sexual activity because of their concerns that their foster daughter was already emotionally hurt and craving love. Nonetheless, as pregnancy prevention was a priority, the following was the advice she reportedly imparted:

*I do say, 'To be prepared is to be wise'. It doesn't mean because you are on something you have to be sexually active, but it means if something was to occur you have a measure of protection.*

Another participant intimated that health professionals who supplied condoms to her sexually active teenage daughter left a number of issues around sexuality unaddressed. The young woman in question had been found to be engaging in prostitution and the participant's view was the girl's lack of motivation to use contraception and other issues relating to the circumstances surrounding her drifting to prostitution in the first place also needed to be addressed.

### **The public management of private sex**

In the case of non-abusive underage sex between minors, in conventional family situations the birth parents may choose to deal with the matter privately and informally and not bring it to the attention of the HSE or An Garda Síochána. However, in the case of foster children, participants reported feeling obliged to interface with the HSE where underage sex was believed to have occurred. The difference between how sexual information from foster children is managed compared to that of birth children was summed up as follows.

*And if I have a conversation with my birth daughter, it doesn't have to go outside of us, but if I have a conversation with my foster children, it might have to.*

The participant went on to explain how she was once obliged to share information with social workers that her foster daughter had had underage non-abusive sex (aspects of this narrative were presented earlier in Section 4) when this fact had come to her attention. The young man was also apparently under the age of legal consent to sexual intercourse and admitted to having sex with the young woman. The participant explained that had she lived with her birth parents, both sets of parents may have chosen to manage the issue themselves privately. What reportedly transpired was that the foster mother told the boy's parents what had happened and a meeting was held between both parties (the young man and his parents and the young woman and her foster carers). The foster mother found the boys' parents to be receptive and co-operative when she explained that she was obliged to report it.

In another case, a foster father reported that he and his wife had concerns that their 16-year-old foster daughter might be sexually active. They reported their disquiet to the social worker, who in turn reported this to the service-provider charged with dealing with sexual relationships among minors. At the time of the study interview, that young woman was due to have a visit from the Gardaí concerning the matter. The participant went on to explain that they had also informed the social worker on occasions when the young woman had not observed curfews, as they were worried about her sexual health. On two occasions they felt it necessary to bring her to the doctor for a check-up, all of which was done with social-work support.

In another case in which a social worker was informed about the possibility that a young woman was sexually active, the foster mother described the delicacy of the situation and how she referred the matter to the social worker. Once sexual activity was confirmed, the social worker dealt with accessing the health services on the foster teenager's behalf. The participant continued in her role as foster mother but withdrew from engaging in sexual health provision for the young woman.

*I had it at the back of my head that she needed to be watched. There was something about the way she dressed, and I had a feeling that she was keeping stuff from me - sure, they all do. So I said, 'Would you like to talk to [names social worker]? It's very easy for a girl to get pregnant' and all this sort of thing. I was picking my words, so she kind of fuffed some answer, so I said it to the social worker who said okay, she'd talk to her . . . and yeah, social worker arranged it with the birth mother . . . She was coming up to 16 at that stage. . . . She was given not the bar, the 3-month injection, but we never once talked about it again after that. As far as I was concerned at least she wouldn't get pregnant.*

In an altogether different example, a foster mother's view was that the HSE were not proactive in addressing her foster-daughters sexual permissiveness but rather were focused on maintaining the foster placement, as the young woman had had multiple short-term placements between the ages of 14 and 15. That participant explained that the reason that she had been left to deal with the situation was because those in the HSE trusted that she would do the best that could be done and would manage the young woman capably. In a lengthy description of how events unfolded for her, the participant narrated how her foster daughter (17 at the time of the interview) initially joined her family for respite care at the age of 15 years. During the respite placement, the young woman revealed to her that she was sexually active, information that the participant passed to the social worker. The participant reportedly expressed her anxiety to the social worker that the girl would become pregnant and insisted on reliable contraception being in place as a condition of a longer placement. The participant reported that she had to 'keep after the social worker' to arrange this. She also described it as 'very difficult' having a sexually active teenager in her home, particularly so because the young woman was not using a reliable contraceptive (the foster mother suspected that she may have been using condoms some of the time). The participant went on to explain that the social worker accompanied the girl (who was still 15 years and a 'respite child') to the

doctor on the first occasion. The doctor was not favourably disposed to providing hormonal contraception because the girl was not yet 16 years old. Eventually, with the support of the HSE, a long-acting (with 3-month effectiveness) hormonal contraceptive by injection was prescribed and administered. The participant went on to explain that over the two years since the placement began, she (the foster mother) had overseen the young woman's visits to the GP before the three-month deadline arrived. The HSE furnished the foster mother with a letter granting permission for the contraceptive, without which the doctor apparently would not have administered it. In the following quotation, the foster mother described her proactivity in ensuring the young woman's sexual safety as far as pregnancy prevention was concerned, and the support her presence seemed to offer the young woman at the doctor's surgery.

*And I always kind of renew it maybe five days before the expiry, because one month might be 30 days and one month 31 . . . It is to be renewed now in December. I have to keep a check on this. I went into the doctor on the first occasion and I said to the doctor the story and I said I would leave and you can talk to her yourself. And she [foster teen] said, 'No, no', the doctor said, 'Fine', and the foster child said, 'No, no'. She wanted me there.*

During the interview, that participant expressed her scepticism about the safety of hormonal contraception at such a young age, but concluded that pregnancy prevention was a priority and a better option than a possible abortion. (As indicated earlier, this was a perspective conveyed by several participants).

