

**Communicating about sexual health and  
relationships within local authority care  
placements**

Catherine L. Nixon, BSc, MSc.

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Sciences Unit, University of Glasgow

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## Abstract

**Background:** Evidence from population-level studies demonstrates that adolescent sexual health outcomes are associated with social exclusion, and that certain groups, including young people looked after by local authorities often experience poorer sexual health outcomes. The poorer sexual health outcomes observed for looked after young people has led to the Scottish Government recommending that looked after young people be prioritised for the delivery of sexual health and relationships education, and that residential carers, foster carers and social workers should play a key role in the delivery of sexual health and relationships information to looked after young people. This recommendation builds on existing policy initiatives that have emphasised that parents should be routinely talking to their children about sexual health and relationships. Despite a growing research interest in the health of looked after young people, there is currently little known about how sexual health and relationships discussions are undertaken within the care setting. This is because much of the research that has been published to date has focussed upon identifying barriers to communication rather than establishing how communications are shaped by the characteristics of carers, looked after children and the wider context of the care system. In this thesis I hope to address this research gap by exploring what factors shape communications about sexual health and relationships within the care setting, and examining the extent to which connectedness, monitoring and supervision – parenting factors identified as promoting positive sexual health outcomes for adolescents within the wider literature – mediate these discussions.

**Methods:** 54 in-depth qualitative interviews were conducted with looked after young people (aged 14-18), care leavers (aged 16-23), residential workers, foster carers and social workers in one local authority in Scotland between August and December 2011. Data were analysed thematically, with data collected from corporate parents and looked after young people used to compare and contrast experiences of talking about sexual health within the care setting.

**Findings:** The results presented in this study demonstrate that there has been a perceived shift in attitudes towards talking to looked after young people about their sexual health, and that residential carers, foster carers and social workers believe that talking to young people about sexual health and relationships should be a core responsibility of the corporate parent. Despite this, the results of this study demonstrate that talking to young people about sexual health and relationship is a subject that is fraught with tensions, with many of the corporate parents interviewed expressing difficulties reconciling their own views about the appropriateness of talking to young people about sexual behaviours with their professional responsibility to inform and protect looked after young people from risk. Looking specifically at how communications about sexual health and relationships were undertaken within the care setting, the results of this study show that talking to young people in care about sexual health and relationships is mediated by the impact of pre-care and care histories, in particular maltreatment and poor attachment security, upon young people's understandings of relationships and their ability to trust other people and seek out help and support. Whilst corporate parents emphasised the need for training to help them identify strategies for talking to young people about sexual health and relationships, the results of this study show that corporate parents are already undertaking sexual health and relationships work that is tailored to the age and stage of the child, and is balanced by the provision of monitoring and supervision to minimise risk.

**Conclusions:** The results of this thesis show that discussions about sexual health and relationships need to be underpinned by a trusting relationship between corporate parents and looked after children. As such, an emphasis needs to be placed upon improving young people's ability to trust other people. Improving permanency for young people in the care system, in conjunction with the development of attachment based sexual health practices, may result in the promotion of positive outcomes for looked after young people. Future policies and training relating to the provision of sexual health and relationships education within the care system should reflect this fact.

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## Author's Declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

A handwritten signature in black ink, appearing to read 'Catherine Nixon', written in a cursive style.

Catherine Lisa Nixon, B.Sc. (Hons) M.Sc.

## Abbreviations

ACES	Adverse Child Experiences Study
AES	Alternative Education Settings
BCS	British Cohort Study
DfES	Department for Education and Skills
DSM-V	Diagnostic Statistic Manual Version 5
HIV	Human Immunodeficiency Virus
HR2	Healthy Respect Phase 2
ICD-10	International Classification of Disease Version 10
ISD	Information Services Division
LAC	Looked After Child
NCDS	National Child Development Study
NSPCC	National Society for the Prevention of Cruelty to Children
SHARE	Sexual Health And Relationships Education
STIs	Sexually Transmitted Infections
UNCRC	United Nations Convention on the Rights of the Child
YPSHP	Young People's Sexual Health Planning

## Glossary of Scottish language and idioms

ae	the
aff her nut/aff her heid	off her head, to go mental
aboot	about
ain	own
anymair	anymore
arenae	are not
aw	all
batter	to beat up
cannae	cannot
claithes	clothes
clean/"getting clean"	to no longer be on/getting off drugs
couldnae	could not
da/daw	father
dae/daen/daeing	do/doing
dead	used before other words to mean "really"
didnae/dinnae	did not
disnae	doesn't
dogging off	truanting
doon	down
doonhill	downhill
eccies	Ecstasy (drug)
efter	after
fae	from
faithers	fathers
flinging aff their clothes	taking of their clothes/jackets
gawd	God

gie	give
gig	a concert
gonna crack me for it	to smack/physically punish
gonna/gonnae	going to
guid	good
haim	home
heid	head
'hing about	hang out
hoh	hey
hoose	house
hunners	hundreds of e.g. "hunners of weans"
intae	into
jaggy jumper haim	children's home
kicking aff	kicking off (e.g. getting rowdy, trouble)
lassie	a girl/young woman
ma	my, when used in front of another word
ma, maw	mother
ma nut	my mind/my head
mair	more
messed wi' ma heid	messed with my mind
nae	no
ned	non-educated delinquent
noo	now
o'	of
o'er	over
on the drugs	addicted to drugs, usually heroin
oot	out

papped oot	kicked out
patter	ability to talk in a warm, jokey manner
pure	used before other words to mean “very”
pure heavy	to be very strict
ressie	residential care
riddie	blushing
scared out of ma nut	scared out of my mind/terrified
shite	shit
skelped arse	smacked bottom
slag you	make fun of
steamin’	very drunk
stupit	stupid
tae	to
tellin’ aff	telling off
tellt	told
the polis	the police
the social	social work
wa	with
wance	once
wasnae/wisnae	was not/wasn’t
weans	children/young people
wee	little or small
werenae	weren’t
wi’	with
wis	was
wouldnae	wouldn’t
wrang	wrong

wummen

woman

youse

you (plural)

wae

with

wae a lassie

in a relationship with a girl/young woman

wido

person who does things that shock others

## **Glossary of social work terms**

This glossary provides definitions of the commonly used social work terms used within this thesis.

### **Looked after young people**

Young people who are under the statutory supervision of a local authority, and are looked after either at home or away from home. The conventional term is looked after children; however for this study I decided to replace the term looked after children with looked after young people as the study included teenagers and young adults.

### **Looked after at home**

A young person who is looked after at home is under the statutory supervision of a local authority but lives within their family home. This is also referred to as home supervision, and it is the duty of social work services to monitor the home situation and provide the family with any additional support that has been identified within a young person's care plan.

### **Looked after away from home**

A young person who is looked after away from home is under the statutory supervision of a local authority and lives away from home in either foster or residential care.

### **Residential care**

This includes residential schools (where young people live and attend school) and residential units (where young people live). The latter of these are commonly referred to as children's homes.

### **Foster care**

This refers to young people who are looked after away from home in a family setting by a registered foster carer. Foster care placements are either provided by the local authority or purchased from private companies.

**Kinship care**

This refers to young people who are looked after away from home by an approved family member or family friend.

**Care leaver**

This refers to a young person who has previously been looked after or is currently in the process of being discharged from the care system. Care leavers can be of any age; however for the purpose of this study, a care leaver is any young person under the age of 25 who is eligible to receive social work support.

**Corporate parents**

A corporate parent is an individual that has a statutory responsibility towards looked after young people. The term was introduced by the Scottish Government to highlight the collective responsibility of carers, social workers, education workers, health workers, policy makers and police/ judiciary officers towards ensuring that the needs of looked after children and young people are met. In this thesis the term corporate parent is used specifically to refer to the social workers, residential care workers and foster carers interviewed unless otherwise stated.

**Supervision order**

A supervision order is a legally binding order that is imposed by either a children's panel or a court where a young person is found to be in need of additional care or support. Supervision orders can be issued with or without a condition of residence attached.

# **Chapter 1: Introduction**

## **1.1 Introduction and aims**

The overarching aims of this introductory chapter are to introduce the reader to the provision of local authority care to vulnerable and maltreated young people, and to establish that young people within the care system are vulnerable to experiencing poor sexual health outcomes as a result of the cumulative effects of social, material and familial adversity. The chapter begins by outlining the process through which the state provides care to vulnerable and maltreated young people; beginning with a brief overview of how local authority care has developed within the UK before moving on to discuss the current process through which children and young people in Scotland become looked after. I then move on to demonstrate that becoming a looked after child is strongly associated with poverty and wider social disadvantage; both of which can increase the likelihood of young people experiencing school exclusion, using substances and engaging in early and risky sexual behaviour. I then show that young people in the care system, as a result of their social backgrounds, are at increased risk of experiencing poor sexual health outcomes, before concluding the chapter by outlining the Scottish Government's policy initiative devised at improving the sexual health of looked after young people.

## **1.2 The role of the state in looking after children**

In this section I provide a brief history of the state's role in providing care to vulnerable and maltreated children, before moving on to explore the current legislation underpinning how children and young people become looked after in Scotland.

### **1.2.1 Historical provision of local authority care in the UK**

The provision of local authority care to vulnerable and maltreated children originates from the poor laws of the early 19<sup>th</sup> Century and the practice of "boarding out" children from the work houses to foster care placements. Whilst many facets of the poor laws can still be observed within modern social work

practice, much of the current legislation underpinning the process by which children and young people become looked after is based upon the legislative and social welfare reforms of the late 19<sup>th</sup> and early 20<sup>th</sup> Century (Curror, 1869, Abrams, 1998, Colton and Hellinckx, 1993, Haythornthwaite et al., 1993, Macdonald, 1996, McRae, 2006). These reforms, which reflected societal concerns about the welfare of children from the lower social classes, included the publishing of the Prevention of Cruelty, and Protection of, Children Act (HMSO, , 1889). This act, which was also called the Children's Charter, was the first piece of legislation specifically designed to protect children from abuse and neglect, and it outlined that the state could, in the event of suspecting that a child had been wilfully neglected, abused or abandoned, remove that child to a place of safety whilst an investigation was undertaken. The act also allowed for criminal charges to be filed against parents and for parental responsibility to be transferred to an individual who was deemed by the courts to be 'fit' to parent (ibid).

Although the Children's Charter marked the first steps towards legislating the protection of children, the liberal welfare reforms of 1906 to 1914 marked a move towards improving outcomes for vulnerable children and their families (Hayden et al., 1999). Included in these reforms was the provision of secondary education to working class pupils; the introduction of free school meals; the introduction of a child-tax allowance for low income families; the establishment of juvenile courts and borstals to prevent children being made to stand trial or serve sentences within adult environments; the provision of free medical treatment for school aged children; and the introduction of legislation that made it illegal to sell alcohol or tobacco to children, or to send children out begging for money (HMSO, 1906, 1908). At the same time, the publication of the Children and Young Persons Act introduced additional punitive measures for individuals caught abusing or neglecting children, and transferred the responsibility to intervene in cases of sexual abuse and incest from the church to the state. This in turn led to the first social work departments being established in order to more closely scrutinise the effects of "boarding out" upon children and families (HMSO 1908).

Over the next forty years, minor amendments were made to the legislation underpinning the provision of local authority care; however, it wasn't until the outbreak of the Second World War that the next major shifts in social work policy occurred. This was because the mass displacement of children and young people through evacuation, parental death and abandonment placed unprecedented demands upon local authority care (Abrams, 1998, Holman, 1996). As the demands upon childcare services increased, greater attention was paid to the effects of entering residential and foster care upon young peoples' emotional and mental wellbeing (Holman, 1996, Shaw, 2007). These concerns resulted in the formation of the Clyde and Curtis Committees to investigate whether the provision of care was capable of meeting the needs of children and young people. The committees concluded that young people in foster care were more integrated within their communities, were less starved for affection and showed a greater degree of independence than young people placed into residential care; leading to it being argued that foster care should be the preferred means of caring for young people removed from the family home (Clyde Report, 1946, Curtis Report, 1946).

Post-war social work policy was influenced not only by the findings of the Curtis and Clyde Committees but also by early work on attachment and maternal separation in which it was demonstrated that juvenile delinquency was strongly associated with the experience of maternal separation in the first five years of life (Bowlby, 1944). This led to the formation of a legislative agenda that emphasised the need to try and maintain the place of children within family units. The 1948 Children Act marked the first steps towards this, with the act stipulating that local authority care should be a supportive rather than a punitive measure, and that social services should do everything within their power to help struggling parents to raise their children within a safe and stable family environment (Abrams, 1998, Colton, 1988). The act also stipulated that local authority care should be viewed as a short-term measure, and that childcare services should work with families towards the long-term goal of reintegrating the child within the family home (Jackson and Thomas, 2000). In cases where this was not possible due to concerns about the child's safety, the act stated that adoption and fostering should be the preferred method of

accommodating children as these best reflected the family model (Abrams, 1998). Today, this ethos continues to underpin social work practices, with the 1989 Children Act stipulating that placing children into the UK care system should only be undertaken if doing so is “better for the child” than not doing so (HMSO, 1989, NSPCC, 2010a).

### **1.2.2 Current provision of local authority care in Scotland**

Although the historical roots of providing local authority care to vulnerable children and young people are similar across all four constituent countries of the UK, it should be noted that the process through which a child or young person becomes looked after in Scotland has differed since the recommendations of the Kilbrandon Committee were adopted within the 1968 Social Work (Scotland) Act. In essence, the Kilbrandon Committee argued that children and young people who required the intervention of childcare services should not be exposed to the full 'rigours' of the judicial process. To avoid this, it was recommended that specialised judicial forums called Children's Panels be convened to assess the welfare needs of children and their families. This led to the introduction of the Children's Hearing System in 1971 (Shaw, 2007, McGhee and Waterhouse, 2002, Lockyer and Stone, 1998, Hendrick, 2003).

Today, the process of referring children and young people to the Children's Hearing System is legislated by the Children (Scotland) Act 1995. This act provides local authorities with the power to intervene on the behalf of children and young people where concerns exist about their welfare and safety. Reasons for referral to the Children's Hearing System include the neglect and abuse of children; the need for children to receive specialist education as a result of complex health and/or learning disabilities; young people experiencing persistent truancy and school exclusion; involvement of young people in offending behaviour; and families identified as requiring additional support due to poor parenting skills, parental drug and alcohol misuse and parental ill-health (HMSO, 1995). Where concerns exist about a young person's welfare or safety, a referral is made to the Children's Hearing system by social workers, health care professionals, educational services or the police (The Scottish Executive, 2003).

Once a referral has been made it becomes the responsibility of the Children's Reporter to undertake an official investigation before making a decision about what action(s) are required to safeguard the welfare of the child/young person and support the family. Three actions are available. These are to decide that no further action is required and discharge the case; to refer the child's case to the local authority so that support, advice and guidance can be given to the child and their family on an informal or voluntary basis; or to refer the case to a children's panel in order that compulsory measures of supervision can be decided upon (HMSO, 2011).

A children's panel consists of three lay members who must decide, based upon the evidence presented, whether a compulsory supervision order is required. A compulsory supervision order places the responsibility for looking after young people, and helping them and their families, upon the local authority. Two different types of supervision orders can be issued by Children's Panels. The first is a supervision order with no condition of residence in which it is stipulated that the child continues to reside in the family home with additional support and guidance provided by the local authority. These young people are referred to as being looked after at home. The second is a supervision order with a condition of residence, and through this, the child may be placed either in foster care, a residential unit or school, a secure unit or in a kinship (family/friends) placement. These young people are described as being looked after away from home (HMSO, 1995). As of the 31st July 2011 there were 16,171 children and young people in Scotland being looked after by their local authority; the highest number of young people in local authority care for 25 years (The Scottish Government, 2012). Two fifths (39%) of young people looked after under supervision order were looked after at home, whilst three fifths (61%) were looked after away from home. Of those young people looked after away from home 33% were looked after in kinship care, 52% in foster care and 9% in residential care (The Scottish Government, 2011b).

Looking specifically at the reasons why young people become looked after, routinely recorded data demonstrates that the most common grounds for referral to the Children's Panel are lack of parental care and children being

victims of schedule one offences such as physical, mental and sexual abuse; wilful neglect and abandonment; and sexual grooming or trafficking (SCRA, 2011). These findings are broadly in line with those reported in the wider empirical literature. For example, Steele and Buchi (2008) assessed the records of 6177 children entering public care in one US state between 2001 and 2004, and concluded that 38% of the sample had experienced neglect, 21% were currently homeless and 15% had been either physically or sexually abused. The authors noted that the reasons for entering the care system varied with age, with older children (aged 13-18) significantly more likely to enter the care system as a result of delinquency (36%) or familial problems with alcohol and drugs (56%) than because of neglect (17%). However, as the authors did not assess multiple reasons for entry into the care system it may be that young people entering the care system due to delinquency also had histories of abuse and neglect. Certainly, evidence from cross-sectional data suggests that neglect and abuse are the most common forms of maltreatment experienced by young people entering the care system. For example, Greeson et al (2011) demonstrated that 68% of young people aged 0-21 in the USA entered care as a result of being neglected. The authors also noted that 54% had been exposed to domestic violence, 32% had experienced sexual abuse and 48% had been physically abused; suggesting that young people often experience multiple forms of maltreatment prior to being admitted to local authority care.

### **1.3 Characteristics and experiences of looked after children**

In this section I move on to explore the socio-economic and familial characteristics that increase the risk of children becoming looked after by the state, before drawing on the research evidence to discuss what is currently known about the pre-care and care experiences of looked after young people.

#### **1.3.1 Socioeconomic factors associated with care entry**

The previous section concluded by noting that child protection and welfare concerns are the most common reasons for children and young people becoming looked after. Within the literature, the association between poverty and child maltreatment is well documented. For example, a secondary analysis of data

from two National Family Violence surveys conducted in the USA in 1976 and 1985 concluded that living below the poverty line was associated with a two- to three- fold increase in the experience of violence towards children residing within the household (Gelles, 1992). Similarly, nationally representative data collected from 42 countries as part of the Third National Incidence Study of Child Abuse and Neglect demonstrated that children who resided in households with an annual income below \$15000 were 18-22 times more likely to be maltreated, seriously injured or sexually abused than a child living in a household where the median income exceeded \$30000 (Sedlak and Broadhurst, 1996).

Given the association between poverty and child maltreatment, it is perhaps unsurprising that child protection registrations and child social work cases appear to cluster within communities experiencing multiple deprivation (Baldwin and Spencer, 1993, Bywaters, 2013, Drake and Pandey, 1996, PHRU, 2007). For example, secondary analysis of US child protection data demonstrates that, when compared to their more affluent peers, young people living in areas of high deprivation are 18 times more likely to experience neglect, 7 times more likely to experience physical abuse and 4 times more likely to be sexually abused. Furthermore, Bywaters (2013) used routinely collected social work data to demonstrate that children living in the 20% most deprived local authorities in England were almost three times more likely to be subject to a child protection plan or to be looked after in out-of-home care than children living in the 20% most affluent local authorities. These analyses also showed that the use of child protective services was highly correlated with area-level scores on the Index of Multiple Deprivation, with 53% of the variation in looked after children's rates and 28% of the variance in child protection registrations explained by: income deprivation; employment deprivation; health deprivation and disability; education, skills and training deprivation; barriers to housing and services; crime; and living environment deprivation (*ibid*). Similar findings have been reported in Scotland (PHRU, 2007). That multiple sources of deprivation can be used to explain area-level variations in the use of child protective services suggests that wider social exclusion may underscore the greater usage of child protective services by poor families. Social exclusion is defined as occurring

when people or areas face a combination of linked problems such as unemployment, discrimination, poor skills, low incomes, poor housing, high crime and family breakdown that leads to opportunities to participate in wider social, cultural, economic and political activities being restricted (Levitas, 2006, The Social Exclusion Unit, 2003). Within the child protection literature there is a growing body of evidence demonstrating that indicators of social exclusion increase the likelihood of young people being maltreated by their parents, being placed on child protection registers and entering the care system (Bebbington and Miles, 1989, Howard et al., 2001, Franzén et al., 2008, Jackson et al., 2002, Sedlak and Broadhurst, 1996, Sedlak et al., 2010, Sidebotham and Heron, 2006). For example, data from the Avon Longitudinal Study of Parents and Children demonstrates that low parental educational achievement, parental psychiatric disorders, early parenthood, single parenthood and lack of social support are all independently associated with increased risk of child protection registration (Sidebotham and Heron, 2006). Similar characteristics are evident in the family backgrounds of young people who are looked after by local authorities, with several studies demonstrating that living in a single parent household; living in over-crowded households; having parents who receive financial assistance from the state; having poorly educated parents; having a mother under the age of 21; and having a mother diagnosed with a psychiatric disorder all significantly and independently increase the likelihood of a young person entering the care system (Bebbington and Miles, 1989, Franzén et al., 2008, Jackson et al., 2002,).

Thus far it has been demonstrated that both child maltreatment and the use of child protective services are highly correlated with social exclusion; however, it should be noted that the majority of children living in low income and socially excluded households are neither maltreated nor do they become looked after. So what might explain why some children living within in socially excluded households experience maltreatment whilst others do not? One explanation is that maltreatment and the use of child protective services occur in situations where there is an accumulation of socio-economic and psychosocial risk factors (Annerbäck et al., 2010, Bardi and Borgognini-Tarli, 2001, Cleaver and Unell, 2011, Franzén et al., 2008, MacKenzie et al., 2011, Masten and Wright, 1998). For instance, Bardi and Borgognini-Tarli (2001) concluded from a secondary

analysis of cohort data that children living in multi-child households characterised by low income, parental mental health difficulties and parental stress were at the greatest risk of being physically maltreated by their parents. Similarly, Franzen et al (2008) used data routinely collected from 1.5 million individuals born in Sweden between 1981 and 1996 to demonstrate that the risk of young people entering the care system increased dramatically when indicators of social disadvantage were aggregated. In particular, the authors demonstrated that children who lived with a single mother who was unemployed, had received only a basic education and had been in receipt of state assistance for over three years had a 1 in 7 chance of being placed into care before their seventh birthday. This was compared to a 1 in 2000 chance amongst children from two parent families who did not receive state assistance, were employed and had completed post-secondary education.

Within the literature it is argued that the accumulation of socio-economic and psychosocial risk factors places undue stress upon families, and that this stress serves to mediate the relationship between social exclusion, child maltreatment and the use of child protective services (Belsky, 1984, Belsky et al., 2007, Bradley et al., 2001, Conger and Donnellan, 2007, Elder et al., 1995, Vondra and Belsky, 1993). The stress that families experience when they are exposed to social and economic hardship can become toxic; resulting in relationships within the home becoming conflict-prone and increasing the risk of harmful, maltreating and neglectful parenting practices being adopted (Guralnick et al., 2008, McCurdy, 2005). For instance, it has been shown that parents who externalise their reactions to stress can: become more easily frustrated; experience parent-child conflict; and adopt harsh or punitive parenting practices (Conger et al., 1994, Gutermuth Anthony et al., 2005, Hilton and Desrochers, 2000, Hooper, 2007, Huth-Bocks and Hughes, 2008, McLoyd and Smith, 2002, Smith and Brooks-Gunn, 1997, Taylor et al., 2009). In the long-term, the adoption of these parenting practices increases the risk of physical abuse occurring (Rodriguez and Richardson, 2007, Nair et al., 2003). In contrast, parents who experience apathy and listlessness when they are stressed can: exhibit less nurturing behaviour; devote less time to playing, talking, going out and taking an interest in their children's lives; and find it difficult to stick to

established routines such as meal times, bedtimes and getting children ready for school (Cleaver and Nicholson, 2007, Hogan and Higgins, 2001, Cleaver and Unell, 2011, Barnard, 2007, Oyserman et al., 2000). In the long-term, the adoption of these parenting practices increases the risk of emotional and physical neglect occurring (Jones Harden et al., 2014).

### **1.3.2 Poor parenting as a predictor of entry into care**

The quality of parenting that children receive is often the main factor that contributes to young people being placed on the risk register and admitted to care. For instance, Woodcock (2003) reported that social workers' decisions about whether to remove a child from the family home and admit them into care are determined largely upon: parents being unable to prevent harm; not providing children with routines and consistent physical care; parents being unable to recognise and meet appropriate developmental demands; and parents being emotionally unavailable to their children. In the remainder of this section I explore how parental difficulties such as parental substance misuse, parental mental ill-health and domestic violence can result in young people growing up in unsafe, violent and neglectful homes. In doing so, I discuss how growing up in these circumstances can: affect young people's emotional wellbeing; result in their adopting care giving roles within the home; and experiencing social isolation and lack of stability within the home.

#### ***1.3.2.1 Unsafe and violent home lives***

Children and young people who enter the care system as a result of parental substance misuse have often been exposed to risky situations and unsafe adults prior to becoming looked after (Brophy, 2006, Hogan, 2003, Velleman, 2009a, Velleman, 2009b). This is because parents who misuse substances, although recognising that their lifestyle can be harmful to their children, will often continue to misuse drugs and alcohol within the home (Hogan, 2003). Drug use within the home can result in children being exposed to drug related paraphernalia, which in turn can place them at risk of needle stick injuries, the transmission of blood-borne viruses and unintended ingestion of substances (Foster, 2008, Velleman, 2009a, Velleman, 2009b). Parental substance misuse

can also increase the risk of children being exposed to criminal activities such as drug dealing and prostitution (Hogan, 1998, Barnard, 2007). These activities, which are often used by parents to fund excessive drinking and escalating drug use, can result in children being exposed to physical and sexual violence. For instance, qualitative interviews conducted with parents who have a history of selling illegal drugs reveal that their children were often present within the home when it was raided by individuals who used violence and intimidation in order to steal money and drugs (Barnard, 2007). Whilst drug dealing within the home has been shown to increase the risk of children being exposed to violence, prostitution within the home can increase the risk of children observing and participating in inappropriate and exploitative sexual activities (Barnard, 2007, Brophy, 2006, Buelow, 1994, Cleaver and Unell, 2011, Velleman, 2009a, Velleman, 2009b).

Parental substance misuse can also result in young people witnessing or experiencing violence at the hands of the parent who is misusing substances (Bancroft et al., 2004, Fals-Stewart and Kennedy, 2005, Fleming, 2010, Gorin, 2004, McGee, 2000, Velleman, 2001, Webster et al., 2002). For instance, a study conducted with 54 children and 48 mothers, found that 71% of the children had been present when their mother had been physically assaulted, and 10% had witnessed their mother being raped (McGee, 2000). This has implications for the safety of young people living within the home, as there is some evidence to suggest that serious injuries to children are most likely to occur when they try to intervene in conflict between their parents, or try to protect the abused parent or their siblings from violence (Fantuzzo and Mohr, 1999). Additionally, young people who witness domestic violence have an increased risk of being abused themselves, with a number of studies demonstrating that between 45-70% of individuals perpetrating domestic violence abused both their spouse and their children (Appel and Holden, 1998, Beeman et al., 2001, Edleson, 1999, Shepard and Raschick, 1999). Exposure to violence on a regular basis can have a profound impact upon young people's emotional wellbeing, with a number of qualitative studies reporting that children living with violent parents experience a range of feelings, including sadness, loneliness, anger, worthlessness, confusion, helplessness, anxiety and fear (Alexander et al., 2005, Bancroft et al., 2004,

Gorin, 2004, Joseph et al., 2006). Of these emotions, fear and anxiety are most commonly discussed, with young people's narratives being filled with descriptions of: their fears of being hit or hurt; the desire to protect themselves by running away and hiding; having to walk on eggshells around the abusive parent, and the associated anxiety experienced by not knowing how a parent will react; and feeling afraid of leaving an abused parent or their siblings alone with the abusive parent (Bancroft et al., 2004, Gorin, 2004, Joseph et al., 2006).

### ***1.3.2.2 Neglectful and isolated home lives***

In addition to exposing young people to unsafe and violent home environments, parental difficulties can result in young people experiencing neglectful and isolated home lives. One group of young people who are at particular risk of experiencing neglect are those who live with parents who misuse substances. This is because parents who misuse substances can experience difficulties instilling and maintaining routine household tasks such as shopping and cooking (Cleaver and Unell, 2011). Parents' ability to provide for their children may also be adversely affected when money that would otherwise be used to pay for essential household items such as food, shampoo, soap and clothing is used to fund the parents' alcohol or drugs habit. Where parents struggle to maintain routines, and have limited resources to provide for their children, it is likely that children will show indicators of physical neglect, including: not have sufficient food to eat; not be provided with routine medical and dental care; wear clothes that do not fit or are inappropriate for the season; be unable to shower and wash (Bancroft et al., 2004, Cleaver and Unell, 2011, Houston, 1997). It is also likely that young people will have experienced their parents being unable to plan for, or forgetting and cancelling, events such as birthdays, Christmas, holidays and school-related events (Bancroft et al., 2004, Handley et al., 2001).