In a separate case, a participant described how a consultation with the doctor was arranged for a 14-year-old foster teen in order to obtain a prescription for the contraceptive pill. The foster mother explained that it was the girl's birth mother who instigated the decision and who accompanied her to the GP. However, she explained that the doctor was reluctant to prescribe the pill in view of the girl's age. In the following extract from the participant's interview, she conveyed implicitly her sense that the GP's reluctance to prescribe related to a fear of being held accountable in the context of the mandatory reporting of underage sex. She also imparted her own lack of power to influence any decision about the girl's sexual health with the comment that the judgement was 'not [her] call'.

*Because obviously it is against the law, because you are presuming that they are having sex, which we are not allowed to condone. But the birth mother brought her to the doctor and the doctor spoke to her for a while and said to put it off for three months . . . Realistically, in the real world she would be better off on it, but it's not my call. And in fairness to the GP she is probably shocked and she has a rule to uphold, but it probably makes more sense to go on the pill than let her get pregnant. Not that it's the right thing to do but having children is the biggest consequence of anything.*

In general, while there were individual participants who were critical of some decisions made by service-providers, the overwhelming sense from data was that social workers and sexual

health service-providers were supportive of foster carers' attempts to maintain sexual health. As one participant put it: 'No one wants to see young people having babies or getting diseases. We are all singing off the same hymn sheet, really'.

### Key points: Section 9

- Participants tended to be resigned to the fact that their control over a foster teen's sexual behaviour was limited.
- In situations where a foster teen was suspected of being sexually active or had indicated that they were sexually active, the focus was predominantly on pregnancy prevention.
- Foster carers' knowledge of penetrative sexual activity (and sometimes also other sexual activity) of YPIFC was reportedly imparted to service-providers, in line with their perceived obligations as foster carers.
- That foster carers reported feeling obliged to report underage non-abusive sex to professionals outside the family, meant that the private underage sex of YPIC was managed publicly. This was a matter that participants believed could be contained within the family in the case of birth children.
- Several foster carers reported that they had interacted with health and social professionals in order to maintain the sexual health of the young person. Most of this interaction was related to accessing hormonally-based contraception for foster daughters.
- Some foster carers were of the view that service-providers were restricted by the law in exercising their professional judgement and participants generally found them to be supportive within the limits of their role.

## Section 10:

# RSE and sexual health with reference to foster fathers

### Introduction

It was noted in the literature review (Section 1) that the presence and engagement of fathers in young people's lives appears to have a protective effect on the sexual health of adolescents. In this, the final findings' section, we consider foster fathers' role in providing RSE and promoting the sexual health of their foster children, and in particular, of their foster daughters. A salient aspect of the data from foster fathers was their sense that any role that they might have in RSE provision with their foster children was compromised by the pervasive effects of child protection discourses and the fear of a false allegation of sexual abuse. In this section, this issue is explored, as well as the wider matter of how the discourse of child protection reportedly influenced routine social interactions between foster fathers and foster daughters to a greater extent than arose in the case of birth children.

### Fosters fathers and child protection discourses

One of the striking features of data from male participants when asked about what they believed the needs of their foster child were in relation to sexual health was the dominance of anxiety about child protection discourses that positioned men as potential sex abusers. One man described his sense of discomfort when he first set in motion plans to become a foster carer and realised that the expectations of parental interactions with foster children were gendered, with one set of practices and obligations for men and another for women.

*Well I had an issue with my foster training. There is an element of sexism there as far as I was concerned. Men have to be more mindful of the boundaries that they have. I personally had an issue with this, I felt it was sexism.*

That participant went on to explain that his sense of discomfort around foster fathers being treated differently from foster mothers did not appear to be shared by other men undertaking the training programme, yet this did not appease his sense of disquiet about gender differentiation.

*I was actually very surprised when I was doing my training, because there was other people there and let's say it was pretty much ten men and ten women in my training and at least seven of the men were saying, 'Oh yes that is right'. And I lost the plot: that is sexist, whatever applies to women applies to men . . . If it is preventing yourself from allegations, that applies equally to women as it does to men.*

Almost all of the men interviewed reported a heightened sense of consciousness of the discourse of abuse by foster fathers, which was reportedly never far from the thoughts of some.

*So there is a boundary there that has been put into my head by the HSE . . . And it is a male thing . . . It is constantly consciousness that plays along almost every moment of every day.*

The male participants spoke of deliberately working at maintaining their identities as upstanding members of the community and were constantly on their guard so as to distance themselves from the identity of abuser. When it came to sexual boundaries with their foster children, participants reported being constantly on the defensive, merely to maintain their identity as beyond suspicion.

*That is the fear that is planted in your head; it is to prevent an allegation. You have to have absolutely no opportunity for an allegation to come about.*

*It is unfair and it is difficult but in a sense you are just so open to anything.*

One man reported that the suspicion that hangs over men was a societal phenomenon rather than just a 'HSE' issue, and it was perceived to be unfair. Indeed, the words 'not fair' were mentioned by a few participants in relation to the constant suspicions that mediated foster fathering, which cast every foster father in the identity of potential abuser in far stronger and more explicit terms than was the case for either foster mothers or birth fathers. Several of the foster mothers interviewed corroborated the views of male participants, conveying that their husbands or male partners were very conscious of the fear of an allegation of sexual abuse being made against them.