In addition to experiencing physical neglect, the research evidence suggests that parental substance use and mental ill-health increases the risk of young people experiencing emotional abuse and neglect. This is because emotional neglect and abuse often occur when parents become preoccupied with their own difficulties, and fail to be emotionally available and responsive to the needs of

their child (Glaser, 2002). For instance, Aldridge and Becker (2003) used qualitative data to demonstrate that parents experiencing mental illness often became 'wrapped up' in their own problems, and that this made it very difficult for them to address their children's needs. Similar findings have been reported in relation to drug and alcohol addiction, with qualitative research highlighting that addiction can result in parents being focussed more upon securing drugs and alcohol than ensuring that their children are emotionally and physically provided for (Barnard, 2007). Young people living with parents who misuse substances or are experiencing mental ill-health often worry about their parents' ability to look after them. For instance, Houston (1997) reported that young people worried about there not being sufficient food within the home, and that their parents would not remember to pick them up from school. The same study revealed that parents failing to meet children's basic clothing and hygiene needs resulted in children feeling self-conscious, being ashamed of their appearance, and being bullied or losing friends because of 'being dirty', 'smelly' and not wearing 'good clothes' (Houston et al., 1997). These experiences can result in young people feeling isolated, unwanted, alone and uncertain as to whether they are loved (Bancroft et al., 2004, Barnard and Barlow, 2003, Barnard, 2007, Brooks and Rice, 1997, Thompson, 1998).

Concerns about parents' ability to undertake routine household tasks and to provide care for individuals in the household can result in young people adopting care giving responsibilities within the home (Cleaver, 2007). For instance, children living with parents who misuse substances or have mental health difficulties often report that they do the shopping, cooking and cleaning, and that it is their responsibility to make sure that younger siblings within the home are bathed, clothed and attending school (Aldridge, 2006, Aldridge and Becker, 2003, Somers, 2007). Whilst the adoption of care giving responsibilities can mean that young people can become extremely skilled in carrying out chores and providing care to others, taking on a care giving role can place a significant burden upon children. It can also result in their becoming socially isolated and being denied opportunities to interact with their peers and other adults (Glaser, 2002). For instance, studies exploring the experiences of young carers have demonstrated that young people who adopt care giving roles will often choose to

stay home from school in order to: complete household tasks; provide care and support to their parents and siblings; try and protect an abused parent from the actions of an abusive parent; and, try and prevent a parent from using drugs or alcohol (Aldridge and Becker, 2003, Aldridge, 2006, Barnard, 2007, Cleaver, 2007, Houston et al., 1997, Kroll, 2004).

Young people may also choose to isolate themselves when parents' unreliable behaviours results in them feeling ashamed and embarrassed of their home life. For instance, a number of studies have demonstrated that children will try to keep their home lives secret when parents' problems lead to their behaving in unpredictable and embarrassing ways. This can result in young people deliberately disengaging from social activities such as bringing friends home because they fear how their parents will interact with others, and how their home lives will be perceived by their friends (Bancroft et al., 2004, Butler and Astbury, 2005, Kroll and Taylor, 2003, Somers, 2007). Young people are often acutely aware of the stigma associated with mental illness, substance misuse and domestic violence, and believe that withdrawing from their peers will protect them from being teased or bullied by their peers (Aldridge and Becker, 2003, Somers, 2007). Whereas some children choose to conceal familial difficulties because of embarrassment and shame, others may choose to conceal their family situations out of fear. For instance, there is some evidence to suggest that young people living with parents who misuse drugs often choose not to discuss their home lives because they are scared that their parents may get in trouble with the police or end up in prison if they discuss what is happening at home (Hogan and Higgins, 2001, Hogan, 1997). Young people may also choose to hide what is happening within the home out of fear that social services will find out and break up the family (Bancroft et al., 2004).

Although young people try to conceal family difficulties, they want it to be recognised that there is a problem so that they can receive help to try and sort things out (Cleaver and Nicholson, 2007). The conflict between wanting help, but being scared of the consequences of seeking out that help, can result in young people feeling trapped in a position where they feel unable to ask for help or acknowledge their fears to outsiders (Barnard and Barlow, 2003). However, as

the home situation deteriorates, and young people start to feel out of control, their behaviours often begin to deteriorate. For instance, Booth and Booth's (1997) found widespread evidence that feeling out of control resulted in young people: experiencing educational difficulties; being absent from school due to truanting or suspension; reacting with anger and aggression; frequently getting into fights; being bullied; and becoming isolated from their peer group and having few friends. In addition, a number of studies reported young people choosing to self-harm or run away from home in order to cope with parental difficulties, and to escape from parents that they believed did not care about them (Cleaver and Nicholson, 2007, Rees and Lee, 2005, Stein et al., 2009). These behaviours are often 'a cry for help', and the responsibility falls upon professionals to recognise that intervention is required (Cleaver and Unell, 2011).

#### ***1.3.2.3 Changes of home and caregivers***

Parental difficulties can result in young people having to be separated from one of both parents. This can happen for a variety of reasons, including: a parent experiencing mental health difficulties or misusing substances having to be hospitalised in order to receive treatment; a parent that has been dealing drugs ending up imprisoned; or a parent experiencing domestic violence ending up in hospital or having to go and stay in a refuge (Cleaver and Unell, 2011). Separation from parents can be upsetting, and result in young people feeling anxious and afraid; however, when the other parent or another relative can provide young people with the stability, support and care that they need during this time, the psychological impact of the separation can be minimised. This care is often provided by other relatives, with grandparents in particular playing an important role in ensuring the welfare of children is maintained when parental difficulties make it difficult for parents to look after their children (Booth and Booth, 1997, Cleaver and Nicholson, 2007, Cleaver et al., 2007, Hogan and Higgins, 2001, McGee, 2000).

Unfortunately, not all young people have another parent or relative who can step in to provide informal care in the absence of a parent. One reason for this

is that parents who are experiencing difficulties will often have strained relationships with their own parents and siblings. For instance, there is some evidence to suggest that close family relationships and friendships can become strained when adults with mental health difficulties or drug and alcohol problems: withdraw from reality and become increasingly focussed upon their own problems; experience embarrassment and shame at their circumstances; or steal from their families in order to fund their habit or meet debts (Cleaver and Unell, 2011). Parents who have experienced domestic violence may also cut themselves off from their families due to the influence of a controlling partner, or because they wish to conceal their whereabouts in order to protect themselves and their children from the violent (Tarleton et al., 2006). These factors can result in families becoming isolated and having nobody to turn to when they need additional support looking after their children. Where this happens it is likely that the young person will be admitted to care on an emergency basis (Cleaver and Unell, 2011).

In addition to experiencing parental separation, there is anecdotal evidence to suggest that children who are at risk of maltreatment can also experience instability as a result of having lived at numerous addresses (Halpenny, 2012, Hutchings et al., 2010, Sawyer et al., 2014, The Centre for Social Justice, 2013). These moves are often associated with the difficulties being experienced by parents, and include moving to avoid drug and other debts, or to escape harassment and violence within the community (Cleaver and Unell, 2011). Domestic violence may also result in parent and child needing to leave their home in order to ensure their own safety. This can result in families requiring somewhere safe and secret to go to in the short-term and moving between temporary housing solutions whilst longer-term housing solutions are identified (Cleaver and Unell, 2011, Stafford et al., 2007, Tarleton et al., 2006). Leaving home in an emergency means children have little time to plan and pack. This can result in their being forced to move without getting to say goodbye to their friends, or having to leave behind personal belongings and pets (Stafford et al., 2007). In addition, to having an emotional impact, housing instability can have adverse effects upon children's wellbeing, with a number of studies demonstrating that young people who have experienced repeated house moves

and periods of homelessness often have: poorer school attendance; experience poor health and developmental delays; experience anxiety and depression; and have behavioural difficulties (Bassuk et al., 1997, Buckner, 2008, Shinn and Weitzman, 1996).

### **1.3.3 Being a looked after child**

In the previous section it was demonstrated that young people who are at risk of entering the care system due to abuse and neglect have often lived in households characterised by domestic violence, substance misuse, mental illness and poor parenting. It was also shown that young people will often try to conceal familial difficulties out of concerns that their parents will get into trouble or that their family will be broken up, and that this can result in their not receiving timely help and support. And, that social work intervention, including the child being admitted to care, often occurs when difficulties in the family result in nobody being able to care for the child, or when parental difficulties adversely affect young people's behaviour or education. Having described the types of experiences that young people will have had prior to becoming looked after, I now move on to establish what it is like to be a looked after child.

#### ***1.3.3.1 How it feels to be a looked after child***

Being received into care can cause conflicting emotions. On the one hand, children may feel relieved at escaping from an environment where violence and abuse were present, but on the other hand they may blame themselves for the fact that they have been separated from their parents. They may also believe that they are being punished for circumstances that were outwith their control (NCB, 2007, OFSTED, 2014). These feelings may be heightened when young people have unanswered questions about why they have not been able to continue living with their parents or are troubled by events that they do not understand (Farmer et al., 2013). Young people can also feel scared, anxious and confused about what will happen to them, and who will look after them whilst they are in care (Holland and Randerson, 2005). Young people who have adopted a caregiving role within the home may also express anxiety about who will care for their parents and siblings now that they have been removed from

the household (NCB, 2007, Shaw, 1998). The fear and confusion that young people feel when they enter the care system can often manifest within their behaviours. For instance, residential and foster carers often report that children appear anxious, withdrawn and prone to mood swings upon entry into the care system. This can result in young people choosing to hide away in their bedrooms, reacting to carers with anger, hostility and aggression, or becoming clingy and over-possessive of their new carers (NCB, 2007). These behaviours are perceived by carers to reflect young people feeling as if they have been abandoned and rejected by their parents, and their fears that their new carers will also reject them (ChildLine, 1997).

#### ***1.3.3.2 Learning the rules, trying to fit in and dealing with stigma***

Entering the care system can result in new rules, boundaries and regulations having to be learned (Mullan et al., 2007). These rules, which are often used to establish routines and provide young people with a sense of normality and predictability, can be difficult to adapt to, especially where young people have been living in households where parental difficulties have meant that routines such as mealtimes and bedtimes have been abandoned (Marshall, 2005, McIntosh et al., 2010, Mullan et al., 2007). In addition to having to learn new rules, young people who become looked after have to adjust to living with children and adults who are effectively strangers. This is often a source of anxiety for young people, as they worry that they will not fit in or be accepted within a new care placement (Heptinstall et al., 2001, Berridge et al., 2012).

Qualitative research demonstrates that young people will often adopt new, or suppress existing, behaviours in order to be accepted. For instance, young people entering foster care placements have reported that they have tried suppressing behaviours identified by social workers as being challenging or provoking in order not to jeopardise their place within a new placement (Mullan et al., 2007). In contrast, young people entering residential care often report feeling pressured into appearing tougher or engaging in risky behaviours in order to be accepted by the peer group (*ibid*). Living with other young people can be a source of stress for looked after young people, with young people reporting that

they feel stressed when young people in placement argue and fight with each other, and when their possessions are borrowed, broken or stolen. However, it should be noted that living with other young people can also be a source of comfort, with a number of studies emphasising that young people often develop strong bonds and derive support and comfort from other young people in placement (Berridge et al., 2012, Emond, 2003). This comfort is often based upon having access to other young people who have experienced parental difficulties, and as a result are able to understand what that young person is going through (*ibid*).

Understanding and empathy have been identified as helping young people to feel more integrated into their new families. For instance, it has been shown that young people feel more accepted and ‘a part of the family’ when foster parents manage to acknowledge the difficulties that they have had, whilst also making the young person feel that they are ‘the same’ as other members of the household (Hill et al., 1996, Luke and Coyne, 2008). This feeling of acceptance is furthered when foster parents help to reduce any sense of ‘difference’ by including young people in family outings and holidays, give gifts to mark special occasions, praise and punish all of the children in the household in the same way, and encourage the young person to become involved in community-based activities (Schofield and Beek, 2005, Schofield, 2003, Sinclair et al., 2001). It should be noted that residential care workers try to provide the same sense of stability and belonging for young people living in children’s homes; however, the institutionalised nature of children’s homes often results in young people reflecting that they wished residential care was more like ‘a home’ or ‘a family’ (Berridge et al., 2012).

In addition to having to adjust to living with new rules and new people, many young people who become looked after state that they have had to learn how to cope with the stigma of being in residential or foster care. For instance, a number of studies have demonstrated that looked after young people have experienced other children say spiteful things about the fact that they are being brought up by relatives or are living in foster or residential care (Aldgate and McIntosh, 2006, Hislop et al., 2004, Farmer et al., 2013, Messing, 2006). In

addition to judgements being made about young people's families, there is some evidence to suggest that lack of awareness about the care system can result in young people being perceived by others as being 'trouble makers', 'bad' and 'failures', and being bullied by other children (Martin and Jackson, 2002). For instance, a number of studies have demonstrated that the majority of looked after children have been called names and taunted by their peer group (Borland et al., 1998, McClung and Gayle, 2010, Rao and Simkiss, 2007). Being bullied for 'being in care' can result in young people becoming anxious about sharing information with other people. This can result in young people having a marked aversion towards revealing any information that would identify them as 'being in care' (Broad, 2001, Farmer et al., 2013, Messing, 2006, Selwyn et al., 2013). Bullying may also result in young people refusing to attend school (Mcshane et al., 2001).

#### ***1.3.3.3 Placement instability***

There is a growing body of evidence demonstrating that placement instability can negatively affect young people's emotional well-being and self-esteem, and their ability to develop secure and trusting relationships with the adults caring for them (Beck, 2006, Broad, 2004, Leathers, 2002, McAuley and Young, 2006, Skuse and Ward, 2003, Unrau et al., 2008, Ward et al., 2006). For instance, young people living in stable kinship placements are more likely than young people in unstable placements to report that they feel loved and valued, have a sense of belonging, and have strong and continuing family ties (Aldgate and McIntosh, 2006, Broad, 2001, Harden et al., 2004). Young people who have experienced multiple placement moves often report that they feel unsafe, unsettled and unloved (Broad, 2004). Although it is recognised that stability is important for young people's socio-emotional functioning, the research evidence demonstrates that young people's care histories are often characterised by frequent placement moves (Stein and Munro, 2008, Unrau, 2007, Ward, 2009). For instance, Ward used data routinely collected by six social work departments to demonstrate that a quarter (26%) of young people admitted to care had experienced six or more placement moves over a three year period. The author also noted that just under two fifths (37%) of the young people had experienced three to five placement moves. To place these findings into context, it is worth

noting that children living at home with their parents will, on average, experience three household moves during the course of their childhood (Moyers and Mason, 1995).

Placement instability is caused by a range of factors, including: institutional policies and practices; children's characteristics and experiences; and carers' experiences and circumstances. Looking first at institutional factors, it has been hypothesised that the high level of placement moves experienced by looked after young people may reflect social work services not having the capacity to provide fixed, long-term placements for all children. For instance, Waterhouse and Brocklesby (2001) reported that up to two thirds of admissions into care are unplanned, and that adolescents were particularly vulnerable to experiencing emergency admissions into the care service. Research demonstrates that placements that are crisis-driven are those at most risk of breaking down (Farmer et al., 2004, Sinclair, 2005). One reason for this is that emergency admissions into the care system can result in young people being placed into foster homes or residential units that are inappropriate to their needs, and where the skill sets and circumstances of carers may not have been considered in relation to the needs of the child (Holland et al., 2005, Minty, 1999, Sinclair, 2005).

Moving on to look at the characteristics of children, the research evidence suggests that children who are aged ten and over, or who have been successfully reunited with their parents but then returned to the care system, are more likely to experience multiple placement moves (Biehal et al., 2010, Minty, 1999, Sinclair, 2007, Selwyn and Quinton, 2004, Ward and Skuse, 2001, Ward, 2009). In addition, Sinclair et al (2005) concluded that young people who had a history of being emotionally abused, or who felt rejected and estranged from their families, were particularly vulnerable to frequent placement moves. One explanation for this is that young people who feel rejected by their parents may adopt behaviours that are designed to make themselves appear unlovable, promote distance between themselves and their new carers and test whether or not a new carer will reject them. These behaviours, in addition to creating a distance between carer and child, may be used by the child as a way of trying to

protect themselves from the emotional impact of further rejection (Munro and Hardy, 2006). This can be extremely stressful for carers, and there is some evidence to suggest that placements can fail when carers find their attempts to bond with young people continuously rebuffed (Reder and Lucey, 2000). This can then result in young people's perceptions of themselves as being unlovable and unwanted being reinforced (Munro and Hardy, 2006).

Other factors that have been identified as increasing the risk of placements breaking down include young people having a history of behavioural or mental health difficulties. For instance, it has been demonstrated that young people who have conduct difficulties, display oppositionally defiant and aggressive behaviours, show signs of hyperactivity and attentional deficits, and engage in behaviours such as stealing are at increased risk of experiencing placement breakdown (Farmer et al., 2005, Fratter, 1991, McCarthy, 2004, Sempik et al., 2008, Ward and Skuse, 2001). Within the literature it has been demonstrated that the overloading of stressful events such as child illness, ever changing household composition and dealing with difficult behaviour can place a high level of strain upon residential and foster carers. Where this happens, the risk of placements breaking down can increase due to carers being less capable of ensuring that the needs of the child in placement are being met (Farmer et al., 2005). This risk is greatest where: carers feel unsupported by social workers; are unaware of where they can access advice and help; have not received training in how to manage difficult and challenging behaviours; where contact with birth parents proves stressful and unmanageable; and when the behaviour of children in placement is perceived as threatening the safety of carer's biological children (Farmer et al., 2004, Farmer et al., 2005, Fratter, 1991, Pithouse et al., 2002, Macdonald and Turner, 2005, Minty, 1999, Selwyn and Quinton, 2004, Sinclair, 2005, Ward et al., 2006).

#### ***1.3.3.4 Turnover of children in placements and social workers***

The high turnover rates of children in placement can also result in looked after young people experiencing instability, even when their own placements are secure. For instance, Berridge et al (2012) in a study of residential care

concluded that the total proportion of residents who remained in the same placement during any six month period ranged from 37-56%, and that over a six month period over half of the residents had moved out of residential care. The author noted that the high turnover levels of children in placement could have an adverse effect upon young people due to their losing friendships, and having to constantly readjust to changing dynamics within the peer group. Young people in residential care may also experience instability associated with being exposed to a constantly changing group of adults. For instance, Furnivall et al (2007) used data from a study designed to assess residential carers' awareness of mental health difficulties amongst the looked after population to demonstrate that 84% of residential workers worked in units where children were regularly cared for by more than eleven people. This was noted as potentially affecting the ability of carers and children to build strong, close and supportive relationships.

In addition to experiencing other children moving in and out of placement, young people in the care system are often affected by the high turnover rates of social workers. Research evidence suggests that high turnover rates have serious implications for the quality, consistency and stability of care provided to children. There are several reasons for this. First, high turnover levels mean that over time a number of individuals may become involved with a child's care, with the potential for no one individual to have a complete overview of the child's life. Second, it has been noted that high levels of turnover can have detrimental effects upon the management of care plans due to remaining social workers struggling to provide cover when positions are vacated or filled by inexperienced personnel (Powell and York, 1992). Within the literature it has been argued that high turnover rates of social workers can reinforce clients' mistrust of the system (Geurts et al., 1999, Munro, 2001, Todd and Deery-Schmitt, 1996). For instance, Munro reported that the high turnover rate of social workers made young people feel as if they were unimportant, and that the high turnover rate meant that it wasn't worth taking the time to get to know new social workers.

### ***1.3.3.5 Contact with birth families***

Within the social work literature it is widely accepted that contact with the birth family can be beneficial for children as “it holds the potential to assist children in managing their dual identities and to develop or sustain positive relationships with their relatives” (Beek and Schofield, 2004, p124). Contacts with birth families can be direct (e.g. the young person sees their parent face-to-face) or ‘indirect’ (e.g. the young person is allowed telephone, email or written contact with their parents). They can also be supervised or unsupervised, with supervised contacts being predominantly used for younger children or when there is a concern that unsupervised contact will adversely affect the child or compromise their safety (Cleaver, 2000). Research evidence demonstrates that young people who enter the care system: often identify being separated from their ‘real family’ as a negative aspect of being looked after, and often want to remain in contact with their birth families (Heptinstall et al., 2001, Munro, 2001, Sinclair et al., 2001, Thomas and O’Kane, 1999, Whiting and Lee, 2003, Wilson and Sinclair, 2004). The desire to remain in contact with the birth family is reported even where children state that they do not wish to return home to live with) their parents (Shaw, 1998, Sinclair et al., 2001).

Young people’s desire to maintain contact with their families reflects the fact that birth families, in particular mothers and siblings, remain central to the lives of young people who are placed in out-of-home care (Heptinstall et al., 2001, Moyers et al., 2006). For instance, there is evidence to suggest that children who are looked after away from home remain concerned for, and worry, about the welfare of their birth families, and that these worries are heightened when the young person is not allowed to have contact (Moyers et al., 2006, Shaw, 1998, Sinclair et al., 2001). Separation from siblings can be particularly distressing as shared pre-care experiences mean that siblings are often best placed to understand the circumstances that led to their entering care, and can therefore be a source of comfort and support (McAuley, 1996, Selwyn et al., 2013, Whiting and Lee, 2003). There is some evidence to suggest that lack of contact with birth families is not only upsetting for young people, but can result in their being unable to settle in placement, wanting to be returned to their birth families, and running away from placement (Atwool, 2013).

The empirical evidence suggests that 40-50% of looked after children have contact with a family member on a weekly basis (Sinclair, 2005, Cleaver, 2000); however, a number of studies that have sought to elucidate children's views on contact have demonstrated that young people are often dissatisfied with the frequency and nature of contact (Hegar, 2005, Kosonen, 1996, McAuley, 2004, Moyers et al., 2006, Sinclair and Gibbs, 1998, Sinclair et al., 2001). This dissatisfaction may occur when young people feel that their views are not being taken into consideration, or when they have requested more contact than social workers believe that they will be able to cope with (Sen and Broadhurst, 2011). Young people's dissatisfaction with contact may also reflect parental difficulties in adhering to contact schedules. For instance, a number of studies have demonstrated that although parents often desperately miss their children once they have been placed into care they find the contact process to be distressing and stigmatising; resulting in their either being inconsistent or ceasing contacts with their child (Freeman and Hunt, 1998, Grigsby, 1994, Malet et al., 2010, Utting et al., 2001). In addition, parents may continue to struggle with the issues that resulted in their child becoming looked after, which in turn can affect their ability to be reliable in their contacts with their child (Freeman and Hunt, 1998).

The quality of contacts between children and their birth families can be broadly divided into three categories, including: contact that promoted security and had good management of risk; contact that caused anxiety and had partially managed risks; and contact that was actively harmful and had poorly managed risks (Beek and Schofield, 2004). Looking first at contact that promoted security, the authors noted that these contacts were characterised by carers accompanying children to the contact, and being supportive of both the child and the individual that they were having contact with. In these situations the carer was identified as acting as a secure base who worked with both the child and the member of their birth family to ensure that difficulties and complex emotions could be anticipated, acknowledged and dealt with as they arose within the contact. Moving on to look at contacts that promoted anxiety, the authors noted that carers had little involvement in arranging or attending contact sessions. In these situations, carers described trying to be sensitive to the needs of the child and their desire to have contact with their birth families,

but feeling anxious as they had little understanding of what was happening during contacts. This lack of knowledge was associated with carers feeling uncertain about contacts, and feeling unable to ask questions or challenge situations that they felt placed the child at risk. Finally, it was noted that contacts that were actively harmful were characterised by young people receiving no supervision and being exposed to relationships that were manifestly causing them stress or potential harm.

These findings suggest that contact with birth families can be a cause of stress and anxiety for young people. This is because contact can re-expose young people to family members who may have been abusive or unable to provide them with consistent care in the past. Confronting past traumas and recalling painful memories and feelings can leave young people feeling vulnerable and overwhelmed (Atwool, 2013, Beek and Schofield, 2004). This can be particularly distressing where parents are unwilling to accept any responsibility for the neglect or abuse, and disclose that they actively blame the young person for disclosing maltreatment to social services and splitting the family up (McAuley, 2004). Young people can also experience distress when contact results in the dysfunctional patterns that led to the young person becoming looked after being re-enacted (Atwool, 2013, Farmer et al., 2005, McAuley, 2004, Moyers et al., 2006, Selwyn, 2004). Re-enactments of dysfunctional family dynamics can result in young people being at risk of being abused or neglected within family contacts. For instance, carers have reported children in their care being allowed to consume drugs and alcohol and watch pornography during contacts, or returning from all day contacts having not been given anything to eat or drink (Atwool, 2013). Furthermore, a study exploring the experiences of contact amongst 130 young people who were going to be placed for adoption, reported that just under a quarter of the young people had been abused during contacts with their parents (Selwyn, 2004).

Interviews conducted with caregivers suggest that poorly managed contacts can result in young people being further rejected by their parents (Farmer et al., 2005, Farmer and Pollock, 1998, Moyers et al., 2006). Young people who experience difficulties with or are traumatised by the experience of contact can

become extremely upset and emotionally withdrawn (Howe and Steele, 2004). They may also demonstrate chaotic, disorganised, defiant and oppositional behaviour in the days and weeks that follow contact (Moyers et al., 2006). The effects of poorly managed contacts upon young people's behaviour can affect the stability of placements and increase the risk of placements breaking down (Sinclair et al., 2005).

#### **1.4 The sexual health of looked after young people**

Thus far it has been demonstrated that looked after young people are a particularly vulnerable group who are likely to have been maltreated and experienced a lack of parental care. It has also been shown that the pre-care and care experiences of young people are often characterised by frequent moves, lack of stability and isolation; all of which can have profound and adverse impacts upon young people's psychosocial, emotional, behavioural and educational wellbeing. Within the public health literature it is noted that vulnerable populations, including those who are exposed to linked social problems such as substance misuse, domestic violence, poverty and homelessness, are at increased risk of experiencing poor physical and sexual health (Aday, 2002, Becker et al., 1998, Hudson and Nandy, 2012, Mastro et al., 2012). Young people who are looked after in local authority care are one group of adolescents who may be at increased risk of experiencing poor sexual health outcomes. This is because, although looked after young people face the same health challenges as their peers, contextual factors such as family discord, frequent changes of home and school, and lack of access to supportive and trusted adults can result in health problems being suffered to a greater degree (Mooney et al., 2009). I now move on to demonstrate that many of the factors that increase the risk of young people becoming looked after are also significantly and negatively associated with sexual health outcomes during adolescence. In doing so I demonstrate that looked after young people are at increased risk of experiencing poor sexual health outcomes, including increased levels of sexually transmitted infections, early pregnancy and parenthood, and abortions.

### **1.4.1 Predictors of entry into care and their links to sexual health**

I begin this section by looking at the relationship between adolescent sexual health outcomes and the factors thus far identified as increasing the risk of young people entering local authority care.

#### ***1.4.1.1 Socio-economic status and adolescent sexual health***

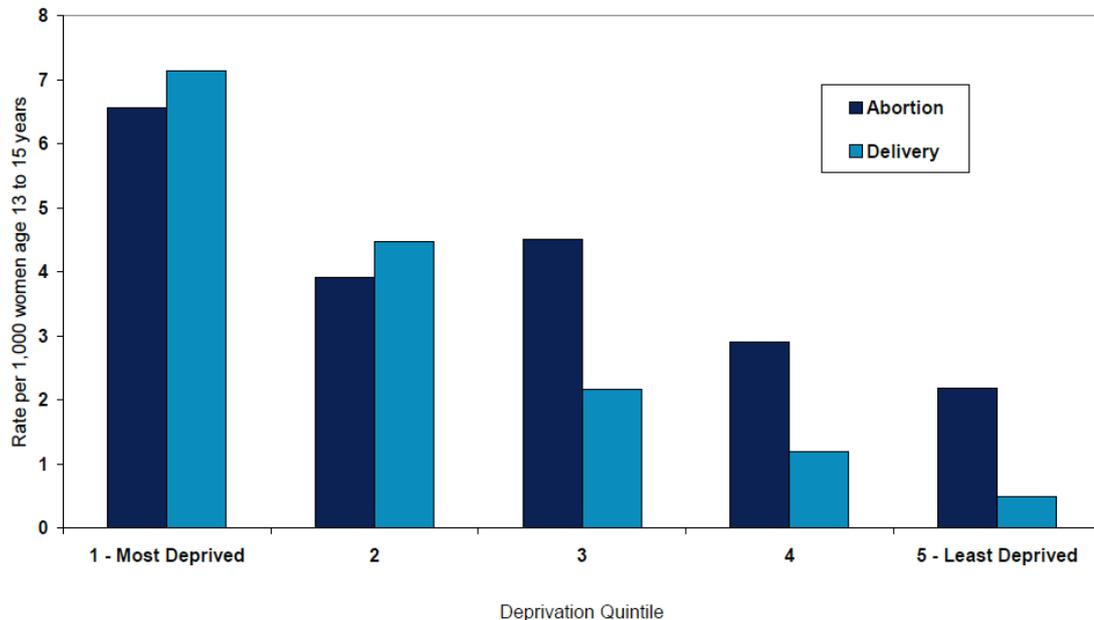
In section 1.2.3 it was identified that the odds of being maltreated and entering local authority care were significantly elevated for young people growing up in households experiencing poverty and social exclusion. Given that there is a significant body of evidence demonstrating that both poverty and social exclusion have a deleterious effect upon the health of individuals (Pickett and Wilkinson, 2007, Marmot, 2005, Macintyre and Ellaway, 2000) it is perhaps not surprising that a number of studies have demonstrated that young people growing up in households typified by low income, low parental educational attainment and high levels of unemployment are significantly more likely to: have engaged in sexual activity at a younger age, have increased numbers of sexual partners; have lower levels of contraceptive use; and are at greater risk of contracting sexually transmitted infections and experiencing unintended pregnancy (Santelli et al., 2000, Bignell et al., 2006, Bonell et al., 2005, Dickson et al., 1998, Edgardh, 2000, ISD, 2000, ISD, 2008, ISD, 2012, Kufuji et al., 2003, Parkes et al., 2004, Shahmanesh et al., 2000, Wellings et al., 2001, Winter et al., 2000, Wight et al., 2000, Wight and Henderson, 2004).