Speaking of this anxiety of allegations 'hanging over them [foster fathers]' one man related having heard 'horror stories of false allegations'. Another was of the view that most claims against foster carers are against those who have been engaged in fostering for several years. He put this down to experienced foster carers becoming complacent and letting their guard down by way of 'shortcuts'.

It was noted by a male participant who had been fostering for almost 20 years that the intensity of suspicion around men as potential abusers had markedly increased as knowledge about

the prevalence of sexual abuse pervaded societal discourses more heavily. He recalled how in other areas of life accepted behaviours have also altered over that time; for example, a juvenile sports club with which he was associated now mandated that a female be present at coaching events for minors, which was not a requirement a decade earlier. As he contended, 'So we all became very conscious of the fact of how vulnerable we are in any situation where there are young people'.

While being constantly on the alert that all of their encounters had to be incontestably above reproach, there was simultaneously an acceptance among foster fathers that there was no alternative to this high level of vigilance.

*I wouldn't call it a burden, it is just the way it has to be.*

*Do I think it [child protection at a societal level] has gone too far? I do think it has gone too far now but we don't have another alternative to that at the moment . . . I think it is there for a reason, I accept that, but while children are very protected now I think for people like me it is almost a suspicion over you all the time and that is not nice.*

One man went on to describe how he had come to the realisation that the prescribed rules of conduct around interacting with foster children were designed not just to protect young people from abuse, but also foster fathers themselves from allegations of abuse in situations where they may be innocent of any wrongdoing.

*And I asked them [at the foster carer training programme] again and, oh yes, because 90% allegations are against men anyway. Well actually 90% of sexual child abuse comes from men . . . I was sort of idealistic a small bit then but having seen in group sessions [with other foster fathers], I have seen the other side of the coin and it is malicious: the birth families aren't happy about something so they convince the child to put in an allegation.*

There was also an acceptance among foster fathers that any allegations of sexual misconduct ought to be taken seriously.

*You can imagine if a public allegation . . . it has to be taken seriously, you are put through the wringer.*

*It's very hard, I mean what can the HSE do? You can't lighten up on the rules because that could put children at risk.*

## Foster fathers' interactions with foster daughters

Foster fathers' concerns about allegations of sexual misconduct had implications for their relations with their foster daughters. In particular, it affected degrees of trust in the relationship, impacted on RSE delivery by foster fathers and regulated their daily movements. Before considering these issues, it should be noted that reports of fears relating to foster sons were far more marginal in the narratives of participants. When prompted, participants suggested that the same precautions should apply in relation to boys, but they provided far less information about this. The perceived risk of an allegation from a young woman tended to be higher than that from a young man as far as foster fathers were concerned, and this was reflected in their accounts.

*Interviewer: Would you implement the same precautions with a foster son?*

*Participant: I would classify it as being the same . . . But actually, it's probably a bit easier because there's less chance percentage-wise of an allegation being made against you from a boy.*

If we first consider the issue of trust, one man who was fostering two girls - one a preteen and the other aged 17 years - indicated that he had judged which foster child to trust and which to approach with caution. The older of the two (on a relatively short placement) was described as highly sexualised and he was in fear that she might make a false allegation, as she had previously insinuated to his wife that he was looking at her (the young woman) in an inappropriate way. He went on to explain that in relation to their other foster daughter, who had lived with them since she was a baby, he encountered no barriers in his interactions with her.

Another participant revealed that his fear of allegations was eclipsed by his wish to ensure his foster daughter was happy and well-adjusted. He was the participant referred to earlier, who also spoke at length about his sense of indignity that foster fathers were cast as potential abusers, and about his fear of allegations. When he spoke about his warmth and affection for his foster-daughter (aged 12 years) over the course of a long placement, he dismissed the fear of allegations<sup>6</sup> as follows:

*I don't really think about it too much or analyse it [fear of allegations], I just let it be the way it is. As long as she [foster child] wakes up on her 18th birthday and she is healthy, happy, wise and feels connected to where she is in life, I am happy with that.*

## Foster fathers' perceptions of their role in RSE with foster daughters

The intense awareness and underlying fear of being misinterpreted was also found to prevent foster fathers from engaging in any discussions of sexuality with their foster daughters. The complexity of their situation was described by one participant as follows:

<sup>6</sup> One of the strengths of in-depth interviewing is that it can capture 'both coherence and inconsistency' (Soss 2006, p. 143) in how humans perceive their situations, something that may elude other more structured methods. As interviews progress, participants may manifest contradictions and inconsistencies in their thinking reflecting the complexity of human thought patterns.



*The tension that is there between a man even venturing into the area of sexuality with a girl in a sense prohibits you nearly from having the conversation . . . You don't know how it can be misconstrued or how it could come back to bite you later on. So I think foster fathers are in very difficult situations.*

Another participant, was reluctant to discuss his 17-year-old foster daughter's reported promiscuous behaviour with her, although he disapproved of it, for fear any mention of sexuality would be misinterpreted and a complaint be made against him. His strategy was to have his sentiments conveyed through his wife, or to have his wife witness any advice about sexuality that he gave to the young woman.