Looking specifically at early sexual experience, Santelli et al (2000) used cross-sectional data collected from the 1992 Youth Risk Behaviour Survey to demonstrate that parental educational attainment was predictive of early sexual activity for adolescents. In particular, it was shown that young people whose parents had left school prior to completing their secondary education were significantly more likely to have engaged in early sexual activity than young people whose parents had completed tertiary level education. Furthermore, Wellings et al (2001) demonstrated using cross-sectional data collected as part of the National Sexual Attitudes and Lifestyle Study that young women whose parents were employed in manual, non-professional occupations reported sexual

debut at a significantly younger age than young women whose parents were employed in non-manual, professional occupations. Similar findings have been reported for housing tenure, parental educational level and parental occupation (Bonell et al., 2003, Henderson et al., 2007, Penfold et al., 2009); although it should be noted that in these studies the relationship between early sexual debut and socio-economic status was fully explained by adjusting for the quality of parent-child relationships and the amount of parental monitoring that young people received. I shall return to discuss the relationship between parenting and adolescent sexual health outcomes in chapter two.

Moving on to look at teenage pregnancy and parenthood, evidence from cross-sectional research shows that parental education and social class are both associated with adolescent condom use, with the highest levels of condom use observed for young people whose parents are highly educated and are employed in non-manual, professional occupations (Abma et al., 1998, Elliott et al., 2013, Henderson et al., 2007, Manning et al., 2000, Sprecher, 2013). For instance, Sprecher et al (2013) demonstrated that young people who reported using condoms at sexual initiation were more likely to report that their parents were educated beyond high school level, and to perceive that their family were middle or upper social class. It can be argued that the lower rates of condom usage observed amongst young people of low socio-economic status may result in their being at increased risk of experiencing unintended and early pregnancy (Arai, 2003, Bonell et al., 2003, Kirby and Miller, 2002, Martyn and Hutchinson, 2001). Secondary analyses of routinely collected conception and birth data appear to support this argument; consistently demonstrating that there is a social gradient to both teenage pregnancy and early parenthood (Bradshaw et al., 2005, Clements et al., 1998, Diamond et al., 1999, ISD, 2008, ISD, 2000, ISD, 2012, ISD, 2009, McLeod, 2001, Paton, 2002).

Figure 1: Teenage (<16yrs) pregnancies deprivation quintile and outcome, reproduced from ISD (2012), Teenage pregnancies, year ending 31<sup>st</sup> December 2010. Permission to reproduce this work was granted by ISD Scotland in accordance with the terms of Version 2.0 of the Open Government Licence (see: <https://www.nationalarchives.gov.uk/doc/open-government-licence/version/2/> for details).



For example, Bradshaw et al (2005) identified that more than three quarters of the area-level variation in age 15-17 conception rates for young women living in England could be explained by deprivation. Evidence of this association for Scottish youth can be viewed in Figure 1. From this it can be seen that there is a strong deprivation gradient for live births during adolescence, with young women in the most deprived quintile fourteen times more likely to carry a pregnancy to term, and three times more likely to have an abortion, than young women in the least deprived quintile. Figure 1 also shows that in the least deprived quintile, four out of five pregnancies end in abortion (ISD, 2012). Given the associations between socio-economic status, younger age at sexual debut and poor contraceptive use it is perhaps not surprising that conception rates are highest amongst adolescents from socially deprived backgrounds. Statistics compiled by NHS Health Scotland on teenage pregnancy rates amongst 13-15 year olds demonstrate clear socioeconomic disparities. Looking at teenage pregnancy it can be seen that there were 70.4 births per 1000 conceptions amongst the most deprived socioeconomic quintile compared to 8.3 births per

1000 conceptions amongst the most affluent quintile (ISD, 2009). This is a delivery rate that is 8-10 times greater for the most deprived quintile than for the least deprived quintile (ISD, 2008, ISD, 2009). As to why such a difference exists in the rates of live births seen, the principal reason relates to the fact that affluent young women are significantly more likely to terminate an unwanted pregnancy than their deprived peers (ISD, 2008, ISD, 2009, Henderson et al., 2007).

Looking beyond the evidence from routinely collected data, Vikat et al (2002) reported a significant association between father's occupation and educational level, and young people reporting that they had experienced teenage pregnancy. Bonell et al (2004) in a review of quantitative literature concluded that there was overwhelming evidence to suggest that young women whose parents were not in full-time employment were significantly more likely to have experienced a pregnancy by age 16. In addition, Wellings et al (2001) concluded that there is a bivariate association between parental social class and the proportion of young women experiencing pregnancy prior to age 18, and that young women whose parents were unemployed or employed in low-skilled, manual occupations were most likely to report that they had had a teenage pregnancy. In addition to the association between teenage pregnancy and socio-economic status, there is evidence to suggest that low socio-economic status is associated with early parenthood. For example, a number of studies have demonstrated that young people from socio-economically disadvantaged backgrounds, in particular those whose parents had experienced persistent financial difficulties during their childhoods, are more likely to become teenage parents (Dearden et al., 1995, Ekeus and Christensson, 2003, Ermisch and Francesconi, 2001, Ermisch et al., 2004, Kiernan, 1997, Manlove, 1997, Maughan and Lindelow, 1997, McCulloch, 2001, Ní Bhrolcháin et al., 2000, Nebot et al., 1997, Olausson et al., 2000, Russell, 2002, Sloggett and Joshi, 1998).

#### ***1.4.1.2 Family conflict, domestic violence and adolescent sexual health***

In section 1.3.2 it was demonstrated that young people who enter the care system are likely to come from families where relationship breakdown and

domestic violence have been present (Stanley et al., 2005). Within the sexual health literature there is a substantial body of evidence that suggests that the breakdown of parental relationships and parental conflict can elevate the odds of young people experiencing teenage pregnancy and parenthood. Looking first at the breakdown of parental relationships, the research evidence suggests that not living with both biological parents at ages 11 and 15 has been shown to be associated with young age at sexual, increased numbers of sexual partners, lack of contraceptive use and increased risk of pregnancy (Feldman and Nancy, 1993, Holmberg and Berg-Kelly, 2002, Sweeting et al., 1998, Vikat et al., 2002). For instance, Holmberg and Berg-Kelly (2002) demonstrated, using bivariate analyses, that young men under the age of 18 who did not live with both parents were significantly more likely to report that they had gotten their partner pregnant. Similar findings have been reported for young women, with Vikat et al (2002) concluding that young women aged 14-19 were significantly more likely to experience pregnancy if they were living in a stepfamily or lone-parent household. Moving on to consider early parenthood, a number of studies have demonstrated that living in a single parent household during childhood is associated with having a child before the age of 21 (Ermisch and Francesconi, 2001, Ermisch et al., 2004, Ní Bhrolcháin et al., 2000, Manlove, 1997, Russell, 1998a, Russell, 1998b, Russell, 2002). Whilst the evidence suggests that living in a single parent household increases the risk of young people experiencing poor sexual health outcomes, it can be argued that these findings may in fact reflect the fact that single-parent households are more likely to experience poverty (Sweeting et al., 1998).

The breakdown of parental relationships may expose young people to conflict within the home. Within the sexual health literature there is some evidence to suggest that witnessing domestic violence, the most extreme form of inter-parental conflict, is significantly associated with: younger age at sexual debut; inconsistent contraceptive use; the use drugs and alcohol during sexual contact; higher numbers of lifetime sexual partners; being a younger age at STI diagnosis; and having a greater frequency of unintended pregnancy (Anda et al., 2001, Anda et al., 2002, Hillis et al., 2001, Hillis et al., 2000, Hillis et al., 2004, Quinlivan et al., 2004, Oz and Fine, 1988, Tan and Quinlivan, 2006). For

instance, evidence from a prospective cross-sectional study conducted in Australia demonstrated that childhood adversity was a significant predictor of early parenthood, with the authors noting that the strongest associations were observed for childhood exposure to domestic violence (Quinlivan et al., 2004). Furthermore, retrospective cohort data from the ACE study concluded that young men who had witnessed their mothers being battered were 140% more likely to have impregnated a partner (Anda et al., 2001). As to why there is such a marked risk of teenage parenthood amongst young people who have witnessed domestic violence, Quinlivan et al (2004) argues that the presence of violence within the household can result in young people choosing to spend increasing amounts of time outwith the family home, which in turn can result in their receiving little parental monitoring and being potentially exposed to risky and sexually exploitative situations. This is something that I shall return to discuss in chapter two.

#### ***1.4.1.3 Child maltreatment and adolescent sexual health***

Young people who are raised in households where social exclusion, poverty and domestic violence are present have an elevated risk of being maltreated by their parents (Bebbington and Miles, 1989, Franzén et al., 2008, Howard et al., 2001, Jackson et al., 2002, Sedlak and Broadhurst, 1996, Sedlak et al., 2010, Sidebotham and Heron, 2006). Evidence from studies conducted largely within the USA demonstrates that young people who have been physically or sexually abused by their parents have an increased risk of: being a younger age at sexual debut; having inconsistent contraceptive use; reporting that they used drugs and alcohol during sexual contact; having higher numbers of lifetime sexual partners; being a younger age at STI diagnosis; and having a greater frequency of unintended pregnancy (Anda et al., 2001, Anda et al., 2002, Hillis et al., 2001, Hillis et al., 2000, Hillis et al., 2004, Roberts et al., 2004, Saewyc et al., 2004). For instance, data from the Avon Longitudinal Study of Parents and Children shows that young women who experienced child sexual abuse prior to becoming a teenager were significantly more likely to become pregnant as a teenager (Roberts et al., 2004). Furthermore, evidence from two Minnesota Student Surveys conducted in 1992 and 1998 shows that young people who had experienced child sexual abuse were significantly more likely than those who

had never been sexually abused to report that they had had multiple sexual partners and had rarely used condoms during intercourse (Saewyc et al., 2004).

Within the literature there is some evidence to suggest that both the type of abuse experienced and the frequency of abuse incidents are predictive of sexual health outcomes during adolescence (Fergusson et al., 1997, Hillis et al., 2000, Hillis et al., 2001). For instance, Fergusson et al (1997) concluded that the sexual health outcomes of young women who had experienced child sexual abuse that involved attempted or completed intercourse differed significantly from those who had been sexually abused but had not experienced forced intercourse. In particular, the authors demonstrated that young women who had experienced sexual abuse that involved attempted or completed intercourse initiated sex earlier, were less likely to use contraception and had the highest rates of pregnancy, sexually transmitted infections and sexual victimisation at age 16. Similarly, Hillis et al (2001) demonstrated using data from the ACES study that as the numbers of abusive incidents experienced increased so did the odds of intercourse by age 15, perceiving oneself to be at risk of contracting HIV and having 30 or more sexual partners. For instance, where women had experienced one adverse childhood event, the odds of having 30 or more sexual partners were 1.6 but increased to 8.2 for those with 6-7 adverse events. Similarly, the odds of sexual intercourse prior to age 15 were 1.8 for those with one adverse event, but rose to 7.0 for those with 6-7 adverse events. Similar findings have been reported for men (Hillis et al., 2000).

#### ***1.4.1.4 Parental mental health, drug and alcohol misuse and adolescent sexual health***

Parental psychiatric problems and drug and alcohol misuse are commonly observed within the pre-care histories of looked after young people (Department of Health, 1995). Evidence from a number of longitudinal birth cohort studies demonstrate that young people who grow up in families where parents experience mental health difficulties or misuse drugs and alcohol have an increased risk of engaging in early and risky sex, and experiencing early parenthood (Augustine and Crosnoe, 2010, Bohon et al., 2007, Christoffersen and

Soothill, 2003, Ensminger et al., 2003).. For instance, evidence from the 1966 Danish birth cohort demonstrates that young women who had a parent who had been hospitalised at least once as a result of alcohol abuse were significantly more likely to become teenage parents, even after adjusting for the effects of household socio-economic circumstances (Christofferson and Soothill, 2003). Furthermore, Bohon et al (2007) demonstrated that both moderate and chronic/severe depression increases young people's risk of early sexual behaviour. The authors also noted that the effects of maternal depression upon adolescent sexual behaviour were heightened when experienced in conjunction with father absence.

#### **1.4.2 Why do predictors of care entry increase the odds of poor adolescent sexual health?**

Thus far it has been demonstrated that socio-economic status, parental relationship breakdown, exposure to domestic violence, parental psychiatric problems, parental drug and alcohol misuse and child maltreatment, in addition to being predictive of entry into the care system, are all known antecedents of sexual risk taking and early parenthood during adolescence. I now move on to discuss how the relationship between these factors and sexual risk behaviour during adolescence may be mediated by factors such as attachment security, adolescent mental health difficulties, involvement in prosocial activities, educational engagement, the use of drugs and alcohol and associations with high risk peers. In doing so, it will be demonstrated that looked after young people can exhibit a clustering of risk factors that increases their likelihood of experiencing poor sexual health outcomes.

One explanation for the positive observed for young people raised by nurturing and sensitive parenting is that the presence of these factors within the parent-child relationships helps to foster emotional security and teaches children that their parents can be relied upon. This is the central tenet of attachment theory, which was developed to describe the formation of the mother-infant bond (Bowlby, 1969). Attachment theory argues that infants have a number of innate proximity seeking behaviours that serve to promote closeness to their primary

caregiver or 'attachment figure'. These behaviours, which include crying, reaching, grasping, smiling, vocalising, clinging and sucking, are used by the infant to convey their the infant's desire to receive comfort and protection from their caregiver (Ainsworth et al., 1978, Ainsworth, 1982, Crittenden and Claussen, 2003, Isabella, 1993, Main and Solomon, 1986, Bowlby, 1969). Attachment security develops through sophisticated maternal attunement to the tone, pitch and rhythm of infant's vocalisations, and baby's posture, facial expressions, movement and touch (Stern, 2009). Where mum is sensitive and attuned she will reflect back the baby's emotions, giving them meaning, and in doing so begins teaching the infant how to regulate their emotions (Rees, 2007). This is important as babies are unable to regulate affect in the first four months of life, and can become very quickly overwhelmed by emotions such as fear, pleasure and sadness.

The caregiver who picks up and cuddles an infant which has been startled helps to modulate the negative emotion of fear, with the positive emotions associated with being comforted. In contrast, the parent who is unresponsive and not attuned to their infant's distress may either ignore the infant's cries or react with hostility or anger. Both of these pathways amplify rather than moderate the infant's negative arousal state, which in turn acts as a barrier to their learning to effectively regulate their emotions (Shore and Shore, 2008). Within the neuroscience literature it is believed that the neurobiological mechanisms that underscore our ability to react to, and regulate involuntary stress, are established in infancy (Gunnar and Quevedo, 2007, Tarullo and Gunnar, 2006). The level of stress and type of stress that the system is able to cope with before becoming overloaded is believed to be related to the quality and consistency of care that is provided in infancy. Thus, the infant who has received highly attuned and responsive parenting will have a stress-regulation system that results in their experiencing minimal distress when incidental stress occurs. In contrast, the infant whose primary caregiver was unresponsive, intrusive and inconsistent is likely to show an exaggerated fear response, whilst the infant whose caregiver was abusive and frightening is likely to have become switched off and show no fear response at all when exposed to incidental stress (Rees, 2007, Schore, 2005).

The extent to which infants learn to self-regulate their emotions and cope with involuntary stress is important for experiential learning and exploration (Bowlby, 2005). For instance, attuned and responsive parenting teaches the infant that their caregiver is a secure base that can be relied upon to recognise their needs, and from which they can explore their environment. Where this child becomes scared or upset whilst exploring they will return to the primary caregiver for comfort. Once contact with the attachment figure has been made the infant will quickly soothe, and return to exploring their environment. This pattern of behaviour is described as secure attachment (Ainsworth et al., 1978, Ainsworth, 1982, Crittenden and Claussen, 2003, Isabella, 1993, Main and Solomon, 1986). The infant who has received inconsistent parenting will perceive their caregiver as an insecure base. This is because they have come to expect that their attachment figure will not be responsive to their needs. As a result of this the insecurely attached infant, when they become scared or upset, will not signal their distress and desire for comfort from their caregiver (Ainsworth et al., 1978, Spangler and Grossmann, 1993).

Three insecure attachment styles have been described in the literature. These are: insecure-avoidant, insecure-resistant and disorganised. Infants who are classified as having an avoidant attachment will have been perpetually rejected or rebuffed by their caregiver during times of distress. As such they may choose to avoid their caregiver altogether when they become stressed. Infants who display an ambivalent attachment have often experienced care giving that is inconsistent, vacillating from attuned and responsive, to unresponsive and intrusive. When these infants become stressed they will often display angry avoidance of the caregiver whilst at the same time seeking proximity and contact (Ainsworth et al., 1978, Spangler and Grossmann, 1993). Finally, infants who have disorganised attachment styles often display a complete breakdown in the attachment strategies, and display no proximity seeking behaviours towards their caregiver. When these infants become distressed and are in their caregivers' presence they will often freeze, show disorientation and confusion, and make repetitive and ritualistic movements and sounds (Main and Solomon, 1990). Insecure attachment classifications are most commonly observed amongst children and young people who have been raised in households where parental

drug and alcohol misuse, parental psychiatric disorder, domestic violence and child maltreatment are present (Bluestone and Tamis-LeMonda, 1999, Dietz, 2000, Durrant et al., 2003, Giles-Sims et al., 1995, Reich et al., 1988, Smith and Brooks-Gunn, 1997, Woodward and Fergusson, 2002).

The quality of care provided to children and young people by their parents is thought to act as a template for future relationships by promoting “a lasting psychological connectedness between human beings” (Bowlby, 1969, p194). This is because attuned and responsive parenting acts as a foundation from which infants develop trust, empathy and an understanding of relationship interactions. In contrast, inconsistent and unresponsive parenting can be damaging to young people’s psychosocial development. This is because this form of parenting, rather than teaching the infant that emotions are positive things that can be shared, the parent instead teaches the child that they should minimise and hide their emotions in order to avoid being further rejected (Braungart and Stifter, 1991, Spangler and Grossmann, 1993). Cameron and Maginn (2008, p11) argue that:

“children who experience or perceive significant rejection are likely to experience ever-increasing anger, resentment and other destructive emotions that may become intensely painful. As a result, rejected children tend to suppress these painful emotions in an effort to protect themselves from the hurt of further rejection; that is, they become less emotionally responsive. In doing so, they often have problems with being able or willing to express affection and warmth and in knowing how to give, or even being capable of accepting these positive emotions from others”.

Failing to learn how to properly regulate emotions can have a profound effect upon children’s ability to form and maintain peer relationships. For example, the child who becomes actively withdrawn in order to protect themselves from the negative and rejecting interactions that they have learned characterise relationships may appear to be submissive and easily controlled by other young

people, which in turn can increase the likelihood that they become victimised or bullied by their peers (Georgiou, 2008). In contrast, the child whose emotional responses have been met with hostility, aggression and anger may demonstrate these behaviours in response to other young people's friendship overtures (Renken et al., 1989). This can result in that young person being viewed by their peers as frightening, and lead to their becoming socially isolated (Rubin et al., 2004). As peer relationships often serve as a training arena for romantic and sexual relationships, it is likely that young people who experience difficulties forming and maintaining peer relationships will also have difficulty forming secure, trusting and respectful romantic relationships (Bagwell et al., 2001, Collins and Sroufe, 1999, Connolly et al., 2000, Crockett and Randall, 2006, Furman et al., 2002, Furman, 1999).

One reason for this is that the relationships that young people form with their peers are used to construct internal working models or mental representations of the self (Bowlby, 1973). These models, which can either be positively or negatively constructed, underpin how children view themselves and can result in their believing that they are "worthy of care or not, worthy of protection or not, loveable or not, likeable or not, valued or not, subject of interest or not, socially effective or not, competent or not" (Howe, 1999, p24). Where young people view themselves positively, and see themselves as being worthy of other people's love, it is likely that they will enter into loving, secure and trusting relationships. However, where young people have developed negative representations of the self, their romantic and sexual relationship experiences may be characterised by fear of intimacy, jealousy and suspicion, fear of abandonment or rejection (Hazan and Shaver, 1987). Furthermore, it has been argued that young people who have experienced significant levels of parental rejection may form romantic and sexual relationships that are characterised by craving love and fearing rejection (Simons et al., 2008). Where this occurs, there is some evidence that such individuals are at risk of being sexually exploited or of using sexual coercion to gain love and intimacy (Bartholomew and Horowitz, 1991, Chase et al., 2006, Hazan and Shaver, 1987, Knight et al., 2006, Patel-Kanwal and Lenderyou, 1998)

Crittenden (1997) argues that the formation of bonds between romantic and sexual partners mimics the attachment process, and that expectations about the characteristics of romantic relationships are experientially learned in the same way that the infant learns to react to stressful situations. In particular, she argues that just as infants have an innate propensity to organise self-protective strategies, humans have an innate propensity for organising their sexual strategies after puberty has occurred. This argument is based upon the fact that behaviours within romantic and sexual relationships are very similar to those used within the promotion of the mother-infant bond. For instance, Crittenden (2006) argues that both attachment and sexual behaviour rely upon approach, vocalisation, smiling, kissing, touching, caressing and holding/clinging. As a result of this, sexual behaviour can be thought of as being late maturation attachment behaviour.

As with infant attachment, it is argued that experiential learning and emotional regulation contribute to the organisation of the sexual attachment strategies. In particular, Crittenden states that sexual strategies are organised is based upon the order in which the brain processes cognitive information about the temporal sequence of events, and affective information about the emotional intensity of events. Information relating to cognition and affect combines to form three attachment strategies known as 'Type A', 'Type B' and 'Type C'. Individuals who demonstrate Type 'A' strategies organise their experiences cognitively, and base their expectations about what will happen around the outcomes that they expect to experience. For instance, looking at the example provided by Hazan and Shaver (1987) it would be possible to hypothesise that a young person might be frightened of experiencing rejection as the last time they were in a romantic relationship their partner left them after the relationship had been consummated. As a result of this, they may expect their next relationship to fail. Individuals with 'Type A' strategies will do anything that they can do to minimise their awareness of those negative feelings, will do that which they expect will be reinforced and will avoid doing what they expect will result in their being punished (Crittenden, 2006). These individuals may be at risk of experiencing isolation.

Turning to 'Type C' strategies, Crittenden (2006) argues that these individuals are largely driven by affective processes. These individuals lack confidence about what will happen next, and use their feelings as a basis for guiding their behavioural choices. Often these feelings are characterised by negativity, with the individual experiencing a desire to be comforted along with anger, fear, sexual desire and pain. The expression of this negative affect increases the risk of the individual being at risk of experiencing anxious fearfulness, agitation, disorders of aggressions and separation-based anxiety disorders. These individuals may be viewed as being most at risk of engaging in promiscuous and dangerous sexual experiences, and choosing romantic and sexual partners who are potentially exploitative. Type 'B' strategies can be thought of as offering a middle ground between 'Type A' and 'Type C'; this is because 'Type B' strategies integrate cognitive and affective beliefs about relationships. Individuals who utilise 'Type B' strategies are often open, direct and balance expectations about the emotional aspects of relationships with expectations about what will happen. As such it is believed that individuals utilising these strategies will be least likely to experience psychopathology within romantic and sexual relationships.

#### ***1.4.2.1 The effect of the home environment on young people's psychosocial development***

Looking first at the home environment, it has long been recognised that the quality of parenting that young people receive during childhood and adolescence can have a profound impact upon their psychosocial development and health. For instance, there is a wealth of empirical evidence that demonstrates that young people whose parents are attuned, supportive and acquiescent of their children's needs, provide non-punitive discipline and are consistent in their approach to parenting are significantly less likely to: have low self-esteem; be diagnosed with internalising problems such as depression and anxiety; be an early school leaver; gain fewer educational qualifications; misuse alcohol or illicit drugs; have histories of truancy, antisocial behaviour and aggression; and, be involved in the criminal justice system during adolescence. In contrast, children and young people who are raised by parents who are unresponsive, intrusive and inconsistent in their parenting have an increased risk of

experiencing poor mental health, educational and health outcomes (Baumrind, 1991, Chan and Koo, 2011, Cohen and Rice, 1997, Garcia and Gracia, 2009, Lamborn et al., 1991, Maccoby and Martin, 1983, Montgomery et al., 2008, Rothrauff et al., 2009, Radziszewska et al., 1996, Shucksmith et al., 1997, Spera, 2005).

#### ***1.4.2.2 Mental health and educational difficulties as predictors of poor sexual health***

Moving beyond young people's understandings of relationships there is some evidence to suggest that attachment insecurity is associated with poorer psychiatric outcomes for young people (Armsden et al., 1990, Kobak et al., 1991, Muris et al., 2001, Muris et al., 2000, Warren et al., 1997). For instance, Warren et al (1997) demonstrated that young people who were classified as having insecure attachment styles at age 12 were significantly more likely than young people classified as having a secure attachment style to have a previous or current history of anxiety disorder at age 17. Similar findings have been reported for depression and conduct disorder, with a number of studies demonstrating that young people with insecure attachments display higher levels of depressive symptoms and behavioural problems than their securely attached peers (Armsden et al., 1990, Kobak et al., 1991). Looking specifically at conduct disorder, it has previously been argued in this chapter that young people form mental representations or schemas of how they should behave based upon the interactions they have with their parents. For the child that is treated with hostility by their parents, the likelihood is that the young person will view the world as hostile and as such may develop coercive, aggressive and antisocial behaviours (Cicchetti et al., 1995, Dodge, 1993, Keiley, 2002). This can result in young people becoming increasingly isolated from prosocial peers and spending increasing amounts of time with antisocial peers; something that I shall return to discuss later in this section.

Given the increased likelihood of young people in the care system having insecure attachment styles, it is perhaps not surprising that looked after young people have an increased risk of experiencing mental health difficulties, with

the most commonly observed psychiatric diagnoses being post-traumatic stress disorder, conduct disorder, anxiety disorders and depression (Buchanan, 1999, Buchanan et al., 2000, Courtney et al., 2005, Dimigen et al., 1999, Ford et al., 2007, Hobcraft, 1998, McCann et al., 1996, Meltzer et al., 2003a, Meltzer et al., 2003b, Meltzer et al., 2004a, Rutter et al., 1983, Viner and Taylor, 2005). For example, Hobcroft (1998) used data collected from the 1958 and 1991 sweeps of the National Child Development Study (NCDS) to assess the risk of depression for adults (aged 33) with and without a history of being looked after in public care. The author concluded that the odds of depression were 1.6 (female) to 2.1 (male) times higher for adults who had been in the care of the local authority. Similar findings have been reported at age 16 in the NCDS sample and at age 30 in the 1970 British birth cohort study (Buchanan, 1999, Buchanan et al., 2000, Viner and Taylor, 2005). Beyond examination of cohort data, a 14 year prospective study compared mental health outcomes of women who had been looked after in local authority children's homes in 1964 (n=81) with an age-matched, non-looked after control group (n=41). The authors concluded that those who had been looked after in the care system were twice as likely to experience depression, six times more likely to experience psychiatric distress and twenty-two times more likely to have been hospitalised as a result of psychiatric problems (Rutter et al., 1983). More recently, Ford et al (2007) demonstrated using a secondary analysis of four surveys assessing psychopathology in both the looked after and general youth population that looked after young people are five times more likely than their non-looked after peers to have a mental health diagnosis, and 9 times more likely to be diagnosed with conduct disorder.

Mental health difficulties during adolescence can have long-term and adverse effects upon young people's sexual health in two ways, namely by affecting young people's engagement with education and by exposing young people with behavioural difficulties to risky peers. Looking first at education, it has been demonstrated that young people who have emotional and behavioural disorders are significantly more likely to experience school exclusion, leave school prior to the legal school leaving age and gain fewer qualifications (Fergusson and Horwood, 1998, Fergusson et al., 2005, Fletcher, 2010, Meltzer et al., 2003b).

Evidence from a cross-sectional cohort study assessing the prevalence of psychiatric illness in a representative sample of young people in the UK shows that young people with conduct disorder are 25 times more likely than their peers to be excluded from school (Meltzer et al., 2003b). Furthermore, the authors noted that young people with depression, anxiety or conduct disorders were three and a half times less likely to still be in education at age 15, and twice as likely to have gained no age-16 qualifications, than young people with no history of mental health disorder (ibid).

One reason for the higher rates of school exclusion observed amongst young people who are experiencing mental health difficulties is that emotional and behavioural difficulties can affect how young people engage within the classroom environment. For instance, there is some evidence to suggest that depression and anxiety can result in young people: experiencing low self-confidence; having difficulty sleeping; experiencing poor concentration; and having difficulties with decision making; all of which can adversely affect educational engagement and attainment (Atala and Baxter, 1989, Beasley and Beardslee, 1998, Robbins and Alessi, 1985, Shrier et al., 2001). These difficulties may be further compounded for young people who are being maltreated, or who are living with parents who have psychiatric problems, abuse alcohol or are addicted to drugs. This is because in these scenarios young people are likely to experience additional anxieties relating to either their own, their siblings or their parents' welfare and safety that may result in sleep deprivation and/or unauthorised absences from school (NSPCC, 2010b).

Thus, it is not surprising that looked after young people often experience poorer educational outcomes than their non-looked after peers. For instance, evidence from routinely collated education statistics shows that young people who are looked after by local authorities in Scotland are absent from school an additional 11 days per year and are approximately ten times more likely to be temporarily or permanently excluded from mainstream education (The Scottish Government, 2007). Similar findings have been reported using routinely collated education data in England, Wales and Northern Ireland (Department for Health Social Services and Public Safety Northern Ireland, 2010 , Thomas, 2012). In addition to

the higher rates of school absence and exclusion observed, evidence from nationally representative longitudinal and cross-sectional cohort studies demonstrates that looked after young people are significantly more likely than their non-looked after peers to experience educational delays, learning difficulties and to gain fewer qualifications during their secondary education (McClung and Gayle, 2010, O'Sullivan and Westerman, 2007).

Poor educational engagement and attainment may mediate the relationship between sexual health outcomes and adverse childhood experiences. This is because disengagement from education is a known antecedent of poor sexual health during adolescence as school exclusion often results in young people receiving less monitoring and supervision, which in turn can result in their spending increasing amounts of time with other school excluded youth and increasing the likelihood of their being exposed to risky behaviours, including risky sexual behaviours (Hemphill et al., 2012). Evidence from the qualitative literature suggests that school exclusion can result in young people feeling increasingly isolated from the wider peer group and to counter those feelings young people seek out the support, approval and friendship of other excluded youth (Laird et al., 2001, McCrystal, 2004). For instance, McCrystal (2004) argues that young people in this position can have pressure exerted upon them to adopt antisocial and risky behaviours in order to become accepted by the peer group. Where adopting these behaviours provides the young person with friendship and support it would be expected that this would serve to normalise the acceptability of risk taking behaviours; thus beginning a vicious cycle through which acceptability by antisocial peers results in the school excluded youth becoming further isolated from prosocial peers and experiencing wider social exclusion from society as a result of being labelled by society as 'bad', 'dangerous', 'problem', 'failing' and 'damaged' youth (Becker, 2010, Berridge et al., 2012, Brown and Strasburger, 2007, Carpenter-Aeby and Aeby, 2009, Johnson et al., 2001, Kim and Taylor, 2008, Loutzenheiser, 2002, McCrystal, 2004, Rondón et al., 2012, Shoemaker, 1990).

Qualitative studies exploring the effects of peer influence on looked after young people's risk taking behaviour appear to support this hypothesis. For instance,

several studies highlight that alcohol consumption and illicit drug use by young people looked after in residential care either begins or increases upon entry into the care system; with many young people stating that the reason for their use of alcohol or drugs was that they felt pressurised to adopt risky behaviours in order to make friends and be accepted by the peer group (Berridge et al., 2012, Boylan et al., 2001, Chase et al., 2006, Corlyon and McGuire, 1997, Coy, 2008, Greishbach and Currie, 2001, Knight et al., 2006, Ridley and McCluskey, 2003, Ritchie et al., 2003). Furthermore, there is evidence to suggest that young people in residential care are more likely to truant or refuse to attend school when other young people in placement regularly refuse to attend school (Ritchie et al., 2003; Berridge et al., 2012).

Young people who are excluded from education and are encouraged by their peers to adopt risky behaviours may experience poor sexual health outcomes for three reasons. First, it has been widely reported within the empirical literature that young people who regularly smoke cigarettes, drink to the point of drunkenness and use recreational drugs, in particular cannabis, are significantly more likely to experience early sexual initiation, to experience sexual debut under the influence of substances and to use condoms inconsistently or not at all; all of which significantly increase the likelihood of their contracting a sexually transmitted infection and experiencing early pregnancy and parenthood (Guo et al., 2002, Parkes et al., 2007, Tapert et al., 2001). Second, it can be argued that young people who are pressurised into engaging in antisocial behaviour and adopting health risk behaviours such as smoking, alcohol consumption and illicit drug use would be more vulnerable to peer pressure focussed upon sexual behaviour. Certainly, there is some qualitative evidence that suggests that peer pressure in the care system can result in a normalisation of risky sexual behaviour. For instance, several qualitative studies conducted with young people in residential care have shown that peer pressure within children's units increases the likelihood of young people engaging in risky sexual activity (Corlyon and McGuire, 1997; Chase et al., 2004; Ridley and McCluskey, 2003; Waldman et al., 2001). In particular, the authors of these studies noted that older youth in residential care actively encouraged their younger peers to engage in sexual activity, with young men at most risk of being influenced.

Furthermore, it was noted that some young people in residential care experienced peer pressure to engage in transactional sex in order to gain material goods (Coy et al., 2008, Knight et al., 2006). This is particularly concerning given that the trading of sexual activities for material goods can be an early introduction to sex work, which in turn is associated with increased risk of exposure to sexually transmitted infections, including HIV.

Finally, there is evidence to suggest that school exclusion and poor educational attainment can result in young people having low expectations of entering further education or employment, and aspiring towards early parenthood (Daguerre and Nativel, 2006). Where these aspirations are experienced within the context of peer, familial and community level factors that “highlight the normative aspect of early motherhood in the social milieu” (Lee et al., 2006, p54) it is likely that should a deprived young woman with limited aspirations experience an early or unplanned pregnancy she will be significantly less likely to terminate that pregnancy than an affluent young person who is aspiring towards tertiary level education (ISD, 2008, ISD, 2009, Henderson et al., 2007). Whilst for some young people early parenthood can be a positive and rational choice (Arai, 2003, DfES, 2006, Duncan, 2007) it has potentially negative consequences. In particular, early parenthood can negatively affect the socio-economic and health status of parent and child, and result in young people being removed from education and the labour market; thus increasing public spending, promoting welfare-dependence and resulting in inter-generational transmission of social exclusion (Berthoud et al., 2004, Ermisch and Pevalin, 2003, Hamlyn et al., 2002, Moffitt and E-Risk Study Team, 2002, Social Exclusion Unit, 1999, Wiggins et al., 2005, Wilkinson et al., 2006). Evidence from qualitative research conducted with young women who have been in local authority care suggests that pregnancy and parenthood are often aspired to in order for the young person to create a family of their own (Chase et al., 2006, Knight et al., 2006, Love et al., 2005).

### ***1.4.2.3 Multiple risk as a predictor of poor sexual health outcomes***

Thus far it has been demonstrated that pre-care experiences, including relationship breakdown, domestic violence, parental drug and alcohol misuse, parental psychiatric problems and child maltreatment increase the risk of young people experiencing poor sexual health outcomes. In addition, it has been shown that pre-care histories may be mediated by other factors such as attachment security, adolescent mental health difficulties, involvement in prosocial activities, educational engagement, the use of drugs and alcohol, and associations with high risk peers. However, whilst it has been shown that each of these factors can independently increase the risk of young people experiencing poor sexual health outcomes, the research evidence suggests that the poorest sexual health outcomes are observed for young people who have experienced multiple adversity during childhood and adolescence (Gest et al., 1999, Jackson et al., 2012, Kalil and Kunz, 1999, Thornberry et al., 2000, Woodward et al., 2001). For instance, data from the Carolina Longitudinal Study demonstrates that young people who had experienced difficulties at school, had dropped out of high school, exhibited behavioural problems and were of low socio-economic status were significantly more likely than young people with no risk factors to experience early parenthood (Gest et al., 1999). Similarly, longitudinal data from the Christchurch Health and Development Study demonstrates that: “early maturing, antisocial girls raised in families characterized by parental instability, early motherhood and maternal role models of single parenthood” have the highest risk of experiencing early pregnancy (Woodward et al., 2001, p26). Given that young people in local authority care tend to come from socially excluded backgrounds, and are often exposed to multiple forms of familial, educational and social exclusion, it stands to reason that they may be particularly vulnerable to experiencing poor sexual health during adolescence. I now move on to review what is currently known about the sexual health outcomes of looked after young people.

### **1.4.3 Sexual health outcomes of young people in the care system**

In order to understand whether young people in the care system experience poor sexual health, a literature search was conducted using the terms presented in Table 1 (overleaf).

**Table 1: Literature search terms for looked after young people's sexual health**

Search Parameters	
Looked after children	Looked after children; children in care; foster care; residential child care; residential care; group care; group homes; out of home care; kinship care; adoption; adopted children; maltreated children; neglected children; abused children
Sexual health outcomes	sexual health; condoms; chlamydia; hepatitis; gonorrhoea; herpes; syphilis; sexually transmitted; sexual infections; sexual behaviour; terminations; abortions; sexual risk; hiv risk; hiv tests; hiv positive; hiv interventions; hiv status; hiv prevention; cervical cancer; family planning; reproduction; reproductive health; pregnant; GUM; genitourinary; contraception; contraceptive; HPV; human papilloma; pelvic inflammatory; birth control; emergency contraception; sex education
Data bases	ASSIA; CINAHL; Embase; ERIC; IBSS; ISI Web of Knowledge; MEDLINE; PsychINFO; Social Care Online; Google
Inclusion Criteria	Peer reviewed journals, government reports, grey literature Longitudinal, Cross-sectional, Record linkage, Cohort, Panel surveys; Qualitative January 1990 - December 2013 Language: English

The search revealed that a substantial body of evidence has been amassed that demonstrates that young people in local authority care experience poor sexual health outcomes. However, the methods used to collect the data mean that these findings should be interpreted cautiously. There are two reasons for this. First, much of what is currently known about the sexual health of looked after young people is based upon small, non-comparative studies of looked after young people. This is because young people within local authority care are often excluded from epidemiological and cohort studies due to their high mobility and the difficulties that researchers experience in gaining informed parental consent (Rosenfeld et al., 1997). Data drawn from these studies should be viewed with caution as it is not possible to ascertain whether the findings from these studies can be generalised to all young people who are looked after in local authority care. Second, the use of non-comparative samples makes it difficult to ascertain

whether the sexual health outcomes of young people in the care system are one, significantly poorer than those experienced by young people in the general population, and two explained by the increased levels of material, familial and educational disadvantage experienced by young people in the care system.

Although the literature review did identify several studies which utilised data from cross-sectional and longitudinal studies, including secondary analyses of linked records, the findings presented tend to be based upon one, the experiences of young people in the care system during the 1970s, 1980s and 1990s, and two, research conducted largely in Scandinavia and the USA. As such the findings of these studies should be viewed cautiously as differences in welfare, childcare and sexual health policy may mean that the findings cannot be generalised to young people currently looked after in Scotland. Despite these caveats it should be noted that studies assessing the sexual health outcomes associated with local authority care consistently paint a picture of young people being at increased risk of: experiencing early and risky sexual activity; contracting sexually transmitted infections; engaging in transactional sex and prostitution; and early parenthood. These findings will now be discussed.

#### ***1.4.3.1 Early and risky sexual behaviour***

Looking first at sexual risk taking and early sexual debut, evidence from a number of non-comparative studies of young people looked after by local authorities suggests that looked after young people have higher rates of sexual activity than their non-looked after peers (Ahrens et al., 2010, Carpenter et al., 2001, Courtney et al., 2005, Courtney et al., 2010, Courtney et al., 2011, Crocker and Carlin, 2002, Dworsky and Courtney, 2010, Henderson et al., 2002, Henderson et al., 2011b, James et al., 2009, Meltzer et al., 2003a, Meltzer et al., 2004a, Meltzer et al., 2004b, Polit et al., 1987, Polit et al., 1989, Risley-Curtiss, 1997, Robertson, 2013). For example, Meltzer et al (2003, 2004a and 2004b) reported that 31% of 11-17 year olds and 70% of 16-17 year olds living in residential and foster care in England, Wales and Scotland were sexually active. Similarly, Crocker and Carlin (2002) reported that 77% of women with a history of being looked after in local authority care were sexually active prior to age 16.

This is in comparison to approximately a third of young people in the general youth population being sexually active at age 16 (Henderson et al., 2002). These findings are broadly supported by the findings of cross-sectional studies which have compared outcomes for young people in the care system with those observed within the general population. For example, Polit et al (1989) concluded that white female child welfare clients aged 13-18, who were either in foster care placements or remained living at home under social work supervision in the USA, were four times more likely to be sexually active than young women in the general population. They also had significantly poorer knowledge of contraception and were significantly less likely to report having used birth control at last intercourse.

More recently, Ahrens et al (2010) used data from three waves of the National Longitudinal Study of Adolescent Health to demonstrate that, compared to young people in the general youth population, young women in foster care placements in the USA had a three-fold increase in the risk of being sexually active before age 16. Looking specifically at those young people who were sexually active, Ahrens and colleagues reported that young women in foster care were significantly younger than their non-looked after peers at sexual debut, had more sexual partners and had sex more frequently. The same patterns of behaviour were not observed for young men. Similar findings were reported by Carpenter et al (2001) in an analysis of data from the 1995 sweep of the National Survey of Family Growth, with the authors noting that being placed in foster or kinship care during adolescence was associated with increased levels of sexual risk for young women. More specifically, the authors concluded that being placed into kinship care was associated with a younger age at sexual initiation. Furthermore, being in foster care or kinship care was associated with young people having greater than the median number of sexual partners; findings that remained after adjusting for demographics, respondent and parental education, maternal marital status and how much first intercourse was desired by the respondent.

Turning to the UK, Henderson et al (2002) in a randomised controlled trial evaluating the effectiveness of teacher-led sexual health education (SHARE)

demonstrated that young people living in residential or foster care were significantly more likely than their peers to report early sexual initiation (pre-14 years); findings that remained after adjusting for deprivation and other known predictors of adolescent sexual risk taking. The authors also demonstrated that young people in residential and foster care had lower levels of condom usage at sexual initiation. Similar findings were reported when looked after status was used as a covariate in a comparative analysis of cross-sectional data on pre-16 sexual activity for young people in alternative and mainstream education settings (Henderson et al., 2011b). For the purpose of this PhD I conducted a secondary analysis of data from this study in order to compare the sexual health outcomes of young people in residential and foster care with those observed for young people in the general youth population. Details of this analysis are presented in Appendix 1. From this it can be seen that the odds of looked after young people having had anal or vaginal intercourse by age 16 were 2.5 times greater than those observed for non-looked after peers of a similar age and from a similar geographical background. The results also demonstrate that the circumstances around looked after young people's first sexual behaviour was significantly riskier, with: five-fold increase in the likelihood of sexual debut occurring prior to age 13; a four-fold increase in the likelihood of sexual initiation occurring under the influence of drugs and alcohol; and, a five-fold increase in the likelihood of young people having used emergency contraception.

#### ***1.4.3.2 Sexually transmitted infections***

The higher incidence of early sexual risk taking amongst looked after young people, including their increased reliance upon emergency forms of contraception, increases the risk of young people in the care system contracting a sexually transmitted infection (Ahrens et al., 2010, Auslander et al., 2002, Courtney et al., 2011, Crocker and Carlin, 2002, Polit et al., 1987, Shields et al., 2004, Sullivan and van Zyl, 2008). For example, Crocker and Carlin (2002) assessed whether having a history of being looked after in local authority care was associated with differential rates of sexually transmitted infections (STIs) diagnosed amongst women attending a genitourinary medicine clinic in the UK. The authors concluded that women with a history of being in care had significantly higher rates of previous STI diagnoses (60% vs. 41% for those with no

care history). Similar findings have been reported by Courtney et al (2011) who concluded that at age 25 young men and women with a history of being in foster care were almost twice as likely as youth participating in the National Longitudinal Study of Adolescent Health to report that they had been diagnosed with an STI. For young people in the foster care system the three most commonly reported diagnoses were Chlamydia, Trichomoniasis and Gonorrhoea, with the most commonly reported STI being Chlamydia. This was not the case in the National Longitudinal Study of Adolescent Health sample, with the most common STIs reported being the human papillomavirus (young women) and Gonorrhoea (young men).

Similar findings were reported by Ahrens et al (2010) who used data from three waves of the National Longitudinal Study of Adolescent Health to assess whether there was an association between having been placed in foster care and future risk of STI contraction. The authors concluded that women who had been in foster care had a three-fold increased risk of contracting Trichomoniasis but had no elevated risk for either Gonorrhoea or Chlamydia. In contrast, young men who had been in foster care had a 14-fold increased risk of contracting Gonorrhoea and a three-fold increased risk of contracting Chlamydia but no elevated risk for Trichomoniasis. No reasons were given for the gender differences in sexual transmission rates; however it may be that the increased risk of infection with Gonorrhoea and Chlamydia amongst young men in the care system is related to sexual abuse histories or increased risk of prostitution given the high proportions of men who have sex with men who contract these infections (Turner et al., 2013). The higher incidence of STIs evidenced for young people in local authority care may be partly explained by the fact that, in addition to having poorer contraceptive usage, young people in local authority care are significantly more likely than young people in the general population to report that they have knowingly had sex with another person who was infected with an STI (Courtney et al., 2007). Data from the same study also demonstrated that increased levels of STI diagnosis amongst foster care youth was also associated with inconsistent condom usage, having more than five sexual partners and exchanging sex for money (Ahrens et al., 2013).

### **1.4.3.3 Pregnancy and parenthood**

Moving on to look at pregnancy and parenthood, evidence from non-comparative samples of looked after young people suggests that 7-25% of young people in the UK will experience pregnancy or become a parent within one year of leaving care (Biehal et al., 1992, Biehal, 1995, Dixon and Stein, 2003, Garnett, 1992). For example, Dixon and Stein (2003) in a small sample of care leavers (n=107) in Scotland demonstrated that 9% of the young men and 16% of the young women had a child or were pregnant by age 17; both figures noted as being higher than the national average of 7% teenage pregnancy seen for the 16-19 year group at that time (ISD, 2000). Higher proportions of teenage pregnancy have also been reported by Biehal et al (1992, 1995), with the authors concluding that 25% of female care leavers (N=74) had a child by the age of 16, rising to 50% within 18-24 months of leaving local authority care.

Similar findings have been reported within small, non-comparative samples of young people in kinship and foster care in the USA (Collins et al., 2007, Gotbaum, 2005, Krebs and de Castro, 1995, Polit et al., 1989, Sakai et al., 2011, Shaw et al., 2010). For example, Polit et al (1989) concluded that white young women aged 13-18 who were looked after in foster care or under home supervision were eight times more likely to have experienced a pregnancy. Furthermore, Gotbaum (2005) concluded from data collected as part of an exploratory survey of foster care agencies in one US state that one in six young women in foster care were either pregnant or parenting, whilst Sakai et al (2011) demonstrated that young people entering kinship care had significantly elevated risks of experiencing pregnancy. Finally, a study of birth rates in one US state concluded that the birth rate for youth in foster care was almost three times higher than that observed within the general population, with 92.7 births per 1000 observed for young women in foster care compared to 32.7 for young women in the general population (Shaw et al., 2010). The findings from these small scale studies are replicated within studies that have compared data collected from young people in local authority care placements with data collected from young people in the general youth population. For instance, data comparing the outcomes of foster youth in three US states with young people participating in the National Longitudinal Study on Adolescent Health reveals

that by age 19, 50% of female youth in foster care have been pregnant compared to 27% of young women in the general population. The authors also noted that repeat pregnancies were slightly more common; with 46% of young women in foster care experiencing more than one pregnancy by age 19 compared to 34% of young women in the general population (Courtney et al., 2001, Dworsky and Courtney, 2010).

Turning to the UK, evidence of increased pregnancy and parenthood risk for young people in care is more equivocal. For instance, Viner and Taylor (2005) used longitudinal data collected from the 1970 National Child Development Study to examine the risk of first pregnancy occurring prior to age 18. The authors concluded that having a history of local authority care did not significantly increase the risk of a young woman falling pregnant. However, it is worth noting that no data was presented upon the outcomes of pregnancies experienced prior to age 18. Given that several qualitative studies have highlighted that young women in the care system aspire to having a family of their own, it may be that whilst no difference exists in conception rates, young women in local authority care are less likely to terminate a pregnancy and thus more likely to become teenage parents (Chase et al., 2004; Knight et al., 2006; Love et al., 2005). Secondary analyses of longitudinal cohort data conducted by Jackson et al (2002) and Vinnerljung et al (2005) appear to support this, demonstrating that having a history of being in local authority care significantly increases the risk of early parenthood. For example, Jackson et al (2002) used data from both the British Birth Cohort Study (BCS) and the National Child Development Study (NCDS) to create estimates of teenage pregnancy risk for women who had experienced local authority care and found that that these women were between 1.5 and 2.5 times more likely to have become a teenage parent. Similarly, Vinnerljung et al (2005) used national register data for all children born in Sweden between 1972 and 1983 to compare pregnancy outcomes for women with and without a history of being in care. The authors concluded that the odds of becoming a teenage parent were four- to five times higher after adjustment for known predictors of early parenthood.

## 1.5 Improving the sexual health of looked after young people

In the previous section it was demonstrated that young people in local authority care often experience poorer sexual health outcomes than young people in the general youth population. In particular, it has been highlighted that having a history of being placed into care is associated with earlier sexual initiation, poor usage of condoms, increased usage of emergency contraception, increased reporting of STI diagnoses and increased likelihood of experiencing teenage pregnancy and early parenthood. It was also shown that there is some evidence to suggest that the poorer sexual health outcomes of looked after young people remain after statistically adjusting for known predictors of adolescent sexual risk, including social deprivation, educational exclusion and parental monitoring. I now move on to outline the Scottish Government's commitment to improving the sexual health of looked after young people; focussing first on policies that are designed to improve whole-population sexual health before moving on to discuss policies that specifically target young people looked after by local authorities.

At the time this thesis began, the key policy underscoring improving the sexual health of young people in Scotland was "Respect and Responsibility: a strategy and action plan for improving sexual health" (The Scottish Executive, 2005, The Scottish Government, 2008b). This policy provided a working framework for the improvement of Scotland's sexual health, with the ultimate aims being to: reduce levels of unintended pregnancy; reduce the prevalence of sexually transmitted infections and HIV transmission; increase access to sexual health services and information; and improve the quality of sexual relationships through reducing the level of coercion and regret experienced. The strategy and recommendations for action that were made within Respect and Responsibility were based upon the belief that sexual health is a "state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sex experiences, free of coercion, discrimination and violence" (World Health Organisation, 2002, p.4). In particular, the Respect and Responsibility strategy focussed upon promoting mutual respect amongst

sexual partners, preventing unwanted pregnancy and preventing the transmission of STIs. Although Respect and Responsibility has now been superseded by the Sexual Health and Blood Borne Infection Framework (The Scottish Government, 2011a), it should be noted that the new policy continues to deliver the aims and principles outlined within the Respect and Responsibility agenda.

In terms of how Respect and Responsibility affected young people, the farthest reaching component of sexual health work implemented as a result of the policy is the provision of information and advice about sexual health and relationships to young people. The main method of delivering this information is through school-based sexual health and relationships education. The Scottish Government identifies learning about sexual health as an important facet of every young person's personal and social development, and as such the provision of sexual health and relationships education, although not compulsory, is considered to be an integral part of the health and wellbeing area of the school curriculum. Sexual health and relationships education lessons currently begins in primary school and continues through to late secondary school, with the intention being to provide young people with objective facts about their developing bodies, puberty and sexual health and relationships. Additionally, sexual health and relationships education aims to empower young people to make informed, responsible and healthy choices; build positive, respectful peer and partner relationships; and to be sexually healthy (The Scottish Executive, 2005, The Scottish Government, 2008b, The Scottish Government, 2011a, The Scottish Government, 2013).

School-based sexual health and relationships education is currently the main source of information and advice about sex for young people (Currie et al., 2008, Healthy Respect Phase Two Programme Evaluation Team, 2010, Macdowall et al., 2006). Evidence from qualitative interviews conducted with looked after young people and care leavers shows that many young people in the care system do not remember having received school-based sexual health and relationships education or being spoken to about topics such as contraception and sexually transmitted infections by a teacher (Billings et al., 2007, Bundle, 2002, Chase et

al., 2006, Dale, 2009, Dale et al., 2011, Greer, 2010, Knight et al., 2006, McFreely, 2003). These findings are concerning as once a young person becomes looked after it becomes the responsibility of the state to safeguard and promote the welfare of that individual and to make use of such services as would be available for children were they cared for by their parents (McRae, 2006). This belief is enshrined within the 1995 Children (Scotland) Act and is designed to ensure that children who are looked after should have the same access to NHS provision and school health services. They should also have the same educational opportunities as all other children, including health education opportunities (HMSO, 1995). Essentially, the legislation states that that no child should be disadvantaged as a result of being looked after by the state.

In order to try and meet this aim the Scottish Government has pledged to improve the outcomes of young people within the care system, and since 2001 a number of policy documents have been published that have placed an emphasis upon helping looked after young people attain positive outcomes. The most significant of these documents is “looked after children and young people: we can and must do better” (The Scottish Government, 2007b). This emphasised the need for practitioners to work together to ensure that the needs of looked after children were met; that children in care should become lifelong learners; that services and support should be provided to young people in order to help them develop into successful and responsible adults; that practitioners should support looked after young people to be emotionally, mentally and physically healthy; and finally, that young people should expect to feel safe and nurtured in a home setting. Looking specifically at the health of looked after young people, “we can and must do better” concluded that there was a significant lack of specialist research into the health needs of looked after children, and echoed calls from elsewhere for more research to be undertaken in the UK to identify whether being a looked after child was associated with poorer health. One particular area where it was noted that there was limited research evidence was the sexual health of looked after children and care leavers, with the NHS Health Scotland’s National Sexual Health Advisory Committee advocating for increased evidence about the effectiveness of interventions designed to improve the sexual health

of this population (Association of Public Health Observatories, 2007, Broad, 1999, Sim et al., 2009).

In addition to the calls for additional research, “we can and must do better” called for all health boards to one, routinely assess the emotional, mental and physical health of looked after young people and two, to identify interventions or services that could address those needs. This recommendation became a requirement with the publication of NHS Scotland’s Chief Executive Letter 16 (CEL-16) in which, it was stated that it was the duty of each health board to ensure that all looked after children: were registered with a GP and dentist, received regular health and dental check-ups; received sexual health and drugs education; and were granted access to specialist mental health and sexual health services where required (Healthcare Policy and Strategy Directorate: Child and Maternal Health Division, 2009, The Scottish Government, 2007a). In essence, CEL-16 called upon both health boards and local authorities to work collaboratively to ensure that young people in local authority care were prioritised for the delivery of sexual health and relationships education.

## **1.6 Chapter summary and overview of thesis**

In this introductory chapter I have demonstrated that young people growing up in households characterised by poverty, social exclusion, relationship breakdown, domestic violence, parental drug and alcohol misuse and parental psychiatric disorders have an increased risk of being maltreated and entering local authority care. It was also shown that many of the antecedents of care entry are also associated with poorer sexual health outcomes during adolescence, and that young people in the care system are significantly more likely to engage in early and risky sex, and to experience teenage pregnancy and parenthood. The chapter concludes by highlighting that the Scottish Government and NHS Scotland in an attempt to improve the sexual health outcomes of looked after young people have prioritised looked after young people for the delivery of sexual health and relationships education. I now move on to discuss what is currently known about looked after young people’s access to sexual health and relationships education.

## **Chapter 2: Literature review**

### **2.1 Introduction and aims**

In the previous chapter it was demonstrated that young people in local authority care have been prioritised for the delivery of sexual health and relationships education as a result of their being particularly vulnerable to experiencing poor sexual health outcomes. The aim of this chapter is to identify what is currently known about the provision of sexual health and relationships education to young people in local authority care. The chapter begins by examining what is currently known about the effectiveness of school-based sexual health and relationships education. In doing so it will be demonstrated that whilst there is evidence suggesting that sexual health and relationships education improves young people's sexual health knowledge, there is limited evidence that the provision of sexual health and relationships education improves behavioural outcomes such as using condoms. And, that it has therefore been identified that parents should play a significant role in the provision of sexual health and relationships education to young people. The chapter concludes with a review of the literature on parental influences upon young people's sexual health, including communication about sexual health and relationships within the care setting. In doing so I consider what is currently known about the influence of social workers, residential and foster carers in order to identify the research questions that will be addressed by this thesis.

### **2.2 Sexual health and relationships education**

In section 1.5 it was demonstrated that the provision of school-based sexual health and relationships education lies at the heart of Scotland's sexual health strategy. Given the emphasis is placed upon ensuring that young people are provided with sexual health and relationships education I begin this chapter by examining what is currently known about the efficacy of sexual health and relationships education.