It was also acknowledged that the foster child's history prior to the foster placement also influenced the sexuality education being delivered. One man noted that where a foster daughter had negative feelings about males arising from past experiences this would influence her relationship with the foster father and impact on direct or indirect sexuality education. He noted that in the case of his foster daughter (aged 16 years), the openness in the relationship between her and his wife regarding RSE was very different from his relationship with her. A few others – both men and women – similarly noted that some foster children, girls in particular, were nervous and withdrawn with the foster father, although in many cases this dissipated over time. This was largely put down to their prior experiences of aggressive and emotionally dysfunctional men.

In another case, a male participant had to some degree broached sexuality education with his 11-year-old foster daughter by offering to clarify anything she had covered at school; however, he added that whether a sustained conversation around sexuality would be maintained as she moved into her teenage years remained to be seen. One of the foster fathers indicated that he himself had undertaken a further education course on RSE, but would never be able to use his knowledge and skills in this regard with foster daughters. He indicated that in relation to schools, he would feel safe providing RSE because the mode of delivery was group work and thus there would be enough witnesses to protect him against allegations.

It should be noted that several participants indicated that even with birth children where they had these, RSE tended to fall to the children's mother, a finding also of the Parents' Study (Hyde *et al.* 2009). One man, though, imparted that in the case of his birth daughter, he was party to sexual health discussions initiated by his wife. Although he revealed that his wife had been the one to undertake sexuality education with their birth daughter, he nonetheless felt completely at liberty to partake in this, a freedom that he did not experience in relation to his foster daughters whom he found to be more sexualised.

*Oh god, I did absolutely feel freer, absolutely I would feel freer. But I didn't have to do it [the sex education]. Foster girls are much more sexualised, depending on their experience.*

Another participant presented a similar view as follows:

*Interviewer: What about with your birth daughters – did you have that issue? Were you able to talk to them?*

*Participant: Oh yeah, no issue whatsoever. With foster children, it's tiptoeing carefully, very much so.*

In relation to a foster daughter's appearance, a few men conveyed their sense of caution about making any references to this. One stated that when his 16-year-old foster daughter 'dressed up' he declined from comments of any description, because of the danger of it being misconstrued. Even a benign comment about her hair being nice, he noted, was avoided lest there be any misunderstanding:

*Because it can be taken . . . I think in the current environment, I think the man has to be doubly sure rather than just...*

Another man recalled how on one occasion he had reprimanded his (then) 16-year-old foster daughter for her scant clothing when cycling because he believed the attire to be inappropriately sexual and revealed her underwear. He indicated that the young woman 'went in and told [wife]. She [foster daughter] made a big deal of it'. In a further case, a foster father indicated that while he would not have ventured into any sex education with his teenage foster daughter, he would voice his disapproval of her inappropriate dress if this was deemed necessary.

### **Regulated interactions with foster daughters**

All aspects of social interaction are regulated by cultural expectations, but interactions between foster fathers and foster daughters in particular were reportedly different from relations between fathers and birth daughters. In addition to dialogues about sexuality education with foster daughters being out of bounds for foster fathers, platonic physical contact that normally signals closeness and affection, such as hugs and non-invasive kisses, were also curtailed, in some instances at least. One foster father described his sensitivity around even the most banal form of physical contact.

*There is almost this sense that you just have to be so careful of situations. And I know I would feel in an awful state if I was a man primary teacher, it can't be easy to handle all these issues and that. And if you are by nature tactile and outgoing, because you are constantly stopping your natural tendencies to put, you know, something like that, so you are conscious of doing things like that [gestures a reassuring pat on the arm].*

The participant went on to explain that while it might be considered acceptable (at a societal level) to give his foster daughter (aged 16 years) a 'little kiss' goodbye were she going away for a weekend, he would nonetheless balk at doing so in view of the delicacy of the situation. In addition, he indicated that displaying normal affection as one would for one's birth teenagers such as hugs and kisses in situations where there are witnesses, but refraining from doing so when alone with the adolescent 'creates an artificial situation', which might confuse the young person.

*But even if you do, if I gave her a hug when there are others around, then you don't do it when there is nobody around that creates an artificial situation as well. So the child doesn't know when you do and when you don't. Because I don't think you can expect them to understand all these different things.*

Without making any claims about the generalisability of these findings, there are likely to be implications for fostered teenagers of missing out on experiencing the subtleties and fine lines between types of physical contact that children imbibe and get a sense of in the normal course of socialisation. Identifying what physical contact is appropriate and in what circumstances would seem to be an important skill-set for adolescents. It enables them to read the subtle cues in potentially intimate situations and alerts them to possibly dangerous ones. If normal levels and types of platonic intimacy as occur between opposite sex relatives are not experienced, opportunities for learning healthy forms of contact that require a cultural literacy around what feels comfortable may be compromised. This literacy involves being able to read the most subtle differences in touch or physical manoeuvres – and acquiring a sensitivity to the signals of boundary shifts from platonic to sexual. It also means that physical contact becomes almost solely associated with the sexual.