### 2.2.1 Does school-based sexual health and relationship education work?

Recent reviews assessing the effectiveness of school-based sexual health and relationships education have shown its potential to improve young people's sexual health knowledge, attitudes and values (Kim and Free, 2008, Kirby, 2001, Kirby et al., 2007, Robin et al., 2004, Shepherd et al., 2000, Shepherd et al., 2010, Song et al., 2000). For example, a meta-analysis of 67 experimental evaluations of school based sexual health and relationships interventions conducted between 1960 and 1997 demonstrated small, but significant improvements in the sexual health knowledge of young people who had received sexual health and relationships education compared with those who had not. More recently, rigorous evaluations of the effectiveness of school-based sexual health and relationships education in the UK have shown that the provision of both teacher- and peer-led programmes are associated with modest improvements to both sexual health attitudes and knowledge (Henderson et al., 2007, Stephenson et al., 2004, Wight et al., 2002).

In addition to showing that school-based sexual health and relationships education improves sexual health knowledge, there is fairly robust evidence showing that sexual health and relationships education has the potential to improve behavioural outcomes (Kirby, 2002, Kirby et al., 2007, Oringanje et al., 2009, Owen et al., 2010, Shepherd et al., 2010). For example, Kirby et al (2007) demonstrated that of 83 curriculum-based sexual health and HIV education programs delivered worldwide since 1990, two thirds (65%) showed evidence of significantly improving one or more sexual behaviours, including delaying or reducing sexual activity, reducing number of sexual partners and increasing condom or contraceptive usage in experimental or quasi-experimental studies. However, it is worth noting that when the relationship between sexual health and relationships education and individual sexual behaviours are considered, the findings are equivocal, with as many studies showing that sexual health and relationships education modestly improves behaviour as there are studies showing no behavioural effects. This has led to Shepherd et al (2010) concluding that policy makers and practitioners should be cautious about the impact of using sexual health and relationships education to effect behavioural change. Certainly, evidence from two UK-based, rigorously conducted longitudinal

randomised controlled trials appear to support this assertion, with no effects of either teacher-led or peer-led school-based sexual health and relationships education upon adolescent sexual initiation, condom use and routinely recorded conception and termination rates being reported (Stephenson et al., 2004, Henderson et al., 2007).

It can be argued that the lack of positive findings in UK-based trials of sexual health and relationships education may reflect the fact that the more rigorously designed an evaluation is, the less likely the study is to report positive outcomes. This is because randomised controlled trials utilise often are accurately powered, and effect sizes need to be sufficiently large in order for whole population change to be reported upon. Randomised controlled trials evaluating the efficacy of sexual health and relationships education in the UK have also suffered from the fact that they are unable to test efficacy against the provision of no care due to ethical constraints, and therefore it may be the case that existing education provision is sufficient enough, thereby reducing the overall margin of difference, and minimising the likelihood of a significant effect being found (Wight et al., 2002). Thus, the only conclusion that can be drawn from these trials is that school-based sexual health and relationships education appears to improve sexual health knowledge but has little to no effect upon behavioural outcomes. This has led to it being argued that school-based sexual health and relationships education may have reached the limits of what it can achieve, and that as such should not be viewed as a panacea (Elliott et al., 2013, McCabe, 2000).

Instead, it has been suggested that in order to improve the sexual health and relationships of young people it is necessary to explore interventions that recognise wider cultural, moral, structural and societal changes (McCabe, 2000). This has resulted in the Scottish Government proposing that parents should play a more fundamental role in the provision of sexual health and relationships education to their children, both directly and through providing a stable family and home life. For looked after young people, who may not have contact with their birth parents, the recommendation that parents should play a key role in the delivery of sexual health and relationships education has been interpreted in

terms of residential care workers, foster carers and social workers undertaking a more active role in talking to young people about their sexual health (Paterson and Windsor, 2009, The Scottish Executive, 2005, The Scottish Government, 2008b). This has resulted in many local authorities in Scotland, including the one where this study was based, providing their workers with specialist training in sexual health and relationships education.

### **2.3 Parental practices and young people's sexual health**

Given the emphasis that the Scottish Government has placed upon parents being actively involved in the sexual health and relationships education of their children I now move on to review the empirical evidence focussed on ascertaining whether family processes such parent-child connectedness, parental monitoring and supervision of young peoples' behaviours and parent-child communication about sexual health can afford young people protection against poor sexual health outcomes. The search terms used to undertake the literature search can be found in Table 2 (overleaf). In presenting the findings of the literature search I begin by reviewing what is known about the influence of family processes upon adolescent sexual health outcomes, before moving on to explore in detail how parent-child communications about sexual health and relationships are undertaken within households. The section concludes by examining what is currently known about the provision of parental monitoring, supervision and sexual health communication within the care system.

**Table 2: Parental influences on adolescent sexual health search terms**

Search parameters	
Adolescents	Adolescents; young people; youth; teenagers
Looked after children	Looked after children; children in care; foster care; residential child care; residential care; group care; group homes; out of home care; kinship care; adoption; adopted children; maltreated children; neglected children; abused children
Sexual health outcomes	Sexual health; condoms; sexually transmitted; sexual infections; sexual behaviour; terminations; abortions; sexual risk; hiv risk; family planning; pregnant; contraception; contraceptive; birth control; emergency contraception; sex education; sexual health education; sexuality education
Family processes	Family of origin; family background; family relations; parental characteristics; parenting style; parent-child relations; parental monitoring; parental supervision; connectedness; parent-child connectedness; parent-child communication; talking about sex; talking about sexual health; childrearing practices; parental role; parental involvement.
Databases	ASSIA; CINAHL; Embase; ERIC; IBSS; ISI Web of Knowledge; MEDLINE; PsychINFO; Social Care Online; Google
Inclusion Criteria	Peer reviewed journals, government reports, grey literature Cross-sectional, longitudinal, cohort data; qualitative literature Date: January 1990 - December 2013 Location: North America, Western Europe, New Zealand, Australia Language: English

### 2.3.1 Parent-child connectedness

In section 1.5 it was argued that sensitive, attuned and responsive parenting is beneficial to young people's socio-emotional development, and helps foster a secure parent-child bond. During adolescence, the quality of the parent-child bond is often described in terms of connectedness, with relationships being described as 'connected' when they are warm and caring, and parents actively demonstrate an interest and take responsibility for their child (Ackard et al., 2006). It has been argued that parents and children who feel connected to one another enjoy spending time together, support and respect one another and are able to communicate openly and honestly about sensitive topics (Wight and Fullerton, 2013). As such it is believed that connected relationships can have protective effects upon the sexual health and wellbeing of young people (Dilorio et al., 2003, Fullerton, 2004, Lezin et al., 2004, Jaccard et al., 1996, Markham et al., 2003, Miller et al., 2001, World Health Organisation, 2007).

For instance, a number of studies have demonstrated that young people who report that they have relationships with their parents that are close, loving and low in conflict are more likely to delay sexual initiation, are more likely to use contraception and are at lower risk of experiencing unintended/early pregnancy (Lezin et al., 2004). Jaccard et al (1996) concluded that adolescents who reported that they were satisfied with the relationship they had with their mother had significantly lower odds of sexual intercourse between the ages of 14 and 17. In addition, students' perceptions of family connectedness were associated with delaying sexual initiation, using contraception and not having been involved in a pregnancy for young people (aged 12-20) in alternative education settings in the US (Markham et al, 2003). In contrast, low levels of parent-child connectedness were shown to be associated with sexual initiation occurring prior to age 13 (*ibid*).

### 2.3.2 Parental monitoring and supervision

In addition to the quality of the relationship between parent and child the empirical evidence demonstrates that parental monitoring and supervision of children's activities can influence young people's sexual health outcomes. Two

forms of monitoring are reported upon, namely indirect and direct monitoring. Indirect monitoring encapsulates facets of parental behaviours such as having knowledge of their children's whereabouts, peers and activities outwith the home, whilst direct monitoring refers to behaviours designed specifically to regulate and supervise young people's activities (Crosby et al., 2001, Jaccard et al., 1996, Markham et al., 2003, Markham et al., 2010, Miller et al., 1999, Miller et al., 2001, Nelson et al., 1999, Neumark-Sztainer et al., 1997, Resnick et al., 1997, Rodgers, 1999, Sieving et al., 2000, Taris and Semin, 1997).

Looking first at indirect monitoring, a number of cross-sectional and longitudinal studies have reported that adolescents who believed that their parents always knew where they were and what they were doing were more likely to delay sexual activity, use condoms more consistently, have lower levels of sexual risk taking, fewer sexual partners and are less likely to contract an STI (Bates et al., 2003, Markham et al., 2010). For example, Bates et al (2003) concluded that those young people who reported that they always informed their parents about where they were going when they were aged 11-13, were significantly less likely to be sexually active at ages 15-17. In contrast, lack of parental knowledge about young people's whereabouts was associated with increased risk of STI contraction in a prospective study, with 18 month follow-up. Moving on to look at direct monitoring it can be seen that the use of family rules, household routines and parental supervision of activities is associated with delayed sexual initiation and reduced pregnancy risk during adolescence (Bates et al., 2003, Borawski et al., 2003, DiClemente et al., 2001, Hope and Chapple, 2004, Huebner and Howell, 2003, Luster and Small, 1994, Metzler et al., 1994, Roche et al., 2005, Rodgers, 1999, Stanton et al., 2002). For example, Roche et al (2005) reported that young people who reported at age 12-13 that their parents established curfews, monitored their TV viewing, had rules about clothing choices and expressed views about appropriateness of friendships were significantly more likely to delay sexual initiation.

Whilst direct forms of parental monitoring may be protective, it has also been demonstrated that excessive, controlling and coercive forms of monitoring and supervision are associated with high risk sexual behaviour (Barber, 1996,

Danziger, 1995, Forste and Haas, 2002, Gray and Steinberg, 1999, Parkes et al., 2011, Pedersen et al., 2003, Roche et al., 1999, Roche et al., 2005, Rodgers, 1999, Upchurch et al., 1999, Wight et al., 2006). Adolescents who report that their parents are over-controlling or do not allow them to make their own decisions have a significantly younger age at sexual debut (Barber, 1996, Forste and Haas, 2002, Gray and Steinberg, 1999, Pedersen et al., 2003, Roche et al., 2005, Rodgers, 1999, Upchurch et al., 1999). In addition, Roche et al (2005) concluded that young people who reported that their parents were very strict were more likely to be sexually active than young people with only moderately strict parents. In contrast, parenting that was characterised by low demandingness or permissiveness, in which no boundaries or rules are established by the parent, can also increase the likelihood of young people experiencing poor sexual health outcomes. For example, Roche et al (2005) reported that sexual experience rates are much higher for young people whose parents do not set any rules at all. Similarly, Wight et al (2006) reported that increased autonomy, as measured by the amount of spending money that young people were granted by their parents, increased the risk of sexual activity for girls and was predictive of the number of sexual partners young men had.

### **2.3.3 Parent-child communication about sexual health and relationships**

Thus far it has been demonstrated that the quality of parent-child relationships and parental monitoring during adolescence can be protective for adolescent sexual risk. Another facet of parental interaction that may afford protective effects for adolescents is communication about sexual health and relationships, including parental attitudes and values relating to sex. The evidence in support of this shall now be discussed.

#### ***2.3.3.1 Parental attitudes and values about sex***

Parental attitudes and values about sexual behaviour can reduce adolescent sexual activity (Kirby and Miller, 2002, Manning et al., 2005, Ward and Wyatt, 1994, Wellings et al., 1996, Sieving et al., 2000). For example, it has been reported that there is an association between parental values about intercourse and young peoples' relationship choices, with those young people who reported

that their parents valued sex within the context of a loving relationship being less likely to report casual sexual behaviour (Manning et al., 2005). In addition, a number of studies have demonstrated that young people who report that their parents display attitudes and values that convey disapproval of adolescent sexual activity have reduced risk of experiencing early sexual initiation. For example, young people who believed that their mother's disapproved of them being sexual activity were more likely to delay sexual initiation; although it should be noted that this effect was only observed where young people also reported high levels of maternal connectedness and where communication began at a young age (Kirby, 2002; Sieving et al., 2000). The same effect was not observed where mothers explicitly conveyed their disapproval to young people during adolescence (Sieving et al, 2000). And, there is some evidence to suggest that overly permissive or overly prohibitive parent-child communications about sexual health may increase the likelihood of young people engaging in risky sexual behaviour (Ward and Wyatt, 1994).

In the UK, Wellings et al (2001) reported that boys who talk to their parents about sex are more likely to report that they consistently use condoms; however, it should be noted that this finding was most strongly observed for young men who also reported that they felt uncomfortable talking to their parents about sex. Similarly, Allen et al (2007) reported that the ease with which young women were able to talk to their mothers about personal problems during adolescence was associated with decreased likelihood of pregnancy at age 16; however, no such association was observed for mother-son, father-son or father-daughter communications. As to why different patterns of outcomes are observed between studies, Miller et al (2001) have argued that differences in quantitative methodology and question wording between surveys has led to a number of ways in which communication is measured, including ever having talked about sex, how often discussions about sex occur and how many topics are discussed. In addition, discrepancies between the way in which behavioural measures are worded in surveys can also result in one study reporting an association for pregnancy risk in terms of actually having been pregnant or the risk of becoming pregnant as measured by proxies such as age at first

intercourse, contraceptive use and a history of having multiple sexual partners (Wight et al., 2006).

### ***2.3.3.2 Do parents and young people talk to each other about sex?***

Kirby and Miller (2002) have argued that the concept of parents as primary sexual educators of their children is politically acceptable. However, whilst most parents report feeling that it is their responsibility to discuss sex with their children the majority state that they want sexual health to be part of the school curricula. The main reason cited for this is that parents feel that they do not know enough about the content and nature of SHRE provided by schools to provide support to the curricula through home-based discussions about sexual health and relationships (Fullerton and Burtney, 2009, Stone and Ingham, 2002). Whilst few young people identify their parents as their main source of information, reporting instead that schools and peers are their main sources of sexual health and relationships advice, data from a number of large surveys conducted in the UK have demonstrated that parents are a significant source of sexual health information for young people (Currie et al., 2008, Healthy Respect Phase Two Programme Evaluation Team, 2010). For example, Currie et al (2008) demonstrated that after schools and peers, parents were the third most commonly identified source of advice for young people about sexual matters. Whilst the findings of these studies demonstrate that parents are not the main source of sexual health information for young people, Kirby (2002) argues that it is important to recognise that there is a difference between providing information and influencing young people's sexual health.

Drawing upon data collected from two large, nationally representative studies conducted in the US, Kirby (2002) concluded that advice and guidance from parents about sexual health and relationships was most commonly identified by young people as having the greatest influence upon their behaviour. In addition, a number of studies have demonstrated that young people often identify that they would like to receive more information about sexual health and relationships from their parents (FMR Research, 2006, Fullerton and Lee, 2004, Stone and Ingham, 2002, Walker, 2001, Wellings et al., 2001). For example,

Wellings et al (2001) stated that a third (33%) of young men and two fifths (41%) of young women aged 16-19 wanted to receive further sexual health advice from parents. Similarly, a survey of 2707 young people aged 14-16 in Glasgow concluded that 48% wanted to talk to their parents about sexual health and relationships more frequently (FMR Research, 2006). However, whilst some young people actively state that they want to talk to their parents about sexual health there is evidence to suggest that those young people who have done so are often critical of the quality of information they receive. This is because sex education within the home is generally unplanned, infrequent, fails to discuss the emotional context of sex and does not go into sufficient depth to allow young people to make informed choices (Fullerton and Lee, 2004, Stone and Ingham, 2002, Walker, 2001).

#### ***2.3.3.3 Content and timing of discussions***

Thus far it has been demonstrated that both parents and young people express a willingness to talk to each other about sexual health and relationships, but that such discussions are often infrequent. Markham (2010) argues that talking about sexual health within the home should be viewed as an all or nothing event and that the content, timing, frequency and quality of parent-child sexual health talks are all important. Looking first at content, it has been reported that the most common sexual health topics discussed by parents are those that focus upon sexual safety, rely upon the provision of factual information and do not include moral, ethical or value based judgement. Thus, it has been noted that topics such as puberty, reproduction, sexual safety and pregnancy are more frequently discussed by parents than contraception, abortion and homosexuality. In addition, parents rarely discuss sexual health from the perspective of sex being pleasurable; often choosing to omit topics such as oral sex, masturbation and orgasm); although it should be noted that there is some evidence to suggest that young people consider these topics to be too private to discuss with their parents (Dilorio et al., 1999, Fullerton and Burtney, 2009, Rosenthal and Feldman, 1999).

The timing of parent-child communication about sexual health is influenced by parental perceptions of adolescent sexual activity, with Raffaelli et al (1998) noting that discussions of parental values about sex are more frequently undertaken when young people are not sexually active, but that once parents suspect that their child is having sex the discussions become more focussed upon birth control and sexually transmitted infections (STIs). Beckett et al (2010) identified three stages of communication about sex that occur between parents and children. These are the pre-sexual, pre-coital and the sexual stage. During the pre-sexual stage communications the main topics discussed are puberty, bodily changes and menstruation. Once young people start engaging in behaviours such as kissing and genital touching, the pre-coital stage is initiated and the topics parents address start to include relationship skills, being able to say no and awareness of contraception and STIs. Finally the coital stage occurs when young people are sexually active, and topics of conversation include effective use of birth control and the symptoms of STIs. Miller et al (1998) reported that discussions about sex-related topics generally precede adolescent sexual initiation.

However, it should be noted that conversations about sexual matters with young women tend to begin in the pre-sexual stage, whilst for young men discussions about their bodies and bodily changes are often initiated during the pre-coital and sexual stages (Beckett et al, 2010). This means that relative to the timing of sexual initiation there is likely to be less opportunity for parents to provide advice and support to young men. Furthermore, it is worth noting that significant proportions of young people become sexually active prior to their parents talking to them about contraception and STIs. For instance, Beckett et al (ibid) concluded that more than 40% of young people in their study had never spoken to/with their parents about contraception and STIs before becoming sexually active. The timing of sexual health discussions are important as they provide young people with the information they require to make informed choices. Certainly, a number of studies have shown that earlier communications about sexual health within the family home is associated with reduced sexual risk. Clawson and Reese-Weber (2003) concluded that young people who had talked to their mothers about sex prior to their sexual debut reported an older

age at sexual debut and fewer lifetime sexual partners; although it is worth noting that there was an elevated risk of early pregnancy amongst this group that could indicate that earlier communications occurred as a result of behavioural cues from the young person indicating that earlier communication was required. Similar findings have been reported for the use of contraceptives at sexual debut by Beckett et al (2010).

Whilst the timing of sexual health discussions may be protective, it has been noted within the literature that sexual health discussions within the home are often infrequent, unplanned and reactive to the needs of adolescents (Walker, 2001). Less frequent communication about sexual health between parents and children is associated with less frequent, lower-quality communication within sexual relationships. In particular, DiClemente et al (2001) demonstrated that adolescents who reported less frequent parent-child communication about sex were significantly less likely to talk to their partners about safe sex, and had lower self-efficacy when it came to negotiating contraceptive use or refusing sex. Despite this, there is evidence to suggest that the majority of parents do not regularly talk to their children about sexual matters, with Wilson and Donenberg (2004) reporting that although two thirds of the parents (67%, n=34) sampled had “occasionally” discussed penetrative sex, birth control and HIV/AIDS, only 3% had discussed these issues “very often”.

Although there is little evidence that parents frequently talk to young people about sexual health matters, it can be seen that young people who report that they have been spoken to about a sexual health topic more than once are more likely to view the conversations that they had with their parents as being open and honest (Beckett et al., 2010). Rather than frequency of communication it can be argued that the quality of parent-child discussions about sexual matters afford more protection for adolescent sexual risk. In particular, it has been shown that parent-child communications about sex that are open, receptive and comfortable will reduce the likelihood of initiation and promotes less risky sexual behaviour during adolescence (Dutra et al., 1999, Miller et al., 1998, Whitaker et al., 1999, Wilson and Donenberg, 2004). This occurs because young people who report that their parents regularly talk to them about sexual health

and relationships also report that they feel closer to their parents (Beckett et al., 2010), thus increasing the likelihood of the sexual health values being communicated by parents being adopted by young people.

#### ***2.3.3.4 Barriers to talking about sexual health and relationships***

Parents and children identify similar barriers to parent-child communications about sexual health and relationships being undertaken. These include parental embarrassment, the embarrassment of the child and parental concerns that they will not be taken seriously (Jaccard et al., 2000). Looking first at embarrassment it has been reported that parental embarrassment about talking about sex decreases as the age of the child increases, but that fears about not being taken seriously increase (ibid). It can be argued that feeling embarrassed or being scared of not being taken seriously may serve to reduce ease of communication by making both children and their parents feel uncomfortable. Feeling embarrassed and uncomfortable may in turn reduce the salience of any sexual health messages communicated, which in turn may reduce the protective effect of communications. For example, Rundle et al (2008) reported that men were more likely to have used contraception at sexual debut if they had found it easy to communicate with their fathers about sex, whilst women were more likely to have used contraception at sexual debut if they found it easy to communicate with their mothers about sex. Similarly, Wellings et al (1999) reported that young women who had found communication about sexual health with their parents difficult or non-existent were more than twice as likely to have become teenage mothers as women who had found communication with their parents about sex to be easy.

A number of studies have noted that there is a significant gendered effect to communications about sexual health and relationships in the home, with mothers being the main communicators (FMR Research, 2006, Holland et al., 1996, Wyness, 1992). A survey of adolescent sexual health communication conducted in Glasgow found that 73% (n=2707) of young people had either never or hardly ever been spoken to by their fathers about sex (FMR Research, 2006). It was also reported that a third of the young men sampled had never been

spoken to about sexual health by either parent; something that echoes findings from qualitative work conducted with school pupils in which it was revealed that young men were far less likely than young women to recall receiving school-based sexual health and relationships education (Buston and Wight, 2006). The sex of both parents and children can have an effect upon ease of communication, with boys often reporting that they feel less comfortable talking to their mothers, and girls stating that they feel less comfortable talking to their fathers about sexual health and relationships (Dilorio et al., 1999; Jaccard et al., 2000; Rosenthal and Feldman, 1999; Wight et al., 2006). As mothers are more likely to communicate about sex within the home than fathers, it could be hypothesised that this could act as a barrier to young men learning about sexual health and relationships within the home environment.

## **2.4 Corporate parenting practices and looked after young people's sexual health**

Thus far I have outlined what is currently known about how parents can influence the sexual health outcomes of their parents using data drawn from studies conducted with young people in the general youth population. In doing so it has been demonstrated that warm, loving and connected parent-child relationships, when combined with one, monitoring and supervision of children's behaviour that is neither controlling nor provides the child with too much autonomy, and two, early and frequent discussions about sexual health that convey parental beliefs about delaying intercourse without being overly prohibitive, can reduce the risk of sexual risk taking during adolescence. I now move on to review what is currently known about how corporate parents, including residential and foster carers, engage with and attempt to influence the sexual health of the young people they look after.

### **2.4.1 Monitoring and supervision within the care system**

Just as biological parents attempt to influence their children's sexual health outcomes by instigating household rules and providing monitoring supervision, there is some evidence to suggest that young people in foster care are significantly more likely to delay sexual activity when they perceive that the

rules of the household they are living are strict (Polit et al., 1989). Furthermore, James et al (2009) reported that young people who were in receipt of child welfare services at age 11 and reported that their caregivers monitored and supervised their behaviours had a two-fold reduction in the likelihood of reporting that they were sexually active at age 16. Similarly, Kerr et al (2009) demonstrated using data collected as part of a randomised controlled trial assessing the impact of multi-treatment that young people who received intensive support and monitoring from a named foster care were significantly less likely to have fallen pregnant two years after admission to MTFC (27% vs. 47%). Finally, Ahrens et al (2013) reported that foster youth who experienced a close relationship with a substitute carer had a significantly lower risk of being diagnosed with a sexually transmitted infection; an association that was mediated by the relationship between connectedness and externalising behaviours, including conduct disorder. The authors also noted that young people who are continuously in care during adolescence are more likely to use condoms consistently, thus decreasing their risk of contracting a sexually transmitted infection.

Despite the finding that monitoring and supervision by corporate parents can have a protective effect upon looked after young people's sexual health outcomes the qualitative literature suggests that corporate parents do not consistently monitor and supervise looked after young people. In particular, it has been shown that the provision of monitoring and supervision differs within and without the home setting, and for different groups of young people within the care system (Farmer and Pollock, 1998, Farmer and Pollock, 2003, Lipscombe et al., 2003, Stace and Lowe, 2007). For instance, corporate parents reported placed additional safeguards upon the behaviours of young people who had histories of sexually abusing other young people, with increased monitoring and supervision reported within both the home and community setting (Farmer and Pollock, 1998). In contrast, young people engaging in risk taking behaviours, including substance use and sexual risk taking, were only provided with increased levels of monitoring and supervision within the home setting. This was because carers reported that they found it difficult to provide monitoring and supervision within the community (Lipscombe et al., 2003). Looking specifically

at the types of monitoring and supervision young people received, it can be seen that young people who had abusing histories were provided with clear household rules about privacy and enforcing boundaries. In addition, some carers reported that they had modified the layout of their homes in order to ensure that greater monitoring of the young persons' behaviour could be undertaken (Farmer and Pollock, 1998). In both cases the aims of the safeguards were to reduce the likelihood of placing the young person in a situation where they could abuse other people; to protect other people living in the household from being placed in risky situations; and to ensure that allegations could not be made against household members (ibid).

Moving on to look at the provision of monitoring to young people engaging in substance use and sexual risk behaviour, Lipscombe et al (2003) reported that foster carers increased monitoring and supervision within the home for two reasons. These were that foster carers did not want to be seen to be condoning young people's adoption of these behaviours, and that they wanted to minimise the risk of other young people within the household being exposed to, and adopting, the behaviours being exhibited. Whilst foster carers reported increased monitoring and supervision within the home, they also discussed the difficulties that they had monitoring and supervising behaviour within the community. These difficulties often arose as a result of foster carers having little to no knowledge of the relationships that young people have outside the care environment, with 95% of those interviewed stating that they were unaware of whether their charges were engaged in sexual relationships. Additionally, foster carers reported that their instinctual methods of dealing with behavioural issues within the care placement had the potential to worsen behaviours by promoting hostility and increasing the influence of individuals encouraging their charge's engagement in risky behaviours (Farmer and Pollock, 2003; Lipscombe et al., 2003).

Being unaware of who young people spent time with was particularly concerning where young people were identified by carers as being at risk of being sexually exploited, as it was recognised that young people who are being groomed are often more receptive to the influence of the individuals grooming them and less

receptive to the efforts of their carers to keep them safe and away from those individuals (Lipscombe et al., 2004). The concerns that carers expressed about looked after young people's susceptibility to grooming and sexual exploitation are substantiated within the wider research evidence, with a number of small scale studies suggesting that looked after young people are particularly vulnerable to being sexually exploited. For instance, an audit of child sexual exploitation services conducted by the University of Bedford found that 22% of children utilising the service were looked after (Jago et al., 2011). Similarly, a survey conducted by Barnardos (2011, 2012) concluded that 14% of their service users had been looked after. Whilst it is important to note that the high proportion of looked after children using specialist services dealing with sexual exploitation may reflect the reasons why young people became looked after (e.g. Gibbs and Sinclair, 2000) it should also be noted that an independent inquiry into child sexual exploitation in Rotherham demonstrated that looked after children, in particular those living in residential care, are often targeted and groomed by sexual predators (Jay, 2014).

#### **2.4.2 Communication about sex between corporate parents and young people in care**

That corporate parents are often unaware of who looked after young people are forming relationships with raises questions about the extent to which carers are able to communicate with young people about sensitive and difficult topics such as sex. Evidence from qualitative studies suggests that communication about sexual health and relationships within the care setting is limited, with several authors noting that the majority of residential and foster carers report never having spoken to their charges about their sexual health (Constantine et al., 2009, Dale, 2009, Farmer and Pollock, 1998, Farmer and Pollock, 2003, Greer, 2010, Hudson et al., 1994, Lipscombe et al., 2003, Morris, 2007, Polit et al., 1987). For example, Polit et al (1987) reported that three quarters of foster carers had never talked to their charges about sexual health, whilst Lipscombe et al (2003) reported that three fifths of the foster carers they interviewed had never spoken to the young person they were caring for about sexual health and contraceptives.

The same pattern of findings have been found in interviews conducted with looked after young people. For example, Dale (2009) reported that whilst young people could recall being clearly spoken to about substance use by their social workers and carers they felt that discussions about sexual health had been avoided by corporate parents. Additionally, Farmer and Pollock (2003) noted that 43% of the young people living in the residential units had not been provided with information about bodily changes during puberty and a third stated that they did not know enough about the dangers of unprotected sex or about contraception. The majority of young people in residential and foster care reported that they had never received information from their carers about HIV and pregnancy risk (Morris, 2007). Similar findings were reported for looked after young people's engagement with health professionals, with young people in the care system reporting that health care professionals do not routinely ask them about their sexual health behaviours, nor do they routinely offer information and advice about preventing pregnancy, sexually transmitted infections and HIV (Hudson, 2012).