While the issue of everyday boundaries and expectations was explored in relation to imparting social skills to YPIC in Section 6, here it is considered with regard to how some male participants spoke of house rules designed in part to protect themselves against allegations of abuse. A few described how they actively participated in strategies/techniques, some of which were advised by HSE staff, to prevent any situation from arising that would leave them open to suspicion. One explained how he had developed 'a whole system at home . . . I knock on the bathroom door in case somebody was in there, especially if it is locked, just in case I might burst in the door'. Speaking of best-practice guidelines about fostering that he had acquired, one man stated that 'You sort of have to apply them in your home at all times'. One man reported that the social worker regularly brought the issue of prevention of allegations to the attention of him and his wife. Another reported that while maintaining formal rules for interacting in his own home was acknowledged as 'a burden', avoiding allegations of misconduct was a priority.

*Yes, it is a burden, but you definitely don't want to be in that 1% where if stuff did come out . . . So if a false allegation came up against you, you wouldn't want any grey areas at all.*

Another man, reportedly circumspet of his 17-year-old-foster daughter (on a relatively short placement), indicated that his way of fending off allegations was to restrict the girl's access to him.

*Participant: I wouldn't have her . . . with me on my own, no, I would make sure . . . [pauses]*

*Interviewer: Is that stressful for you?*

*Participant: It is not stressful. I just keep her out of the way.*

A few foster fathers made reference to a manual about fostering that provided practical advice for foster carers about a range of issues.<sup>7</sup> One piece of advice reported was that foster children should sit in the back seat of the car instead of the front. In relation to this, one recounted that his foster daughter had experienced situations where she was required to sit in the rear of the car while his birth daughter sat in the front. He reported that he attempted to explain the reasons for this to her since she reassured him that from her perspective, 'nothing would happen', to which he reportedly replied, 'Yes I understand, it is nothing about you but it is about the situation that I am in . . . I just can't put myself at that risk'. He indicated that he insisted that when dropping her to school or to a friend's house she would sit in the back seat until she reached 18 years. Some foster fathers did indeed appear to leave themselves somewhat exposed. For example, one imparted that on short car journeys, he sometimes allowed his 12-year-old foster daughter to sit in the front; however, on long journeys she was required to sit in the back seat. He also reported that some of the well-meaning advice was not always practical; for example, the guidance to ensure that two children are present with the foster father at all times. He noted that transporting children to different activities sometimes meant that he was alone with the foster child, but would insist that she sit in the back. In such instances, the guidelines about having two children present would have to be waived in favour of practicalities.

While many men described differences in how they interacted with their foster children compared to birth children (most notably a heightened sensitivity around anything relating to sexuality), there were also continuities. One man indicated that the rules for privacy and containment emerging from the manual about how to interact with foster children were something that he had now begun to put into practice with his birth children. (Courtesies such as knocking on bedroom and bathroom doors before entering were included here).

*And it is interesting as well because that safeness, I actually apply that to my own birth child. She is the youngest of the family . . . So what I apply to both of them, because you can't have one . . . so I just set boundaries.*

<sup>7</sup> The manual being referred to here may be a local initiative developed by social care professionals. It was not possible to precisely identify the reference for the manual, as following the interview there was no further contact with these participants.

The participant's decision to treat both girls equally indicates that while a level of anxiety tended to mediate relations between men and their foster children – girls in particular – there were also shared aspects of the rules of conduct for interacting with foster and birth children.

When asked if there were particular supports for foster fathers to assist them in their role one woman expressed the view that there should be more safeguards in place to protect foster carers against allegations. She did not express confidence that the HSE would support her husband in the event of an allegation against him.

*And the HSE, they say they roll in behind you, but when the time comes they may not do that. There should be more protection for the foster carers against allegations. The HSE has nothing in place because the resource worker has said, 'Watch your allegations, it is up to yourself to protect yourself'.*

A practical support advocated by one foster father was for fostering conferences to include a workshop for men, where a range of issues pertaining to foster fathering could be discussed.

*I would love to see if there was a workshop now for men, foster fathers, to meet and talk about these issues. I'd be going for that because I'd like to see that space, I would like to hear that space. Because I haven't had a chance of hearing that. To have it where you go to a workshop and it is talked about generally, because there is such a difference between how the foster father responds and how the foster mother responds.*

Other men interviewed subsequent to the interview with the above participant, when asked their opinion on the issue, all concurred that they would welcome such a forum for men who foster.

In conclusion to this section, it was clear that foster fathers had an inescapably compromised relationship with their foster children, and their foster daughters in particular. This may well impact on the sexual health of these young women given the evidence of the importance of fathers' emotional engagement as a protective factor (Katz & van der Kloet 2010; Wight *et al.* 2006).

### Key points: Section 10

- A dominant feature of data was for foster fathers to report fear and anxiety about false allegations of sexual abuse of a foster child, in particular of a foster daughter.
- There was a tendency for foster fathers to accept that while negotiating their role in minimising the risk of an allegation was difficult, there was no alternative to these rigorous child protection measures if children in society were to be protected.

- Foster fathers' concerns about allegations of sexual misconduct had implications for their relations with their foster daughters, for levels of trust in the relationship, and restricted them in undertaking RSE with foster teens, particularly young women.
- Platonic physical contact that is normally associated with father-child relations to express closeness and affection tended to be curtailed by foster fathers in relation to their foster children, foster daughters in particular.
- Foster fathers reported a range of practical measures recommended by social care professionals designed to minimise an allegation of abuse. They also described a heightened consciousness about having and enforcing house rules for the same purpose.
- Male participants concurred that a forum such as a workshop for foster fathers to share their concerns and views in relation to the challenges of implementing child protection measures would be helpful.

## Section 11:

# Summary and conclusion to Report No. 4

This study, based on the narratives of 19 foster carers and five birth parents of YPIC focused on identifying what these participants believed to be the needs of YPIC with regard to their sexual health and RSE. The study design employed a qualitative methodological stance that allowed the key objective – a needs’ assessment of sexual health and RSE for YPIC – to be interrogated in depth, and most especially, in the social context of the lives of the young people as described by their foster carers and birth parents. While uncovering ‘needs’ is the central focus of this report, a remarkable amount of contextual information was gathered that illuminated just where these needs were believed to be coming from. Moreover, the complexity of the sexual health and RSE needs of YPIC may only be appreciated by getting a sophisticated picture of their lives in foster care in areas that stretch beyond sexual health in its narrow sense to social and emotional aspects of life.

The findings of this report have addressed the specific objectives of the study as set out in Section 1 by reliably describing the sexual health and sexuality education needs of YPIC from the perspective of foster carers and birth parents. The findings also detailed the degree to which these needs are reportedly being met by foster carers and birth parents. The protective and risk behaviours among YPIC from the perspectives of foster carers and birth parents were also captured in data, as was participants’ sense of their attitudes and knowledge about sexuality. Where appropriate, the findings of the present study were compared and contrasted with those from published Irish qualitative research to highlight the degree to which there were similarities and differences. More difficult to capture, however, was what supports foster and birth parents believed would enhance their role in providing RSE and sexual healthcare to the young people. Participants generally found it difficult to identify discrete supports that might be beneficial. This appears to arise because many of the challenges foster carers faced in delivering RSE and safeguarding the sexual health of the young people in their care lay in wider social, emotional and contextual issues, which are not easily addressed by specific interventions.

In relation to key specific findings, as a context to identifying the sexual health and RSE needs of YPIC, participants’ overall experiences of fostering were captured. Their experiences were

found to vary considerably, both across the sample and for the same participant, according to the demands of an individual young person. Overall, fostering was reported to be a positive experience.

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

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

With reference to participants' perspectives on the sexual attitudes and behaviour of YPIC, it was reported that, notwithstanding individual differences among YPIC, there was a shared recognition that fostered teens tended to present more challenges than did birth teenagers in terms of sexual health. Adolescent girls who were fostered were believed to be more sexualised than those not in care. In contrast to findings from the Parents' Study (Hyde *et al.* 2009), foster carers in the present study readily acknowledged that their foster teen was or might well be sexually active, even by mid-adolescence. Participants expressed greater concerns about the sexual behaviour of teenage fostered girls compared to boys; risky behaviours such as alcohol and illicit drug use were found to be dominant concerns with fostered boys. Awareness that a foster teen was sexually active emerged in a variety of ways, ranging from implicit acknowledgement of a foster carer's suspicion by a foster teen, to uninhibited open admission by the young person.

In relation to the central issue of this report – perspectives on the sexual health and RSE needs of young people in foster care – it was reported that while factual information about sexuality was an essential part of a young person's RSE, this was already being delivered through schools and was not viewed as a priority. There was overwhelming agreement that against a background of often unstable and inconsistent parenting, YPIFC have a strong need for emotional security and stability as a prerequisite to good intimate relationships. Building confidence and strengthening self-esteem and self-worth were deemed to be key needs in terms of providing the building blocks for good sexual health. There was also widespread agreement that YPIC need to learn social skills as a basis for good sexual health. None of the



participants interviewed reported having encountered LGBT issues with foster teenagers, and thus did not identify any particular needs for YPIC around this.

Data suggested that participants attempted to impart social skills and enable emotional learning in YPIC by engaging in everyday interactions and routines that facilitated these. A key opportunity for psycho-social learning was through interactions during family meals. In addition, social skills were sometimes taught in more concrete ways, such as in clarifying the house rules for the young person. A few participants alluded to the skills of contract-making and honouring and respecting agreements, which are important to facilitating mutuality in relationships. Various techniques were reported by participants in order to increase their foster child's confidence and social competence, including role modelling of appropriate behaviour and advocating on their behalf.

As well as facilitating an environment for social and emotional skills' learning, participants also engaged in 'direct' sexuality education with foster children. During the preteen years, this direct RSE tended to be more science-orientated, but became more behaviour-orientated as the teenage years progressed. Messages related to sexual behaviour were heavily focused on the consequences of sex, particularly that of early pregnancy; these were more strongly emphasised with young women. However, values-orientated RSE was also reported with foster children. Values-orientated messages emphasised the morality of actions that pervade intimate relationships.

Participants tended to prioritise pregnancy prevention over other sexual health concerns (e.g. STIs, sexual competence/readiness in relation to age of sexual consent) and to focus this concern towards foster daughters rather than foster sons (for example, by ensuring that the girls had knowledge of, and access to, contraception if they were sexually active). Identifying specific challenges in relation to the sexual health needs of boys were, relatively speaking, absent from participants' narratives.