The low rates of communication about sexual health and relationships within the care setting mirrors those observed for discussions about sexual health and relationships within parental homes, with evidence from a number of studies highlighting that corporate parents feel reticent talking to young people about their sexual health (Lipscombe et al., 2003; Polit et al., 1989; Farmer and Pollock, 1998). As with parent-child discussions about sexual health, corporate parents report that feeling embarrassed and not wanting to be seen as condoning sexual activity were cited as reasons for not talking to young people about sex. For example, Stace and Lowe (2007) concluded that whilst some corporate parents can be very pro-active in discussing sexual health and relationships with their charges, the majority reported that feeling embarrassed, shy and uncomfortable discussing sex acted as a barrier to them discussing sexual matters with young people. In addition, Farmer and Pollock (1998) reported that residential workers refrained from talking to young people under the age of 16 about their sexual health because they did not want to be seen to be condoning sexual activity; something that the authors noted often resulted in young people only being spoken to about their behaviours after they had become

sexually active or, in the case of 4 out of the 22 girls living in the residential units where the interviews took place, fell pregnant. Other reasons cited for not talking to young people about their sexual health included believing that it was unnecessary as young people were not yet engaged in sexual relationships, feeling that they were too young to be having those discussions, waiting for young people to initiate discussions (Stace and Lowe, 2007). It has also been reported that some carers believe that young people were already sexually aware due to sexual abuse histories, problematic sexual behaviour or early onset of sexual activity and did not require sexual health information (Farmer et al., 2003).

Beyond these factors, corporate parents have highlighted several barriers to talking to young people about their sexual health, including not having clear guidance on whose responsibility it is to talk to young people about sex, not having sufficient training in sexual health to undertake the role and feeling anxious or afraid of the consequence of talking to young people about sex (Claiverole et al., 2008, Constantine et al., 2009, Farmer and Pollock, 1998, Farmer and Pollock, 2003, Greer, 2010, Lipscombe et al., 2003, Stace and Lowe, 2007). Looking first at corporate parents not having clear guidance about whose responsibility it is to talk to young people about sex, Constantine et al (2009) demonstrated that the social workers, key workers and foster parents that they interviewed all believed that the role of corporate parents in promoting positive sexual health and relationships was not clearly outlined in formal policies and procedures. In addition it was shown that this lack of guidance extends to corporate parents knowing what can and cannot remain confidential when talking to young people about sexual health and relationships. And, corporate parents not knowing whether or not it is appropriate to talk to young people about sexual health when it is known that the birth parent's political and religious views about sexuality and birth control would mean such discussions were frowned upon (ibid). This has resulted in some carers believing that social workers should grant permission for foster carers to take young people to sexual health services (Greer, 2010).

Several studies have demonstrated that where carers feel uncertain about the appropriateness of sexual health discussions they tend to refrain from proactively undertaking sexual health work with young people. Where this happens, individuals who have a care giving role often report trying to shift the responsibility for talking to young people about sexual health to other professionals. In particular it has been shown that foster carers who feel uncomfortable taking on the role of talking to looked after young people about their sexual health report that they believe that teachers, social workers and nurses should take on this responsibility. In contrast, social workers tend to identify that carers should undertake this role as they are believed to be best placed to talk to young people about sexual health due to residing in the same household and having greater capacity to build a relationship with the young person (Claiverole et al., 2008, Farmer and Pollock, 1998, Greer, 2010, Lipscombe et al., 2003, Lipscombe et al., 2004, Stace and Lowe, 2007). It is worth noting that the views of residential and foster carers about who should talk to young people about sexual health and relationships echo those of parents, who often express a preference for teachers to lead upon their child's sexual health and relationships education (Fullerton and Burtney, 2005).

Moving on to look at training, foster carers and social workers have identified that not having been trained in adolescent sexuality can be a significant barrier to talking to young people about sexual health and relationships (Constantine et al., 2009, Farmer et al., 2003, Greer, 2010, Lipscombe et al., 2004, Love et al., 2005). In one study looking at foster carers' experiences of talking to looked after young people about their sexual health it was identified that, although it was widely recognised that young people had an increased need to receive information on contraception and sexually transmitted infections, carers often felt that they did not have sufficient knowledge to undertake these discussions (Greer, 2010). Similar findings were reported by Constantine et al (2009) who concluded that both social workers and foster carers felt that they had received inadequate training to undertake preventative sexual health work with adolescents. In both cases it was identified that corporate parents would want to either talk to a sexual health nurse or be trained in how to deliver sexual health and relationships education prior to having to talk to young people about

their sexual behaviours. It was also noted that there was a specific need for foster carers and residential carers to receive training in how to talk to young people displaying problematic or abusive sexual behaviours about their sexuality (Farmer et al., 2003; Lipscombe et al., 2004).

In addition to not having the confidence or skills necessary to talk to looked after young people about sexual health and relationships, several studies have noted that being asked to talk to young people about sexual health and relationships can promote fear and anxiety amongst corporate parents. In particular it has been reported that fear of having children and young people make allegations against them acted as a barrier to male workers talking to young people about personal matters. For instance, O'Neill (2001) reported that men working in secure units often abdicated the responsibility of talking to young women about their sexual health as they were concerned that young women would accuse them of inappropriate behaviour as a result of talking to them about sex and sexual matters.

Similar concerns have been raised with regards to corporate parents believing that talking about sexual health with looked after young people can blur the boundaries between providing information and having to address child protection concerns, with some workers noting that they were concerned about talking to young people about sex in case it opened a 'open a can of worms' that the carer might not be prepared to deal with (Claiverole et al., 2008; Stace and Lowe, 2007). Finally, it has been noted that foster carers' worry about getting into trouble for talking to young people about sexual health and relationships. This has led to some carers believing that it is necessary to document all conversations that they have with young people about sex. This belief acts as a barrier to carers talking to young people about their sexual health because it is recognised that documenting every question and concern would infringe upon the young person's right to confidentiality. As such, carers who are worried about this matter report that they would be more likely to direct a young person to have such conversations with their social worker or general practitioner so an official record can be made within the young person's health and social care files (Greer, 2010).

Although the first half of this section has been devoted to demonstrating that corporate parents can be reticent about talking to young people about their sexual health, it was noted that there are foster carers, residential carers and social workers who are talking to young people about sex and relationships. For example, Constantine et al (2009) reported that a third of the children and family social workers that they interviewed had spoken to young people about their sexual health, with the main topics that were discussed being: healthy romantic relationships; raising a child; sexually transmitted infections; condoms; sexual orientation; abstinence; birth control pills; abortion; the diaphragm; adoption; and intra-uterine devices. Other studies conducted with looked after young people and care leavers suggest that conversations about sexual health within the care setting tend to focus upon puberty and imparting the message that young people should use contraception to avoid pregnancy.

For example, Knight et al (2006) reported that the majority of young men in her sample stated that being told to 'use a condom' was the extent of advice they received from carers when they sought advice about sexual health. Young women also recalled being told to use condoms, but also recalled being spoken to about avoiding pregnancies and sexually transmitted infections, and delaying sexual activity. That avoiding pregnancy was the most commonly cited discussion between corporate parents and looked after young people may be explained by the fact that foster carers believe that this issue is most salient to young people (Greer, 2010). In addition to there being limited evidence on what sexual health topics are discussed within the care setting, James et al (2009) argues that it is unclear from the literature how corporate parents talk to young people about their sexual health. Instead, the empirical evidence tends to focus upon identifying barriers and facilitators of sexual health discussions.

Looking first at barriers, qualitative interviews conducted with corporate parents have highlighted that the gender of the child and their developmental age can act as barriers to sexual health discussions occurring. For example, Lipscombe et al (2003) reported that the gender of young people can influence whether or not corporate parents initiate discussions about sensitive topics such as sexual health, with a number of residential and foster carers highlighting that because

boys tend to externalise their feelings they are more likely to be spoken to about topics such as sexual health as part of wider discussions designed to identify the reasons for the externalising behaviours. In contrast, it was highlighted that because young women tend to internalise their feelings there is a danger that corporate parents assume that they do not need to be spoken to about sexual health and relationships. Despite this it has been reported that young women in the care system are much more frequently spoken to about sexual health (Constantine et al., 2009). This may occur because corporate parents believe that the gender of both corporate parent and young person can affect how comfortable young people are discussing their sexual health.

As a result, corporate parents who have discussed sexual health with young people in the care system have argued that they would always attempt to match the gender of the corporate parent and the young person so that young men are spoken to about sex by male workers, and young women are spoken to about sex by male workers (Stace and Lowe, 2007). This might act as a barrier to conversations about sex occurring within residential care as the majority of residential care workers are female. In addition to being sensitive to the issue of gender, Stace and Lowe (2007) highlighted that foster carers believe that the discrepancy between young people's emotional, developmental and physical ages can act as a barrier to discussing sexual health, with foster carers reporting that they felt young people benefited more from conversations about sex and relationships when they were tailored to the emotional and developmental age of the child rather than the physical age. Similar findings were reported by Lipscombe et al (2004) for managing relationships within the care setting, with several carers noting that young people who act younger than their physical age may require additional emotional supports whilst those who act older than they are may need to be strictly monitored to ensure that they are not engaging in age-inappropriate and potentially exploitative sexual behaviour.

In addition to the barriers identified by corporate parents, looked after young people have identified a number of factors that would prevent them from seeking help, support and advice about sexual health and relationships from their carers, including: corporate parents holding strong religious beliefs and

judgemental attitudes toward early sexual activity; corporate parents lacking knowledge about sexual health; not feeling listened to or respected by corporate parents; feeling embarrassed; and, corporate parents making assumptions about young people's sexual behaviour if they asked questions relating to sex. For example, Knight et al (2006) reported that care leavers who recalled having never spoken to residential or foster carers about their sexual health identified that feeling too embarrassed or worrying that their carers wouldn't have approved of their having under-age sexual activity prevented them from asking their carers for advice about sex and contraception.

Similar findings were reported by Constantine et al (2009), who reported that young people often find it difficult to initiate conversations about sexual health and relationships with their carers as a result of feeling embarrassed. In some cases embarrassment meant that looked after young people reported that they would prefer to receive sexual health advice from social workers rather than from their carers as this would be less embarrassing than having to speak to somebody that they had to live with (Fleming et al, 2005). In addition, the authors noted that young people often worried about talking to their carers about their sexual health in case they reacted with anger or disgust to revelations that young person was sexually active. In addition, the authors noted that young people who were worried that their carers would react angrily to revelations that they were sexually active often chose not to seek their advice because they didn't want to have their fears realised when carers reacted as they expected (Constantine et al., 2009; Chase et al., 2006).

Overall, the main facilitator of discussions relating to looked after young people's sexual health was trust (Chase et al., 2006, Dale et al., 2011, Dale, 2009, Knight et al., 2006, Padbury and Frost, 2002, Stace and Lowe, 2007, Tyrer et al., 2005). For example, Stace and Lowe (2007) reported that young people who felt that they couldn't trust their corporate parents, who were made to feel unwelcome within the household and who were afraid of being punished for their behaviours had difficulties approaching their carers for information and advice about sexual health and relationships. In contrast, young people who trusted that their carers would be accepting of their behaviours and would

provide advice in a non-judgement and supportive manner were more likely to report that they had openly and honestly discussed sex and relationships with their carers. Similar findings were reported by Chase et al (2006) in relation to pregnant care leavers' experiences of seeking advice and support about pregnancy and parenting from their social workers. In particular the authors noted that the young women who were most likely to seek advice and support from their social workers were those who trusted them and viewed them as "friends" rather than "professionals"; although it is worth noting that the authors concluded that this could act as a barrier to long-term engagement with services if social workers used information that young women provided within the context of talking to a friend within pre-birth case reports. That trust was a significant facilitator of sexual health and relationships communication with the care system can also be seen in the fact that foster parents identified that they found it difficult to have more than cursory discussions about pregnancy and STI prevention if they did not have a relationship with the young person in their care. This was because they believed that sexual health is a highly personal and sensitive issue that should be discussed within the context of an established relationship; something that the authors noted could act as a barrier to young people who experience placement instability receiving sexual health and relationships advice (Constantine et al., 2009).

## **2.5 Study rationale and research questions**

Having reviewed the literature on parenting and sexual health, I now move on to briefly summaries the research evidence presented in chapters one and two in order to identify how this thesis will contribute to providing a greater understanding of the role that corporate parents can play in the provision of sexual health and relationships education to the young people they look after.

### **2.5.1 Summary of research**

In chapter one of this thesis it was demonstrated that young people entering local authority care have an increased risk of experiencing poor sexual health outcomes as a result of their exhibiting a cluster of risk factors, including: living in low-income, socially excluded households; having a history of child

maltreatment; being exposed to domestic violence and/or intra-parental conflict; living with parents who have psychiatric problems or misuse drugs and alcohol; and having been exposed to dysfunctional parenting. It was also demonstrated that young people who experience maltreatment and rejection during childhood may experience attachment difficulties, which can have adverse effects upon young people's ability to form and maintain peer, romantic and sexual relationships during adolescence and adulthood; resulting in some young people being at risk of becoming isolated from their peer group. Insecure attachment and isolation from the peer group were identified as having adverse effects upon young people's mental well-being, with the overall conclusion from the literature being that the interaction of these may lead to young people experiencing depression, anxiety and externalising behaviours, and in turn becoming disengaged and excluded from education and at risk of adopting health risk behaviours associated with early and risky sexual behaviour.

Throughout chapter one it was identified that the antecedents of entry into the care system, as well as the effects of childhood adversity upon young people's psychosocial development, are all known predictors of poor sexual health outcomes during adolescence; resulting in looked after young people being particularly at risk of engaging in early and risky sex, and experiencing early pregnancy and parenthood. This elevated level of risk was confirmed through a review of the literature, which concluded that young people in local authority care were significantly more likely than their non-looked after peers to report that: their sexual debut occurred prior to age 16; their sexual debut had been under the influence of drugs and alcohol; they never used condoms or had used condoms inconsistently; they had knowingly had unprotected sex with somebody that had had a sexually transmitted infection; they had been diagnosed with a sexually transmitted infection; they had experienced at least one pregnancy prior to age 19; and, they had become a parent prior to age 19. It was also shown that these findings were still evident after adjusting for the co-varying effects of material, educational and familial disadvantage.

Chapter one concluded by demonstrating that improving the sexual health of looked after young people in the care system has been identified as a priority by

the Scottish Government, with one of the key suggestions for doing this being the recommendation that looked after young people be prioritised for the delivery of sexual health relationships education in order to improve their knowledge, and provide them with the information needed to make informed choices. From here it was shown that there is evidence to suggest that young people in local authority care are excluded from school-based sexual health and relationships education, with some studies conducted within the UK reporting that young people leaving the care system often cannot recall having received sexual health and relationships education. It was also shown that this finding has resulted in the Scottish Government and NHS Health Scotland advocating that social workers, residential care workers and foster care workers be encouraged to talk to young people in the care system about their sexual health and relationships; something that has led to many local authorities in Scotland instigating sexual health training courses for their workers.

Given the recommendation that corporate parents play an active role in talking to looked after young people about their sexual health, this chapter focussed upon reviewing what is currently known about the provision of sexual health and relationships education within the home setting. Through this, it was concluded that parental processes such as monitoring, supervision, parent-child connectedness and parent-child communication about sex can be protective against early sexual initiation, encourage contraceptive use and reduce the risk of young people experiencing early parenthood. Moving on to look specifically at research focussed upon communication about sexual health and relationships it was shown that both adults caring for looked after young people, and looked after young people themselves, report that conversations about sex, sexuality and sexual behaviour do not regularly occur within the care setting, and that where such conversations do occur they tend to be limited to the provision of key sexual health messages such as abstaining from sexual activity and using condoms to avoid sexually transmitted infections and pregnancy. It was also shown that adults caring for looked after young people are often reticent to initiate discussions about sexual health as a result of: there being no clear guidance about how these discussions should be undertaken, what could and could not be discussed, and what could remain confidential. Furthermore, it was

demonstrated that corporate parents avoided conversations about sexual health with young people because they were concerned that the child's social worker or natural parent would disapprove of them talking to the young person about sexual health. As a result, it was shown that conversations about sexual health within the care system were predominantly reactive and occurred after corporate parents became aware of risk taking or problematic sexual behaviour occurring. As a result, it was concluded that communication about sexual health within the care system was focussed more upon ensuring that young people were protected from sexual exploitation and abuse rather than upon sexual health promotion.

### **2.5.2 How this study will add to the existing literature**

The literature review undertaken in this chapter has demonstrated that whilst there is some evidence that corporate parents are willing to talk to young people about sexual health and relationships, there is a dearth of information about how such discussions should be undertaken and how communication about sexual health and relationships occurs within the care setting. For instance, whilst Stace and Lowe (2007) concluded that some residential and foster carers are pro-active when it comes to discussing sexual health and relationships with young people in their care the authors made no reference to how these discussions were undertaken in practice. Instead, the authors focussed upon articulating the barriers that corporate parents identified to discussions about sexual health and relationships occurring. Similarly, Constantine (2009) – despite highlighting that two thirds of the corporate parents interviewed either had discussed or were willing to discuss sexual health and relationship with the young people they cared for – failed to provide any insight into how such communications had or could be undertaken; again emphasising the reasons why discussions about sexual health and relationships were problematic or should be avoided. The absence of information about how communication about sexual health and relationships is undertaken within the care setting is notable given the Scottish Government's recommendation that adults caring for looked after young people should be routinely talking to young people about their sexual health and relationships. Qualitatively exploring how this recommendation works in practice is a necessary step to understanding whether communicating about

sexual health and relationships within the care system is feasible, and how such communications are undertaken and shaped by the lived experiences of looked after young people and their carers. Thus, the first research question that will be addressed by this thesis is: “what shapes communication about sexual health and relationships within the care setting?”

Moving beyond understanding how communications about sexual health and relationships are undertaken, and shaped by the lived experiences of looked after young people and their carers, this thesis will explore whether factors known to shape communications about sexual health and relationships between birth parents and their children are present within the communications that occur within the care setting. To recap, within this chapter it has been demonstrated that the evidence shows that parent-child communication about sexual health and relationships is shaped by the quality of the relationship that exists between the parent and the child, with warm, trusting, loving and connected relationships being those that are most likely to facilitate open and honest discussions about sexual health and relationships. Furthermore, it has been shown that the information and values that parents convey about sexual health and relationships offer a protective effect to young people when the information is conveyed: within the context of a connected relationship; is non-judgemental; is not overly permissive or overly dismissive of adolescent sexual activity; and where the parenting style utilised balances the developing autonomy of the young person with the need to provide monitoring and supervision of young people’s behaviours.

Whilst there have been several studies conducted with residential and foster carers that suggest that parental monitoring and supervision play an important role in ensuring that one, young people are protected from exploitation and two, that individuals residing in the same household as young people demonstrating problematic sexual behaviours are protected (Lipscombe et al., 2003; Farmer and Pollock, 1998; Jones et al., 2008) there is no data available on how restriction and monitoring of young people’s behaviours may serve to shape the willingness of young people to communicate with their corporate parents about their sexual health. Furthermore, whilst there is some evidence from interviews

conducted with young people in or leaving care that suggests that trust is a primary facilitator of discussions about sexual health, pregnancy and parenthood (e.g. Stace and Lowe, 2007; Chase et al., 2006; Knight et al., 2006; Aggelton, 2005; Tyrer et al., 2005; Dale, 2009; Dale et al., 2010), few studies have specifically looked at how the perceived connectedness between corporate parents and looked after children shapes the type of discussions that are undertaken. Together, these points illustrate the necessity of research focussed upon understanding the role that parental processes may play in mediating communications about sexual health and relationship within the care system as it is likely that these factors which underpin communications about sexual health and relationships within the home setting may act as significant barriers or facilitators of such discussions occurring. Thus, the second research question that will be addressed by this thesis is: “how is communication about sexual health and relationships within the care system mediated by connectedness, monitoring and supervision?”

## **2.6 Overview of thesis**

The rest of the thesis is laid out as follows. Chapter three describes the research methods that were used to address the research questions identified within this chapter. Chapters four and five present the qualitative research findings. In particular, chapter four examines what factors shape communications about sexual health and relationships within the care setting, whilst chapter five examines whether communications about sexual health and relationships are mediated by connectedness, monitoring and supervision. Chapter six is a reflexive chapter, and provides my observations on how the research was conducted, the ethical challenges faced when interviewing vulnerable young people, and a discussion on how my own life experiences may have impacted upon the data collected and analysed. The thesis concludes in chapter seven with an overview and discussion of the research findings, and recommendations for practice and policy.

## **Chapter 3: Methods**

### **3.1 Introduction and aims**

The aim of this chapter is to describe the research methods used within this study. In doing so I discuss the decision to use qualitative methods to answer the questions outlined at the end of chapter two, before moving on to discuss the identification of the research site, sampling, recruitment and the interview process. The use of thematic analysis to code, interpret and to generate explanations from the data is described; and, in doing so I discuss how the research findings will be grounded within a wider theoretical context.

### **3.2 Research questions**

The overarching aim of this study is to explore how communication about sexual health and relationships was undertaken within the care setting. To address this aim, two research questions were explored. These are:

- What shapes communication about sexual health and relationships within the care setting?
- How is communication about sexual health and relationships within the care system mediated by connectedness, monitoring and supervision?

To address these questions, 54 in-depth qualitative interviews were conducted with looked after young people, care leavers, residential workers, foster carers and social workers in one local authority in Scotland during 2011.

### **3.3 Methodological considerations**

This section will discuss reasons for using qualitative rather than quantitative methods, before going into greater detail about the use of interviews as a research tool.

### 3.3.1 Why use qualitative methods?

Epistemology refers to “the nature of knowledge and how it can be acquired” (Snape and Spencer, 2003, p23). Within the social sciences there are two main epistemological positions from which research methods stem, namely positivism and interpretivism. The positivist researcher believes that phenomena exist independently of human consciousness, and as such can be objectively measured or observed. This has resulted in positivism utilising methods and procedures typically observed within the natural sciences, such as quantifiable laboratory experiments (Bryman, 2012, Snape and Spencer, 2003). Through such methods, “knowledge is developed inductively through the accumulation of verified facts” and “hypotheses are derived deductively from scientific theories to be tested empirically” (Snape and Spencer, 2003, p6). Within the positivistic approach to research, constructs such as “feelings” and “subjective experiences” are not classified as knowledge if they cannot be quantifiably measured (Bryman, 2012). In contrast, interpretivism is grounded in the premise that “knowledge of the world is based on ‘understanding’ which arises from thinking about what happens to us, not just simply from having had particular experiences” (Snape and Spencer, 2003). In essence, this means that knowledge of the world is constructed based upon how individuals interact, perceive and interpret their experiences. Unlike positivism which seeks to quantify, interpretivism use research tools that allow for the individuals’ interpretation and understanding of the world to be captured (ibid). Qualitative research is part of the interpretivist research tradition because it allows researchers to explore the social world, and provide meaning and explanation for complex phenomena (Marshall, 1996, Snape and Spencer, 2003)

As has been shown in the literature review, there is still much to be known about the sexual health experiences of looked after young people. Research in this area is predominantly quantitative, and aims to capture the prevalence of sexual risk behaviours and outcomes. Such research often fails to provide the full picture of what adolescents within the care system experience. As qualitative research is used to interpret and understand people’s experiences the use of these methods may provide a deeper, richer insight into looked after young people’s sexual health experiences than quantitative methods could. This is

because qualitative research is concerned with asking broad questions that allow participants to provide much more detailed answers than the narrowly focused questions in a quantitative survey would allow (Fossey et al., 2002). Furthermore, qualitative methods are well suited for use as a preliminary investigative tool, through which, insight can be gained into little explored and little understood topics. As qualitative methodology provides scope for the generation of rich contextual and explanatory data I felt that it was well suited to the aims of the study, which were to understand what facilitates sexual health discussions within the care setting and to explore how sexual health discussions occur in practice.

### **3.3.2 Qualitative research methods**

Traditionally, qualitative research methods fall into two categories: those which are concerned with recording data and those which are concerned with the generating data (Silverman, 2011). The first refers to the observation of naturally enacted social behaviours within the context of an individual's natural setting and draws heavily upon the principles of anthropology and ethnography, whilst the latter refers to data which are directly recounted and recollected by individuals within the context of interviews and focus groups. After careful consideration it was decided that the use of naturally occurring data would be inappropriate for this study due to the sensitive nature of the research and the vulnerable nature of the participants. In particular it was felt that undertaking ethnographic observations of young people's relationships would not only have been intrusive but, in the case of gaining insight into young people's romantic and sexual behaviours, could have raised serious ethical and legal dilemmas in relation to child protection laws. In addition, whilst it might have been possible to observe health promotion interactions between young people and their corporate parents it was felt that this would be unnecessarily intrusive and might result in corporate parents or young people modifying their behaviours whilst being observed. The use of focus groups was also precluded on the basis that young people might reveal sensitive and distressing information within the group setting; potentially resulting in other young people with similar experiences becoming distressed or the young person who had made the disclosures being bullied or victimised by other participants (Lewis, 2003).

Instead, I opted to conduct face-to-face interviews as I wanted to focus upon individual experiences, and I believed that interviews would be well-suited to gaining the in-depth and detailed responses required to address the research questions. This is because qualitative interviews can be described as “guided conversations” in which the researcher poses an initial question related to the topic and then listens to the meanings that the respondent ascribes to their experiences (Kitzinger, 1994). Because of this, it can be argued that interviews are a highly appropriate method of exploring sensitive, complex and emotive subject matter because the method is participant-centred and the research can support participants to share their own unique thoughts, feelings and experiences (Lewis, 2003). There are three main types of interviews. These are structured, semi-structured and unstructured interviews. Structured interviews are more commonly used within quantitative research, and are most commonly observed within survey based research. They are used to ensure that all respondents within a study are asked the same questions in a standardised manner, e.g. that all of the questions are worded in the same way, they are offered the same responses in the same order and that the questions appear in the same order. In contrast, semi-structured and unstructured interviews offer a more flexible form of interviewing than fully structured interviews. This is because they allow new questions to be introduced to the dialogue by the researcher after reflecting on the responses given by the respondent. They also allow for probing to be undertaken for clarification and additional meaning (Rubin and Rubin, 2005 p7, p26).

The main difference between semi-structured and unstructured interviews is the level of direction that is provided to the interview by the researcher. Semi-structured interviews are in-depth interviews, which are predominantly researcher-led and are used to explore theories and hypotheses that the researcher has already identified. In practice, the researcher conducting a semi-structured interview will have a topic guide that will contain a series of questions or topics that need to be explored during the course of the interview. These questions do not necessarily need to be asked in the same order; however, it is common for all of the questions within the guide to be asked, and worded, in a similar format across all interviews. The researcher can probe respondents’

answers in order to seek clarification or to explore topics of interest in more detail. Questions and topics that are not included in the topic guide can also be explored when raised by participants as these can help elucidate what the participant “views as important in explaining and understanding events, patterns and forms of behaviour” (Bryman, 2001, p314).

In contrast, unstructured interviews are often utilised within grounded research to explore topics or themes that are of interest to the participant, with the participant largely dictating the content and progress of the interview. When conducting unstructured interviews the aim of the researcher is to understand the complexities of individual behaviour without imposing any a priori categorisations upon those meanings (Punch, 1998). Thus, researchers conducting unstructured interviews are encouraged not to develop hypotheses or research questions prior to undertaking the research. In practice, unstructured interviews commonly begin with the interviewer asking a single generalised question such as ‘tell me about a time when’ or ‘tell me about your experience of’. The interview is then built out of the responses of the participant, with each interview undertaken differing in structure and content depending upon what the participant views as being meaningful or relevant to their understanding or experience of the issue being explored (Arthur and Nazroo, 2003, Rubin and Rubin, 2005).

For this study I chose to use semi-structured interviews. These were chosen as, although I wanted participants to be able to talk freely about their experiences and to generate ‘rich’ data about their experiences, I also wanted to be able to explore specific topics that had been identified within the literature review as potentially relevant to learning and communicating about sex to be explored. I also felt that using a semi-structured approach acted as a compromise between one, providing participants with the freedom to act as experts in their own lives and construct a vivid picture of their thoughts, feelings and beliefs and two, my having to direct the interviews to ensure that sufficient data to answer the research questions was being generated. Additionally, I felt that the flexible nature of semi-structured interviews provided a sensitive solution to collecting data from a population in which higher levels of literacy and attentional

difficulties had been reported (Meltzer et al., 2003a, Meltzer et al., 2004a, Meltzer et al., 2004b) as using interviews not only removed poor literacy as a barrier to participation, but the flexible nature of in-depth interviews would allow me to tailor the interviews to the age, emotional capacity and the capability of respondents.

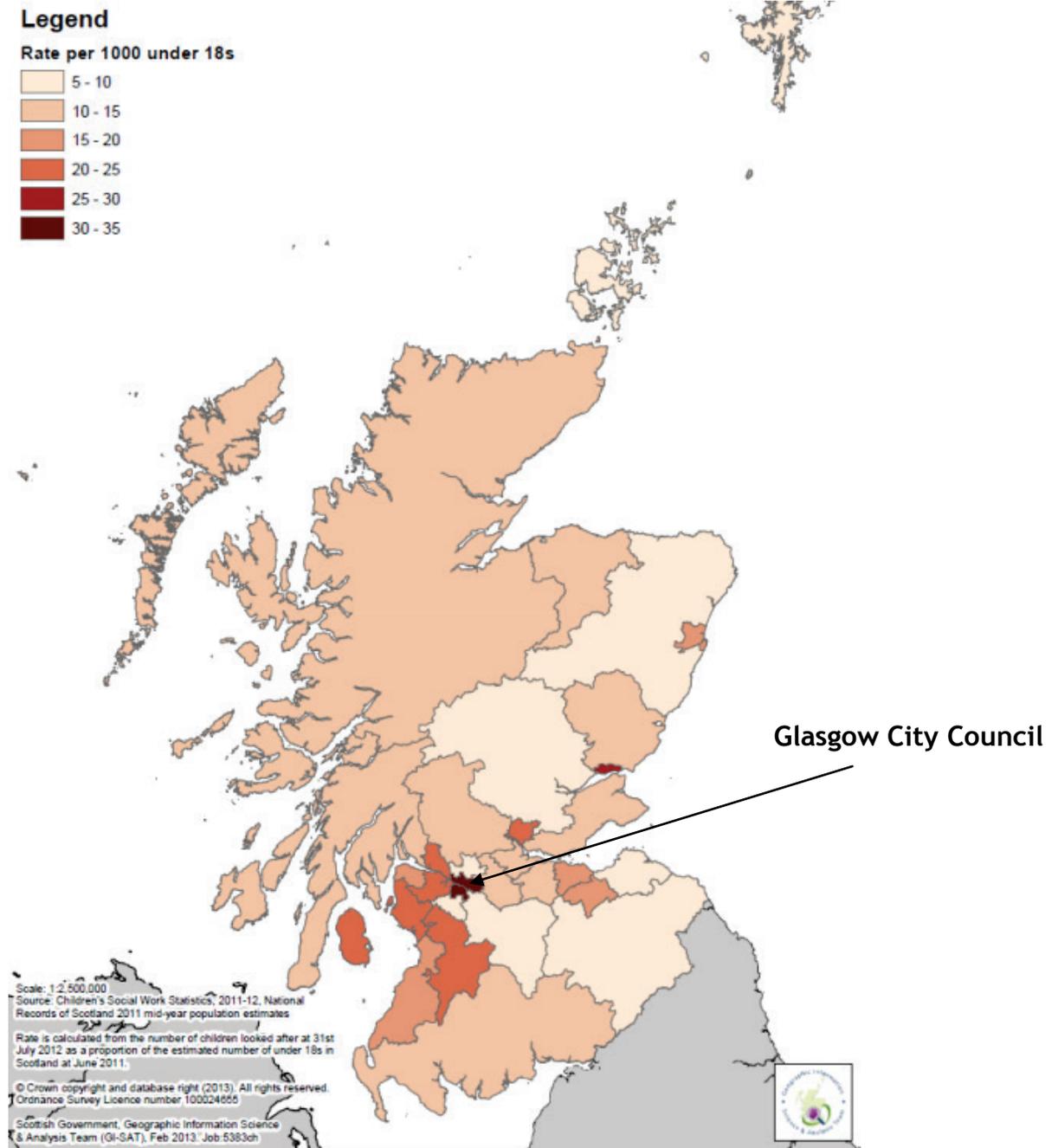
### **3.4 Study design**

I now move on to discuss the design of the study, including the identification of the study site, sampling and the inclusion criteria.

#### **3.4.1 Identifying the study site and negotiating access**

Glasgow City Council was approached about participating in the study on the basis that the rate of looked after children in Glasgow is approximately twice that seen for the majority of local authorities in Scotland, with an average of 3.2% of children and young people in Glasgow being looked compared to 1.5% of children and young people in Scotland (The Scottish Government, 2012). The council is also the largest provider of local authority care in Scotland; caring for between 20-25% of all children looked after in Scotland at the time that data was collected (see Figure 2 overleaf for details). That Glasgow City Council had a potentially large pool of young people that could be sampled from was reassuring as a similar study exploring the sexual health needs of young people in the care system reported difficulties in recruiting looked after young people. Whilst this was mainly due to restrictions placed upon the study by the ethics committee that had approved it, namely having to leave 24 hours between explaining the study and consenting young people to participate in the study, that authors also highlighted that the sensitive nature of the topic and recruiting young people through gatekeepers made recruiting an already hard to reach population more difficult. As similar frustrations have been expressed by other researchers conducting research with looked after young people and vulnerable young people (e.g. Dale and Watson, 2010) I was keen to ensure that there was a large number of young people who could potentially be approached to participate in the study.

Figure 2: Rates of looked after children per 1,000 children under 18 by local authority (2011-12), reproduced from Scottish Government (2012), Children's Social Work Statistics 2011-12. Edinburgh: The Scottish Government. Permission to reproduce this work was granted by PSI National Archives in accordance with the terms of Version 2.0 of the Open Government Licence (see: <https://www.nationalarchives.gov.uk/doc/open-government-licence/version/2/> for details).



After Glasgow City Council had been identified as the research site the process of negotiating access to young people and practitioners within the local

authority began. This process was informed by the advice of colleagues who had experience of recruiting young people within the care system to research studies. This advice, which reflected the difficulties that they had encountered, included identifying at an early stage the individual within social work services whose approval was required for the study, clearly defining research objectives and timelines and identifying a local champion who would be able to help with the recruitment of young people and practitioners throughout the course of the study (e.g. Roesch-Marsh et al., 2011). In order to identify who I should contact within Glasgow City Council to gain support for the study, I spoke to two members of my advisory committee who had previously conducted research with looked after young people in Glasgow. They advised me that the appropriate person to contact would be one of the senior managers for Children and Family Services. On the 23<sup>rd</sup> of February 2010 I sent an email introducing myself, the study and to request a meeting to discuss the study in more depth. I received a reply later that day inviting me to attend a meeting on the 8<sup>th</sup> of March 2010. This meeting, which was attended by me, the senior manager in Children and Family Services and a sexual health lead for Greater Glasgow and Clyde Healthboard, helped ascertain that the research aims of my study were of interest to the department as they had recently started to offer sexual health and relationships training to social workers, residential care workers and foster parents. Thus, the senior manager in Children and Family Services felt that supporting the study would provide the local authority with an opportunity to explore the views of young people and practitioners about talking to each other about sexual health and relationships.

At the conclusion of the meeting it was agreed that a number of shared objectives and deadlines should be agreed, and that the running of the study within social services would be overseen by the sexual health lead. It was also identified that this individual would: promote the study to frontline practitioners at internal social work meetings, schedule meetings between myself and the service managers who needed to be informed about the study and oversee the recruitment of participants. Having a named person within social services proved extremely useful as not only did this help me negotiate an organisational structure I was not familiar with, but it also provided me with the opportunity to

learn more about the sexual health and relationships work that was already being undertaken with looked after young people from the individual who had commissioned it. For example, in subsequent meetings with the sexual health lead it was revealed that the training programme being delivered to social workers, residential care workers and foster parents was the Talk2Parenting package (see <http://www.gypshsg.co.uk/CHttpHandler.ashx?id=15391&p=0> for details). This programme, which Fullerton and Burtney (2009) found improved parents' and guardians' confidence in talking to young people about sexual health and relationships, aims to promote positive communication between adults and young people around all aspects of sexual health and relationships, and was being rolled out to all social workers, residential care workers and foster carers as part of Glasgow City Council's compliance with the recommendations published within CEL-16.

The meetings that I held with the sexual health lead were also useful as they allowed us to clarify what the aims of the study were and how social services would benefit from participating in the study. At one of our earliest meetings the sexual health lead highlighted that no outcome evaluation had been conducted of the Talk2Parenting programme, and that as such they were keen that my study captured information about the effect that being trained in Talk2Parenting had upon the behaviours of the young people that carers were looking after. Conducting an outcome evaluation was something that I felt fell outwith the remit of the funding awarded by the Chief Scientist Office, and was also something that my supervisors advised against based upon the fact that Dale (2009) had encountered significant difficulties recruiting looked after young people to a study on sexual health. These arguments were accepted by the sexual health lead; however, as a compromise, and in order to reciprocate the good will that both the senior manager in children and family services, and the sexual health lead were showing towards me and the study, I agreed that I would include questions in the qualitative interviews to be conducted with carers about their experience of receiving Talk2Parenting training and delivering sexual health and relationships education to young people in their care. I also agreed that upon the conclusion of the study I would share that information with the local authority by providing them with a copy of the final report submitted to

the Chief Scientist Office, and work with the sexual health lead to disseminate the research findings to residential carers, foster carers and social workers.

Table 3 shows that in the months prior to data collection being undertaken, 3761 children and young people were looked after by Glasgow City Council (Scottish Government, 2012). This gave a large potential pool of respondents, with 1602 looked after young people potentially eligible to participate in the study; although it should be noted that this pool was subsequently reduced to only those young people aged 13 and over who were looked after in residential and foster care after permission was not granted by social work services to include young people looked after at home and in kinship placements in the study (see section 3.4.3.2). Table also shows that the majority (93%) of looked after young people are looked after within the community by their parents, friends or relatives or foster carers.

**Table 3: Proportion of children looked after by Glasgow City Council on the 31st July 2011 by age and type of placement**

N=3761		
	%	n
<b>Age</b>		
<5	17.5	658
5-11	39.9	1501
11-15	30.2	1137
16-21	12.4	465
<b>Type of placement</b>		
At home with parents	31.0	1166
With friends/relatives	32.5	1222
With foster carers	29.3	1103
With prospective adopters	0.5	17
Living in children's units	2.9	110
Residential school	1.4	53
Secure accommodation	0.6	23
Other residential care	1.8	67

### 3.4.2 Deciding which areas would be used for recruitment

Social work services in Glasgow are divided into three Community Health and Social Care Partnerships (CHSCP). Due to the large geographical area of the city I felt that it might be best to restrict recruitment to one area of the city. Discussions with the sexual health lead revealed that this would be preferable as it would help to minimise any potential disruption to the service caused by the study. The CHSCP that was chosen to take part in the study was the North-East CHSCP, with the decision reflecting the fact that no other research studies were currently being undertaken in that area and the belief that the area social workers had the operational capacity to support the study.

**Figure 3: Distribution of child (age 0-17) social work cases in Glasgow City, reproduced from Mokrovich (2011), social work area demographics: population estimates, vulnerability, disability and support, and analysis of SWS clients. Permission to reproduce this image was granted by Glasgow City Council in accordance with the terms of a Public Sector (Scotland) End User Licence created on the 30<sup>th</sup> March 2015 between Glasgow City Council and the author of this work.**

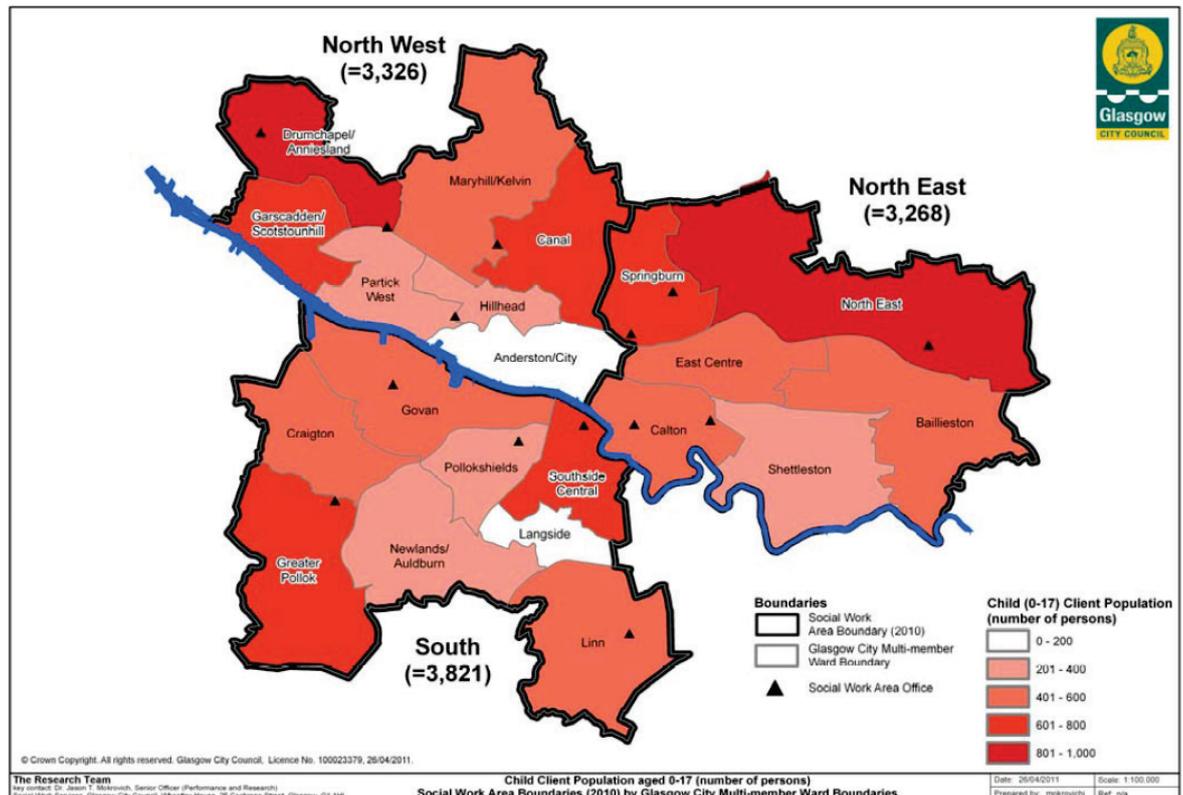
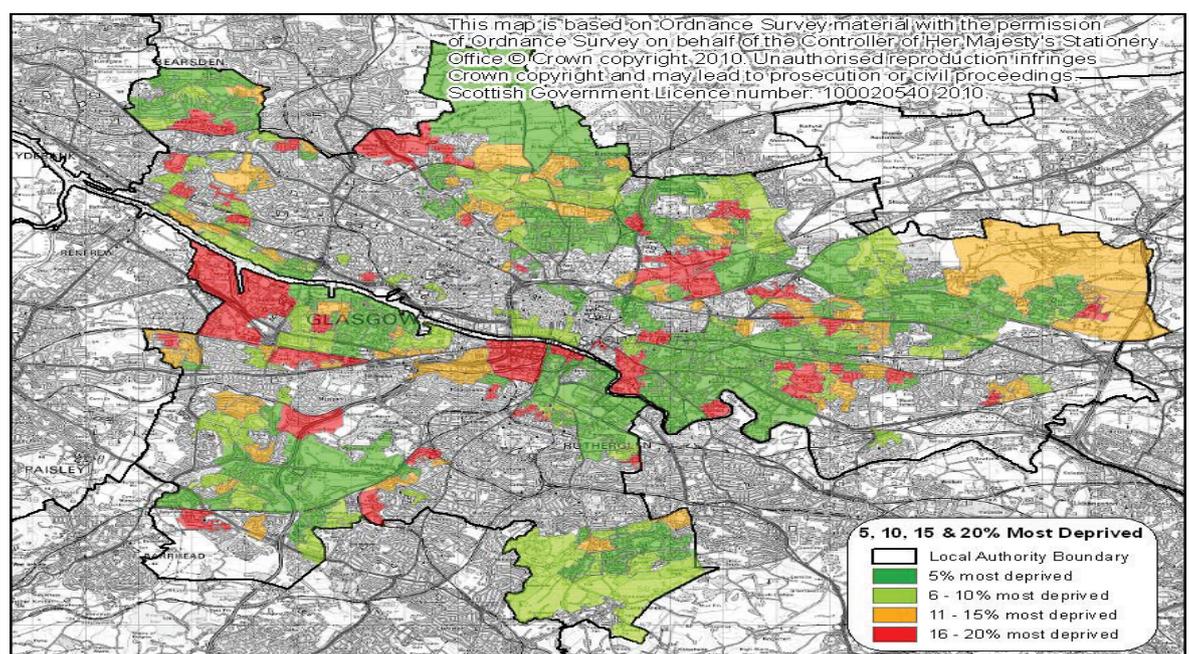


Figure 3 (page 123) shows the distribution of child social work cases in Glasgow. From this it can be seen that there appears to be a higher density of children known to social work within the North East CHSCP. Routinely collected statistics confirm this, with 40% of child social work cases managed by the North East CHSCP compared to 30% in the North West and South CHSCPs (Mokrovich, 2011). That the North East CHSCP has the highest concentration of child social work cases reflects the fact that it includes some of the most deprived areas of Glasgow within its boundaries. In particular, Figure 4 shows that the majority of people living within the North East CHSCP live within the 10% most deprived regions in Scotland (PHRU, 2007). As a result of this, the health of individuals living in the North East CHSCP is poor, with the area having the lowest life expectancy and the highest rates of all-cause mortality in Scotland. The area also has significantly higher rates of coronary heart disease, cerebrovascular disease, cancer, mental health problems, suicide, substance use and teenage pregnancy than the Scottish average (The Scottish Government, 2009).

**Figure 4: Distribution of the most 20% deprived SIMD data zones in Glasgow City, reproduced from The Scottish Government's, Scottish Index of Multiple Deprivation 2009 General Report. Permission to reproduce image was granted by PSI National Archives in accordance with Version 2.0 of the Open Government Licence (see: <https://www.nationalarchives.gov.uk/doc/open-government-licence/version/2/> for details).**



### **3.4.3 Identifying who should participate in the research**

After identifying that the North East CHCSP would be used for recruiting participants, the next step was devising the sampling frameworks for the study. This included deciding which groups of looked after young people and carers should be invited to participate within the study. In this section I will outline why I chose to interview both looked after young people and their carers, before outlining events that contributed to the refinement of the sampling frameworks.

#### ***3.4.3.1 Recording the views of looked after young people and their carers***

The decision to include the voices of both looked after young people and their carers within the research reflected two things. These were one, that the views of looked after young people are often excluded from research that is used to inform the delivery of healthcare services and two, the belief that in order to gain an understanding of how sexual health and relationships are communicated about within care placements it is important to capture the voices of both adult and child. Looking first at the fact that the views of young people are often excluded from research that is used to inform the delivery of healthcare services, it has been argued that children and young people are often believed to be incompetent social actors who lack the verbal and cognitive maturity to convey their experiences (Brannen and O'Brien, 1995, Docherty and Sandelowski, 1999, Morrow and Richards, 1996, Morrow, 2008, Oakley, 1994, Qvortrup, 1994). Additionally, there is an assumption that children and young people's accounts of their beliefs, experiences and desires are unreliable and incomplete (ScotPHO, 2010). Certainly, one of the major criticisms of research that explores the health needs of looked after young people has been that the voices of young people are excluded (Davies and Wright, 2007, Winter, 2006).

For example, Davies and Wright (2007) notes that "children are not always asked for their views by those making decisions about their lives" and that this acts as a barrier to accurately recording the healthcare needs of young people within the care system. This is also noted by Winter (2007) who emphasises that "in contrast with research on outcomes or provision or protection there is much less research on the detailed accounts of these children on their priorities,

preferences and experiences in their healthcare” and that where views are recorded they focus more on recording need than recording young people’s experiences, perceptions and feelings about service engagement. Whilst recording need would appear intuitive from the perspective of organising service provision, the evidence in chapters 1-2 demonstrates that there is a need to provide looked after young people with additional help and support in relation to sexual health and relationships. Thus, rather than focussing on identifying the needs of young people, this study would use the voices of young people to understand what young people believe shapes their communication with their carers about sexual health. By including the voices of young people in this way it can be ensured that the results of this study, if used to inform health and social care policy, do so in a manner that encapsulates the views of young people.

Although I have so far argued that it is necessary to include the voices of children in this study it is important to note that whilst young people may be fully capable of articulating their priorities, preferences and experiences of healthcare they may also have limited frames of reference to know what professionals can provide to meet those needs. For example, when it comes to communicating about sexual health and relationships within the care system it might be that young people have expectations that information they convey to carers about their romantic and sexual behaviours will remain confidential, whilst carers feel that they are bound by child protection rules and organisational policies to share that information. Without interviewing both parties, and exploring the wider contextual factors that might influence confidentiality, there is a danger that the data collected only serves the purpose of providing a voice and does not contribute to understandings of how systems in practice may be modified to reflect the needs of young people and their carers. This argument is neatly expressed by Dickson et al (2006) when they state that is important to consider the views of both looked after young people and the adults that care for them in order to “fully understand the views of both groups... and to consider how their views may differ from one another”.

One final reason for including the voices of corporate parents within the research is that including these voices may serve to explore issues that young

people find it difficult to articulate because of the emotional burdens associated with certain topics. For instance, it is possible that young people might find it difficult to discuss topics such as sexual abuse or problematic sexual abuse because these topics may evoke painful feelings or feelings of shame, and as such may choose to lie or omit details from their interviews in order to create a more favourable impression (Ennew and Morrow, 1994, Gersch et al., 1996, Richman, 2000). Given that this thesis is focussed upon understanding what shapes communication about sexual health and relationships within the care setting, and young people who have been sexually abused have significantly elevated odds of engaging in early and risky sexual behaviour, being able to understand how previous abuse histories may affect communication about sexual health and relationships is important.

#### ***3.4.3.2 Which looked after young people should be included?***

In deciding which looked after young people should be included in the study I had to make decisions about the minimum and maximum ages for participation, whether or not I wanted to sample all young people in the care system or restrict sampling to specific placement types, and whether it was appropriate to recruit young people who had a history of being sexually abused. These issues will now be discussed.

Looking first at the minimum and maximum ages of young people to be included in the study, the funding application to the Chief Scientist Office (CSO) stated that I would recruit young people aged 14-21 to the study. The upper age limit was chosen to allow me to include care leavers in the study, on the basis that after young people leave the care system at age 16 they remain eligible to receive additional support and services until they are 21 years of age (2010). In contrast, the lower age limit was chosen to reflect the concern of colleagues that local area child protection policies might preclude confidentiality being granted to those aged 13 and under who disclosed sexual activity. This concern was based upon their own experiences of having to disclose sexual activity by younger teenagers in a randomised controlled trial; the result being significant under-reporting of sexual behaviours by young people in the local authority

where reporting was mandatory (Henderson et al., 2002). Whilst the funding body expressed satisfaction that care leavers would be included in the study they requested that the lower age limit be reduced to age 12. This request was based upon the known association between early sexual activity and looked after status, and was something that I agreed to explore with the local authority.

During the access negotiations the sexual health lead agreed that including 12 and 13 year olds in the study would be appropriate; however, they also highlighted that the legislation relating to sexual offences was currently being reviewed, and that the new act when it was published would possibly include mandatory reporting of sexual acts by younger children. On the 1<sup>st</sup> of December 2010 the Sexual Offences (Scotland) Act was published, and as predicted by the sexual health lead, the legislation introduced an age-based delineation for sexual acts, which stated that children under the age of 13 lacked the capacity to consent to participation in sexual acts, even if those acts occurred between children of similar ages and without the presence of coercion or force. To aid practitioners in interpreting the Sexual Offences (Scotland) Act, guidance issued by the Scottish Government (2010) stated that “if under age sexual activity involves children under the age of 13 then concerns **must** be passed on in accordance with local child protection policy”. This guidance also applied to historical acts of sexual activity prior to age 13, and as a result, I felt that it would be ethically challenging to include young people in the study whose confidentiality I would have to break if they described having participated in consensual sexual behaviours prior to age 13.

After deciding the age ranges of the young people that would be approached to participate in the study, the next decision was whether or not I wanted to sample all young people in the care system or restrict sampling to specific placement types. Initially I decided that I would sample all young people in the care system. There were two reasons for this. First, as it has already been demonstrated in chapter two, there is evidence that placement type is associated with educational and mental health outcomes for looked after young people. As a result, I felt that including looked after young people in different care settings would add to the existing research evidence by allowing comparisons of sexual health learning by care placement to be undertaken.

Second, it has been highlighted that there is a dearth of research evidence related to the outcomes of care leavers and children who are looked after at home by their parents (Murray et al., 2002 ) and as such I felt that including this group of young people within the study would help to address a gap within the literature. To this end I drafted a purposive sampling framework that included young people who were looked after in residential care, foster care and at home by either their parents, another family member or a family friend. I also included care leavers in the sampling framework, and delineated between those who were receipt of supported care (e.g. living with a foster carer) and those who were living independently.

The sampling framework was submitted for approval by the senior manager for children and families at the end of March 2010. Unfortunately permission to use it was not granted, with the reason being that the senior manager was concerned about my conducting interviews about sexual health and relationships with young people looked after at home or in kinship care. These concerns related to the potential for young people to make disclosures of sexual abuse that I was not trained to deal with, and their concerns that either the young person or I could be placed at risk of harm should disclosures occur. That permission was not granted to recruit young people who were looked after at home was disappointing, given the limited research evidence that exists about their outcomes and experiences within the care system. As a result I started exploring alternative methods of contacting these young people through schools, and charitable organisations working with looked after young people; however, in all cases I was informed that permission from the young person's social worker would be needed in order for the organisation to allow the young person to be contacted about the study. As a result I decided that it was not feasible to include young people looked after at home, and revised the sampling framework to focus solely upon young people living in residential and foster care. The sampling framework that I was granted permission to use can be seen in Table 4 (overleaf).

The final decision that was made was whether or not it would be appropriate to include young people who had been sexually abused within the study. Given the

sensitive nature of the research topic, and the potential for the research questions to cause distress I discussed this issue with the sexual health lead overseeing the study and my supervisors. After much discussion it was agreed that young people who had made recent disclosures of sexual abuse or were currently involved in an active investigation into child sex abuse would be excluded from the study. Details of how this was monitored can be found in section 3.5.

**Table 4: Purposive sampling framework for young people**

Gender	Looked after child		Care Leaver	
	Residential	Foster	Supported care	Independent
Male	4	4	4	4
Female	4	4	4	4

#### ***3.4.3.3 Which corporate parents should be included?***

The term corporate parenting is used to define the formal and local partnerships between local authority departments, services and associated agencies that are responsible for working together to ensure that the needs of looked after young people and care leavers are met (The Scottish Government, 2004). In essence this means that a wide range of individuals, including adults caring for looked after children, social workers, teachers, service providers, doctors and nurses are corporate parents. Whilst I would have been happy to have collected data from all of these groups, I was advised by my supervisors to restrict recruitment to two or three groups of professionals in order to ensure that the amount of data generated for the PhD was manageable. As a result I decided to restrict the recruitment of corporate parents to those who provided direct care or

supervision to young people, namely residential carers, social workers and foster carers. At the time of designing the sampling framework for corporate parents Glasgow City Council had provided sexual health training using the Talk2 Parenting package to all of their residential carers, half of their foster carers and none of their social workers. In order to ensure that a representative sample of views/experiences of talking to looked after young people about sexual health and relationships was gained I designed the sampling framework (Table 5) to reflect whether the corporate parents had received Talk2 training.

**Table 5: Purposive sampling framework for corporate parents**

Professional Role	Completed Talk2 Parenting Training	
	Yes	No
Social Workers	0	6
Foster carers	3	3
Residential carers	6	0

### 3.5 Ethical considerations

In order to conduct the study ethical approval was required from both the University of Glasgow's Faculty of Law, Business and Social Sciences (LBSS) ethics committee and Glasgow City Council's social work department, with the latter requesting that a copy of the LBSS ethics be provided as part of their application process. In October 2010 I submitted an ethics application to the LBSS ethics committee. Usually the review of applications takes 6 weeks; however due to significant restructuring within the University the application was only approved, subject to minor amendments, in March 2011. This resulted in ethical approval only being granted by Glasgow City Council's social work

department in June 2011. A copy of the ethical approval letters can be found in Appendix 2. In this section I discuss ethical issues that were considered prior to the research being undertaken, before returning to discuss those issues that arose as a result of data collection in chapter seven. In particular, this section will focus upon the issue of who would provide informed consent for young people under the age of 16, how learning and attentional difficulties might affect the ability of participants to provide informed consent and how disclosures of sensitive information would be handled within the interview setting.