Participants referred to a variety of strategies that they employed to deliver RSE, including embedding safer sex communications in sex-positive messages, making covert references to sexual behaviour, invoking humour, and using opportunities that arose from everyday life. A diversity of responses from the young people to direct RSE were described by foster carers including embarrassment and disengagement; these mirror the responses that young people in general were reported to employ in the Parents' Study (Hyde *et al.* 2010).

Among the objectives of the study was to identify what is similar and what is different in term of sexual health and RSE when fostered young people are compared to young people in general. The extent to which foster children were deemed to have different RSE needs to birth children tended to depend on the age at which a foster child arrived at a placement. Generally, the earlier in childhood that a foster child had been placed, the more the RSE approach of the

foster carers resembled that they adopted with their birth children. In some cases, even in long-term placements, a recognition of specific needs of a foster child first emerged during the teenage years. In addition, foster daughters were deemed to be in greater need of RSE than birth daughters because they tended to be viewed as more sexually precocious.

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

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

Several foster carers had experience of interacting with health and social professionals in order to maintain the sexual health of the young person. Most of this interaction was related to accessing hormonally-based contraception for foster daughters. Some foster carers perceived service-providers to be restricted by the law in exercising their professional judgement. Participants generally found service-providers to be supportive within the limits of their role.

The final findings' section of this report focused on RSE and sexual health with reference to foster fathers. A dominant finding was for foster fathers to report fear and anxiety about false allegations of sexual abuse of a foster child being made, in particular of a foster daughter. Foster fathers generally accepted that minimising the risk of an allegation was an ongoing personal challenge, and that rigorous child protection measures were necessary in order to protect children in society.

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

The findings of this report have captured the voices of foster carers and birth parents as they expressed their views on the sexual health and RSE needs of YPIC. In the final composite report of the SENYPIC programme of research (Hyde *et al.* 2015c), these voices are synthesised with those of others, namely service-providers and young care leavers, who are also key informants on the topic. In the composite report, an overall conclusion and recommendations relating to the whole SENYPIC programme of research are given.

### **Limitations of the study**

This study of foster carers' perspectives on the sexual health and RSE needs of YPIC, like all studies, has limitations. The fact that this was a volunteer sample may have resulted in attracting participants who were more committed to the fostering (and indeed RSE) role than might ordinarily be found across the broad population of foster carers. In other words, the perspectives expressed by participants may not be representative of foster carers in general. In addition, and this is a limitation of all self-report studies, participants may have been keen to present themselves in a positive light and may have been more likely to invoke socially approved discourses in conveying their attitudes to the fostering role. Finally, the fact that there were only two participants fostering the children of relatives obviated comparisons between those engaged in relative care and those fostering non-related children.

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# Appendix 1:

## Topic guide for interviews with foster carers

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### *Background information*

- Years of experience as foster carer
- Age and sex of current foster care children
- Age and sex of previous foster care children
- Length of time children generally stay with family – e.g. short term or longer care, etc.
- Do you have children of your own? Can you tell me a little about your own family – how many kids, ages?

### *Section 1: Approach to sex education in the home*

*Thinking about your own children (If no children ask directly about foster children)*

1. In general do you discuss issues as a family? Do you/did you spend time talking about your day/interests – family meal time etc.? And is this the same with foster child?
2. When your child was younger (or currently), did you discuss issues around ‘stranger danger’ or the danger of using the internet? And is this the same with foster child?
3. Did you and your partner agree/discuss how you deal with sex education with child/ren?
  - Whose responsibility is it?
  - Are there different roles depending on gender of child?
  - Do you have the same agreement when dealing with foster child/ren?
4. Have you ever discussed sex and relationships with your own child/ren?
  - At what age?
  - If you have not yet discussed RSE with your child – do you plan to?
  - How did you approach the subject? (Once off or longer communication)
  - Can you recall if it was a conscious decision/due to circumstances (e.g. child prompted/parent prompted)?
  - How did your child respond?
  - How do you or your partner deal with sexual content on TV/media or newspapers?
  - What has your experience been with your foster care children?



5. Have you ever discussed lesbian/gay issues with your children?
  - Is this the same for foster care children?
  
6. Have you talked to your child about contraception?
  - Different types?
  - How to use?
  - Where to obtain?
  - Is this the same for foster care children?
  - Do you think your child/foster child knows enough about contraception?
  
7. Have you talked to your child about STIs?
  - Different types?
  - Different types of protection?
  - Is this the same for foster care children living in your family?
  - Do you think your child/foster child knows enough about contraception?
  
8. Have you ever brought your child to:
  - GP for advice on contraception or sexual health? Describe...
  - Sexual health service?
  - Other service?
  - Have you ever brought any of the foster care children to such services? Describe?
  - Would you bring a foster child to a sexual health service?

## **Section 2: Sources of information about RSE**

1. Who in your opinion have the strongest influence on children in care?
  - a. Does social worker/social care staff play a role?
  - b. What about friends/peers?
  - c. Foster carers?
  - d. Other influences
  
2. From your experience as a foster carer, do children in care know enough of relationship and sex education?
  - a. Where do they get this information?
  - b. Whose responsibility is it to provide relationship and sex education?
  
3. Have you had any contact or discussions with
  - a. The school in terms of sex education and dealing with sexuality and relationships?
  - b. The social services in terms of sex education and dealing with sexuality and relationships?
  - c. The birth parents of the foster children on relationship and sex education?
  - d. Foster care support services terms of sex education and dealing with sexuality and relationships?
  - e. Any other agency?

4. Have you ever received support material or attended any course to help with the relationship and sex education courses?  
Would you attend a training course to help you provide relationship and sex education?  
Any suggestions on what would help foster carers in this regard?

### **Section 3: Risk behaviours**

1. Thinking about general behaviours/issues - would you have any concerns about your foster care children in terms of (Prompt)
  - a. School attendance? School achievements?
  - b. Smoking/alcohol use? Illegal drug use?
  - c. Self-esteem/mental health?
  - d. Challenging behaviours?
  - e. Anything else?If there are any issues – how do you handle them?
2. [If appropriate] Has any of the foster care child/ren got a boyfriend/girlfriend?
  - a. How do you deal with this?
  - b. Do you talk to them about being in a relationship - i.e. issues of respect etc. / dealing with sexual intimacy within a relationship?
  - c. Have you discussed contraception?
3. [If appropriate] Do you think their foster child is sexually active?
4. Have you ever had the experience of teenage pregnancy among the foster care children?
  - a. What age?
  - b. Support services?
  - c. Needs?
5. Overall - thinking about your experience as a foster carer – do young people in care have any additional information and support needs regarding relationship and sex education? How might these needs be met?
6. Is there anything else which we haven't covered which you think is important or relevant?
7. Close interview.

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## Appendix 2:

# Topic guide for interviews with birth parents

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The themes for the interviews were:

### *Background information*

- Number of children (Age and sex)
- Type of care order/When care order introduced?
- [If appropriate – to be guided by Social Worker] Reason for care order
- Age /marital status

### *Section 1 - Approach to relationship and sex education in the home*

1. In general did you discuss issues as a family? Do you/did you spend time talking about your day/interests – family meal time, etc?
2. When your child was younger (or currently), did you discuss issues around 'stranger danger' or the danger of using the internet?
3. Did you and your partner agree/discuss how you deal with relationship and sex education of the child/ren?
  - Whose responsibility is it?
  - Are there different roles depending on gender of child?
4. Have you ever discussed sex and relationships with your child/ren?
  - At what age?
  - If you have not yet discussed RSE with your child – do you plan to?
  - How did you approach the subject? (Once-off or longer communication)
  - Can you recall if it was a conscious decision/due to circumstances (e.g. child prompted/parent prompted)?
  - What did you cover?
  - How did your child respond?
  - How do you or your partner deal with sexual content on TV/media or newspapers?
  - How well informed do you think your children are in terms of relationships and sex?

5. Have you every discussed lesbian/gay issues with your children?
6. Have you talked to your child about contraception?
  - Different types?
  - How to use?
  - Where to obtain?
  - Do you think your child knows enough about contraception?
7. Have you talked to your child about STIs?
  - Different types?
  - Different types of protection?
  - Is this the same for foster care children living in your family?
  - Do you think you child knows enough about STIs?
8. [If appropriate for age] Have you ever brought your child to:
  - GP for advice on contraception or sexual health? Describe...
  - Sexual health service?
  - Other service?
  - Would you bring your child to a sexual health service?

### *Section 2: Influences and sources of information*

1. Who in your opinion have the strongest influence on children in care?
  - a. Do social worker/social care staff play a role?
  - b. What about friends/peers?
  - c. Foster carers?
  - d. Other influences?
2. In your opinion do children in care know enough of relationships and sex?
  - a. Where do they get this information?
  - b. Whose responsibility is it to provide relationship and sex education?
3. Have you had any contact or discussions with
  - a. The school in terms of sex education and dealing with sexuality and relationships?
  - b. The social services in terms of relationship and sex education of your child?
  - c. The foster carers in terms of relationship and sex education of your child?
  - d. Anyone else? (e.g. GP, support service etc.)
4. Have you ever received support material or attended any course to help with the relationship and sex education courses?
  - a. Would you like to receive support material?
  - b. Would you attend training?

### Section 3: Risk Behaviours

1. Thinking about general behaviours would you have any concerns about your child in terms of:
  - a. School attendance?
  - b. Smoking/alcohol use? Illegal drug use?
  - c. Self-esteem/mental health?
  - d. Challenging behaviours?
  - e. Anything else?
  
2. [If appropriate for age] Has any of your child/ren got a boyfriend/girlfriend?
  - a. How do you deal with this?
  - b. Do you talk to them about being in a relationship e.g.. issues of respect, etc. / dealing with sexual intimacy within a relationship?
  - c. Have you discussed contraception?
  
3. [If appropriate for age] Do they think your teenage child is sexually active?
  - a. Have you discussed relationships with them?
  - b. Contraception/protection?
  
4. Have you ever had any experience of teenage pregnancy within the family?
  - a. You yourself?
  - b. Any of your children? (What sex? Age?)
  - c. Support services? Did you get any help?
  - d. What was the reason for the pregnancy? (Planned/accidental, etc.)
  - e. What are the needs?
  
5. Overall in your opinion do young people in care have any additional information and support needs regarding relationship and sex education?  
How would these needs be best met?
  
6. Is there anything else which we haven't covered which you think is important or relevant?
  
7. Close interview.

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