### **3.5.1 Deciding who should provide consent for young people**

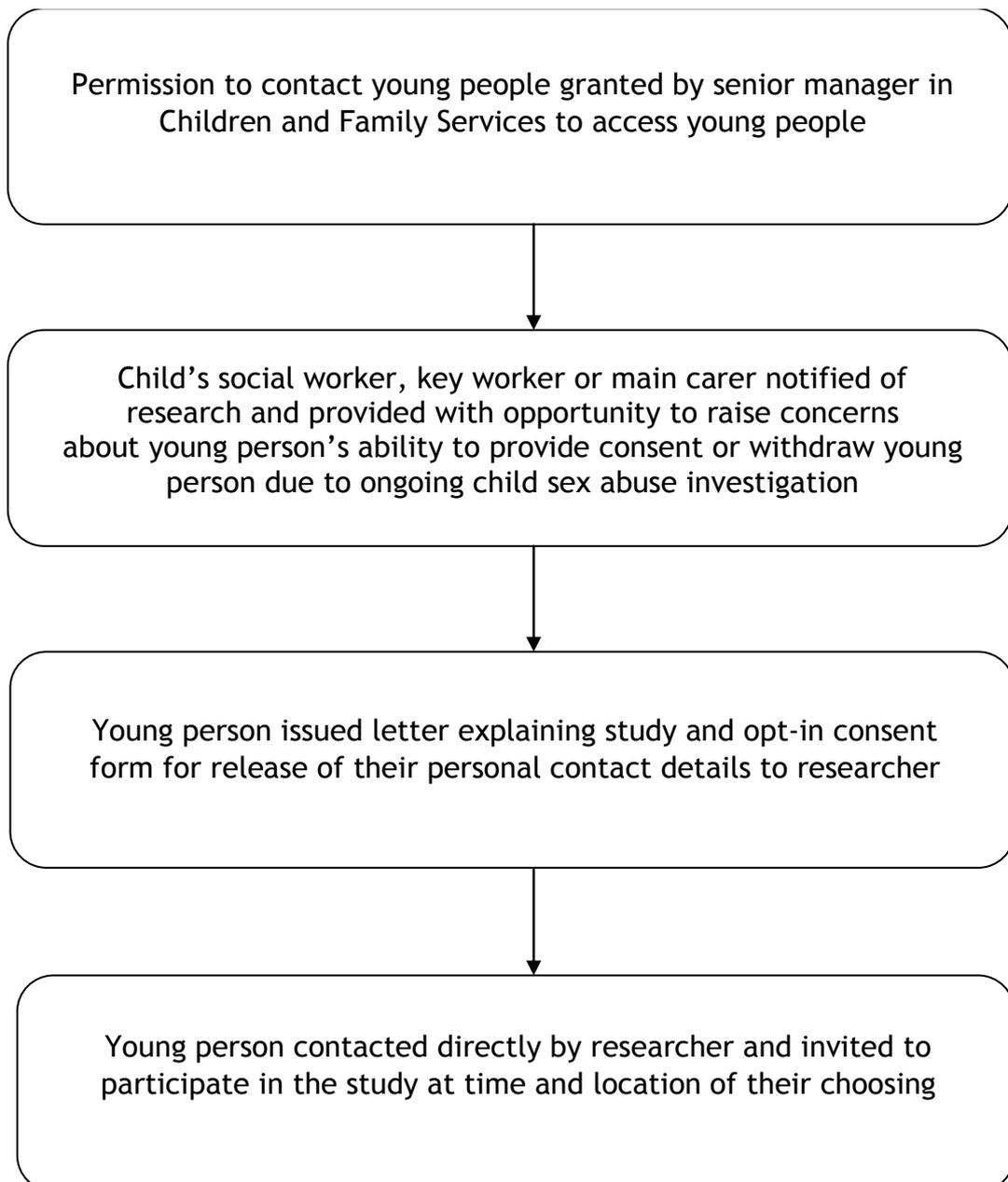
One of the main issues discussed during the process of drafting the ethics application for this study was the question of whether or not parental consent was required for the participation of young people under the age of 16. And, if so, who should provide that consent. This discussion was prompted by the fact that children and young people are often viewed by researchers as incompetent social actors who do not have the capacity to provide their views and participate within the research process (see section 3.4.3.1 for details). This view is often extended to the debate surrounding informed consent, with ethical guidelines tending to outline that whilst children and young people can provide assent to participate within research, the process of providing informed consent for their participation should be deferred to parents or legal guardians. For example, guidance issued by the Royal College of Physicians (2007) states that “those with parental responsibility should be involved in the decision [of young people] to participate” in medical research. However, the issue of who has the “parental responsibility” to provide informed consent for the participation of young people within the care system is not immediately clear as local authorities do not automatically attain parental rights and responsibilities for children and young people under compulsory measures of supervision (Connelly and Chakrabarti, 2007). This means that the parents of looked after young people legally retain the right to be informed about and participate in decisions about their child’s health. As such it could be seen as best practice within medical research to notify these individuals of their child’s potential participation within a research study.

After submitting my application for ethical approval it quickly became apparent the two ethics boards that needed to provide approval held differing views about parental consent. In particular, whilst the LBSS ethics committee felt that it was appropriate to seek opt-in consent from the biological parents of the young people to be included in the study, the social work ethics committee were concerned that attempting to gain opt-in consent would be time consuming, impractical and would potentially hinder data collection. They were also concerned about the sensitive nature of the research topic and expressed concern about instances where young people who had not disclosed familial sexual abuse and maintained contact with their biological parents might be placed at risk if parents became suspicious about what had been disclosed within the context of a research interview. In order to address the concerns of the LBSS ethics committee regarding opt-in consent I discussed with the feasibility of obtaining opt-in or opt-out consent for young people's participation in the study from social workers, foster carers and residential care managers with the social works ethics committee. This was something that they felt should be undertaken as a common courtesy; however, they unequivocally stated that at no point should those individuals be allowed to make the decision about whether or not young people participated in the study. This decision was to be left to the young person on the basis that, as long as permission to conduct the study was granted by a senior manager for Children and Families, both the Age of Legal Capacity (Scotland) Act 1991 and the Children (Scotland) Act 1995 provided young people with the right to provide consent as long as they were judged to be competent to understand what participation in the study would entail (HMSO, , 1991, 1995).

It was thus agreed that no formal parental or guardian consent would be sought for young people's participation in the study. However, in order to ensure that young people were fully competent to participate in the study, I decided that prior to any young person being recruited either their social worker, key worker or carer would be notified of the research by letter, email or telephone and provided with an opportunity to raise concerns about the study. In particular, these individuals were asked to flag one, whether there was any reason why the young person could not provide informed consent and two, if the young person had recently disclosed or was involved in an investigation into child sexual

abuse. Only after this had been done, could I then contact the young person and invite them to participate in the study. The process for obtaining informed consent that was agreed with social work services can be seen in Figure 5. I will return to reflect upon how this process affected recruitment in section 3.6.

**Figure 5: Consent process for looked after young people**



### **3.5.2 Learning and attentional deficits**

The issue of how competency would be assessed in young people raised the question of how learning and attentional deficits might affect participation in the study. Research evidence demonstrates that looked after young people are significantly more likely than young people in the general population to: have additional educational support needs, attend an alternative education setting rather than mainstream school and have socio-emotional or behavioural difficulties (Connelly and Chakrabarti, 2007, Ford et al., 2007, Henderson et al., 2011b, Meltzer et al., 2003a, Meltzer et al., 2004a, Meltzer et al., 2004b). As a result I expected that learning or attentional difficulties might negatively affect young people's ability to provide informed consent and participate in an in-depth interview. Ensuring that comprehension difficulties did not impact young people's ability to participate in the study was addressed in three ways. First, all of the study materials were designed to have a low readability score and adhered to guidance from the Plain English Campaign and the British Dyslexia Association. Second, I made the decision that all of the information sheets would be read aloud to participants during the consent process and that I would offer young people help when completing the forms. Third I decided that young people with substantial learning, communication and attentional difficulties would be excluded from participating in the study; however, when it came to communicating this decision to social workers involved in the recruitment I decided to frame the question in terms of whether young people might have difficulties understanding the study information and whether they were able to provide oral or written consent. This decision was made to allow me to assess individual cases and to ensure that young people who might have been able to participate if a flexible interview approach was used were not excluded from the study. I shall return to reflect upon how learning and attentional difficulties affected recruitment in section 3.6.

### **3.5.3 Conducting research on sensitive topics and handling sensitive disclosures**

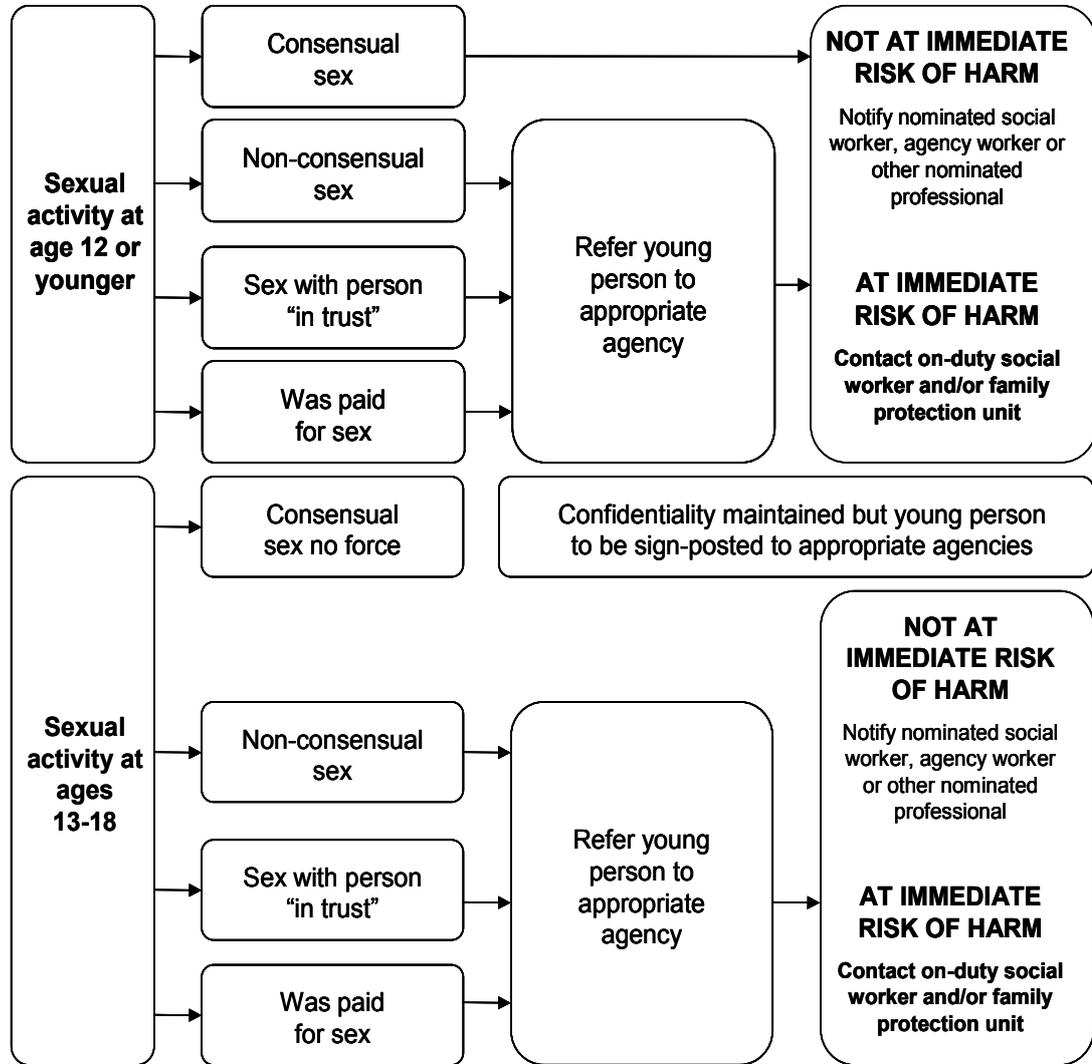
Drafting the application for ethical approval also made me consider the potentially sensitive nature of the research topic. Lee and Renzetti (1993, p5) state that "a sensitive topic is one that potentially poses for those involved a

substantial threat, the emergence of which renders problematic for the researcher and/or the researched the collection, holding and/or dissemination of research data". In essence this means that any research topic can be considered to be sensitive depending upon individual differences and experiences. Thus, it is important to recognise that whilst one participant may find a particular research topic to be non-distressing and innocuous, others may find sharing information on those issues to be emotionally taxing (Dickson-Swift et al., 2008). As the literature suggested that many of the participants would have had negative experiences in relation to pre-care and care experiences, procedures were put in place to manage how I would handle the disclosure of sensitive information by participants using the guidelines outlined by the National Children's Bureau's Guidelines for Research (Shaw et al., 2011). These guidelines state that researchers should be aware that they have a duty of care to ensure that disclosures or events that pose a "risk of significant harm" are communicated to professionals in order that necessary steps be taken to ensure that child(ren) are protected; even if this duty conflicts with a participant's right to confidentiality.

Given the vulnerable nature of the research population it was agreed with social work services that I would adhere to local child protection guidelines whilst conducting the research. Figure 6 (overleaf) shows the rules that were adopted for this study in relation to disclosures of sexual activity. These were developed based upon the Scottish Government's guidance to practitioners on interpreting the Sexual Offences (Scotland) Act, and focussed predominantly on revelations of abusive, non-consensual or transactional sex. Similar procedures were adopted for disclosures of suicidal ideation and situations that could place participants or another named individual at risk of harm. It was agreed that these procedures would be discussed with participants during the consent process. For young people this would consist of explaining that the things they told me would remain confidential unless they told me something that made me worry about them or somebody else. It was agreed with social work services that as part of this process I would ask the young people to provide me with examples of what they thought I meant in order to assess whether they understood that

confidentiality was conditional, and together we would construct the rules that had been identified for the study.

**Figure 6: Child protection protocols adopted for study**



Due to the fact that all current and historical disclosures of sexual activity under the age of 13 years had to be reported to social work services I informed young people that they could tell me about any sexual activity that had happened before they were 13 years old but that if they didn't want that information shared they should avoid discussing how old they were at the time. In practice, these guidelines were applied four times. In three instances the use of the guidelines arose after disclosure of sexual abuse by young women aged 13-18. In

each case the young person became upset after disclosing that they had been sexually abused, and at the end of the interview I checked whether they had previously disclosed the abuse and sought their permission to inform their key worker or carer that they had become distressed when talking about the reasons for becoming looked after. On the fourth occasion I opted to implement the guidelines for a participant who was over the age of 18 who in addition to discussing risky sexual activity was demonstrating very limited sexual health knowledge. In that instance I provided her with contact information for a number of sexual health services in her area, and advised her about the availability of free condoms.

### **3.6 Recruitment and data collection**

Once ethical approval for the study had been granted, recruitment began. Recruitment was undertaken over a five month period from August-December 2011. In this section I begin by explaining the recruitment process used for looked after young people and care leavers, before moving on to discuss the recruitment process used for corporate parents.

#### **3.6.1 Recruiting looked after young people and care leavers**

A list of all the young people currently under the supervision of or in receipt of leaving care services from the North East CHSP was created by extracting data from the social work department's CareFirst database. This was undertaken by Glasgow City Council's Information Systems (IS) team on the 14<sup>th</sup> of July 2011 by searching the system for young people who were looked after in residential or foster care (14-16 years) and care leavers (16-21 years). The list was then refined to only include young people whose cases were managed by the North East CHSCP and who were residing in the following local authorities: Glasgow City, East Dunbartonshire, East Renfrewshire, Renfrewshire, East Ayrshire and North Ayrshire. These areas were selected to reflect the local authorities where looked after children from Glasgow were most commonly placed. Table 6 (overleaf) shows the number of looked after young people and care leavers identified from the data extraction.

**Table 6: Young people identified as looked after in the North East CHCSP**

	Looked after child	Care Leaver
Male	33	38
Female	43	50

A random sample of 40 young people was generated by separating the list generated by IS into four separate lists (looked after males, looked after females, male care leavers and female care leavers), ordering them by date of birth and selecting the fifth person on each list. After this had been done an email was sent by the strategic sexual health lead to the social worker of each young person informing them of the study and asking them to advise whether the young person selected was involved in an on-going sexual abuse investigation; none were. In addition, social workers were asked to flag any potential barriers to young people participating in a 40-60 minute interview. At this stage three individuals were identified as having substantial learning, communication and attentional difficulties by social workers; the reasons given included having special educational needs, being on the autistic spectrum and using heroin. After discussing the individual cases with the social workers I felt that their learning and attentional needs could be supported within an interview setting and the decision was made to contact all 3 participants.

Due to data confidentiality rules, the details of the young people identified could not be provided to me until they had agreed to their contact details being released. As a result, a letter about the study was sent to each young person (see Appendix 3) by the sexual health lead. The letter included information about the study, a stamped addressed envelope and an opt-in consent form that granted permission for me to contact them. A copy of this letter was also sent to the young person's social worker so that they could be asked to remind the young person about the letter if no reply was received. Of the initial 40 young

people who were contacted, three agreed to participate in and two were interviewed; with the reason for not interviewing the third being that they were a heroin user and the only time I managed to make contact with them it was not possible for them to give informed consent due to their intoxicated state. Despite subsequent attempts to contact them they could not be reached. Given the low response rate it was decided that the process would be repeated for the remainder of the young people identified by the IS team. Four individuals were identified as having substantial learning, communication and attentional difficulties by social workers; the reasons given included having special educational needs, being on the autistic spectrum, having ADHD and having received a traumatic brain injury. Of these, only the individual with the traumatic brain injury was not contacted as they were described as having difficulty understanding basic information. With the only modifications to the research procedures being that where participants were not sure what being interviewed meant they were given the opportunity to try answering generic questions before consenting to be interviewed, words on participant information sheets that caused confusion were clearly explained and the pace of the interview was slower.

Out of the additional 124 young people that were contacted in this way, six agreed to be contacted and were interviewed. This gave a total response rate for recruiting by letter of 5%. Frustrated by the low response rate I started contacting charitable organisations that provided support and guidance to looked after young people and care leavers. I contacted six organisations and two agreed to help me with recruitment. One organisation asked me to provide information sheets to the project leads in the area that I was recruiting in. The project leads identified and contacted eight young people who met the inclusion criteria; all of whom agreed to participate in the study. The other project invited me along to an evening session that they were running for young women who had been sexually exploited. These young women seemed quite distrusting of adults and although they were willing to let me explain the study, proved harder to recruit. Of the seven who were approached, only two agreed to be interviewed. Recruitment was further boosted when the manager of a residential unit asked me if I wanted to speak to all of the young people in her unit about

the study face-to-face; of the four young people approached, three agreed to be interviewed. Buoyed by this, I began approaching the managers of other residential units about the possibility of recruiting young people to the study. Nine managers were approached of which four agreed to speak to the young people in their units about participating. This resulted in ten young people being identified; eight of whom were interviewed.

At the same time that I was building a snowball sample through children's units and organisations working with looked after young people, the sexual health lead was negotiating access to care leaving services in Glasgow. Her efforts resulted in my being invited to attend a monthly group meeting and speak to young people at care leaving education services. This resulted in ten young people being approached to participate in the study, seven of which agreed to be interviewed. Table 7 (overleaf) shows the range of recruitment methods used, the number of participants that were contacted and how many were successfully interviewed. From this it can be seen that recruitment methods that involved direct contact with the interviewer were more successful, with an overall response rate of 75% vs. the 5% achieved by contacting young people by mail.

**Table 8** (overleaf) shows the composition of the sample that was achieved, alongside the intended numbers in brackets. From this it can be seen that I was more successful at recruiting young people living in residential care and least successful at recruiting boys living in foster care; reasons for this will be discussed in chapter seven when reflecting upon the use of gate-keepers to access young people in the care system. Further information about the characteristics of the achieved sample can be found in section 3.7.

**Table 7: Recruitment strategies**

Recruitment method used	Looked after young people		Care Leavers	
	Contacted	Interviewed	Contacted	Interviewed
Contacted by letter with social worker follow up email	76	7	88	1
Identified through residential units	9	8	1	0
Snowballing through Who Cares? Scotland	1	1	7	7
Snowballing through Young Women's Project	6	1	1	1
Snowballing through Care Leaving Education Services	N/A	N/A	6	4
Care Leaving Reference Group	1	1	3	2
<b>Total</b>	<b>93</b>	<b>18</b>	<b>106</b>	<b>15</b>

**Table 8: Achieved sample of looked after young people**

Gender	Looked after young people		Care Leavers	
	Residential care	Foster care	Supported care	Independent living
Male	4 (4)	1 (4)	4 (4)	5 (4)
Female	8 (4)	3 (4)	2 (4)	5 (4)

### **3.6.2 Recruiting corporate parents**

Glasgow City Council's Information Systems team generated staff lists for all social workers working within the North East CHSP and all foster carers caring for children whose cases were managed by that region. The lists were sorted by employee date of birth, and in the case of foster carers stratified by whether or not they had received Talk2Parenting training. A random sample of 7 social workers and 7 foster carers was generated. After discussions with the head of service it was decided that the recruitment of residential care staff would be limited to management level in order to prevent disruption to the units. Using the same methods, a random sample of 8 unit managers was created. Emails were circulated to each staff member by the strategic sexual health lead. These included an information sheet about the study, and a request for permission to be contacted by me. Once staff members had agreed to be contacted their details were passed to me and I made follow up telephone calls to arrange a time to conduct the interviews. Of the corporate parents only one declined to participate, with the reason stated being that she could not find time in her diary to accommodate the study.

### **3.6.3 Conducting the interviews**

Data collection was undertaken between August and December 2011. In this section I describe the process of conducting the interviews, including how the study was explained and consent obtained and the process of undertaking the interviews.

#### ***3.6.3.1 Explaining the study and obtaining consent***

After being recruited to the study I made appointments with each of the participants and agreed to meet them at a location of their choosing, including social work offices, children's units, family homes, hostels, care leaving services and family mediation centres. The only stipulation about where the interviews were conducted was that it had to be a place that had a quiet, private space where we could talk. On the majority of occasions I was the only person travelling to these locations; however, on a small number of occasions young

people travelled to a service and I met them there to carry out the interview. On those occasions I reimbursed their travel costs. Each participant was provided with an information sheet and consent form. These can be seen in Appendices 4 (young people) and 5 (corporate parents). Participants were asked to read through this; however in the case of young people I often read the contents of the sheet aloud. The importance of doing this was reinforced on my second interview where one of the participants had learning difficulties and struggled to read words that were longer than two syllables in length. At this stage I asked the participants if they had any questions about the research or wanted any more information. A few of the young people asked for more information about how the data would be used and who would be able to see it, which I answered. After providing time for the participants to ask questions I asked them if they wanted to go ahead with the interview. All of the participants agreed to continue at this stage and were asked to complete a consent form. As part of this process the participant and I negotiated rules about what could and could not remain confidential (see section 3.5.3).

### ***3.6.3.2 The interviews***

After completing the consent forms the young people were asked to complete a short questionnaire about their experiences in care. This included questions on the reasons for them becoming looked after, what age they had entered the care system and how many placement moves they had experienced (see Appendix 6). Whilst the young people completed their questionnaires, the digital recorder remained switched off. This allowed them an opportunity to get used to talking to me, and whilst completing their questionnaires the young people were encouraged to talk about anything they wanted to. In many cases, the young people chose to discuss their care experiences. This ranged from brief comments about certain placements or events through to full descriptions of why the young people had become looked after. Where young people discussed their care experiences I took brief notes and, where it was appropriate to do so, raised these issues within the young person's interview. The majority of the interviews were recorded using a handheld digital audio recorder. Five participants (3 young people; 2 corporate parents) did not want their interviews to be recorded; stating that they would feel too self-conscious and that they didn't like their

voice being recorded. In those situations I asked for and was granted permission to take detailed notes whilst the interview was being conducted; this included verbatim capturing of interesting quotes where the speed of conversation allowed me to do so. The interviews lasted between 30 minutes and 2 hours. The shortest interview was that length because the young person started the interview and then wanted to stop; permission was granted to use their data. The longest interview occurred with a foster carer and arose as a result of her sharing a particularly difficult story.

The interview schedule used was designed in light of the findings of the literature review, and revised throughout the data collection period as topics that had not been identified by the literature review were discussed by participants. The interview schedule was kept deliberately broad because of the exploratory nature of the study, with a generic list of topics rather than a set list of questions being used. This offered the advantage of flexibility, and allowed the research process and the questions asked to be tailored to the needs and experiences of the person that was being interviewed. Not having a set list of questions was particularly useful for exploring topics and meanings that were identified by participants but had not been considered by myself or my supervisors (Meltzer et al., 2003a, Meltzer et al., 2004a, Meltzer et al., 2004b). For young people the topics included reasons for entry into care, experiences of the care system; expectations of relationships; friendships; romantic relationships; knowledge of sexual health; talking about sexual health within the care setting; and experiences of romantic and sexual relationships. Similarly, corporate parents were asked about their experiences of caring for looked after young people, their views on looked after young people's peer, romantic and sexual relationships, their own knowledge, attitudes and values about sexual health and their experiences of learning/communicating about sexual health and relationships. A copy of the topic guides used can be found in Appendices 5 (Young People) and 6 (Corporate Parents).

Each interview started by asking for general background information about the participants. In the case of young people the first question tended to focus on getting young people to talk about what they liked doing in their spare time,

whereas for corporate parents the first question tended to focus upon how they had become a social worker, residential worker or foster carer. I felt that starting the interviews with generic questions helped put participants at ease and provided them with time to get used to being interviewed before I started asking questions about more sensitive topics such as sexual health. Interviewees were then asked about their experiences of either being or looking after a child in local authority care. This was done in order to familiarise myself with the care experiences of looked after young people and corporate parents, and gain an understanding of what it is like to be a looked after child. It is worth noting that the placement of questions that could evoke painful memories at the start of the interview was something that concerned me so often I started this part of the interview by asking what it was like living where they did and did they get on with their carers before moving on to explore what it felt like to be a looked after child and the reasons why they had become looked after. On the whole this worked well and the majority of young people were able to talk about these issues without becoming distressed. After gaining an understanding of what it was like to be a looked after child, the rest of the interview was focussed upon relationships and how corporate parents and young people learned about, and communicated about sexual health and relationships. Topics that emerged within interviews were explored by prompting, and topics that recurred across interviews were added to the interview schedule and explored in more depth.

At the end of each interview I gave participants a contact sheet that included details of services including housing charities, free legal services, mental health services, sexual health services, services aimed at sexual abuse victims, smoking cessation services and alcohol and drugs charities. In addition, I spent between 10 and 20 minutes just talking to participants. During this time I answered questions about the research and myself, and just engaged participants in what they wanted to talk about. This time allowed me to wind down the interviews and ensure that I didn't leave any participants feeling distressed; something that was particularly necessary after interviews that had touched upon childhood sexual abuse, mental health difficulties and suicide. Each of the young people participating in the study was given a £20 gift voucher as a thank you for giving up their time to be interviewed. No payments were given to the corporate

parents. Instead, they were allowed to schedule their interviews during working hours and released from duty to participate. Shortly after the interviews were concluded I wrote detailed ethnographic notes on the interviews, including my perceptions of the young people and the issues that were discussed in the interviews.

### **3.6.4 Reflecting on the interviews**

In the process of data collecting and analysing qualitative data it is important to consider reflexivity. As qualitative literature is focussed upon assessing and interpreting meanings generated through the interplay of the researcher and the researched, the narratives which are generated are mutually and socially constructed. As such, it is important to reflect upon how the values and experiences of both the researcher and the participant might have affected the data collected.

#### ***3.6.4.1 The Influence of the researcher***

Warin et al (2000, p52) argue that researchers and the researched engage in “mutual positioning” and that both personal characteristics and information that is acquired within the interview setting can result in both parties making snap decisions about the other that can affect the quality of the data collected. In practice this means that characteristics such as age, gender, social class, body language and the clothes that are worn can be used to form opinions about the research and the credibility of both researcher and participant. As a result of this I tried to remain aware of how my personal attributes might have affected how participants viewed me.

At the time of collecting the data for this PhD I was a 28 year old, middle class woman who had recently gotten engaged to her partner of six years. Although I had no children of my own I had been a weekend parent to my fiancé’s 13 and 15 year olds for four years. This meant that I was used to speaking to teenagers; something that I believe helped when conducting this research as I had lots of experience talking to young people when they were happy, relaxed, stressed, angry and sad. I was also used to young people trying to shock me in order to

gauge my reactions; something that one participant tried to do within minutes of meeting me by stating that he was suspended from school for burning his school books, and that his carers didn't know he had stolen a bike earlier that week. Whilst what he was telling me might have been true, it appeared to me that the exchange was designed to both shock me, and to see whether I would leave the room and tell his carers what he had done. In addition to providing me with a grounding in talking to young people, my experiences of having to act like a mum whilst not trying to be a mum meant that I could partly empathise with foster carers about what it was like to care for children who were not biologically mine. I was regularly asked by residential and foster carers if I had children of my own and I often confided that whilst I didn't have children my fiancée had two teenagers who stayed with us at weekends. This was something that I felt built rapport and after interviews were finished I often answered questions about what it was like to be "so young" and have to provide advice and guidance to another woman's children. During those times I found myself talking to them about the challenges Ian and I had faced at different stages with his children.

Whilst these experiences helped me relate to participants and vice versa, I noted that my age sometimes seemed to act as a barrier within interviews. For example, older participants often felt the need to explain things in slightly more depth on the basis that I was "much too young to remember" whilst failing to recognise pop-culture references from my youngest participants left me feeling old! Although this did not alter the quality of the data I collected it was something that identified me as being different from my participants. Similarly, before beginning the study I was slightly concerned that my accent could act as a barrier to young people engaging with me. Although I grew up on the west coast of Scotland I have English parents and grew up in a town with a large English population. This has resulted in my having an accent that Scottish people tend to identify as being English. As I was conducting research in Glasgow, with participants who predominantly spoke 'Weegie', I wondered whether my accent would lead to me being viewed as 'an outsider' and somebody who could not be related to.

In addition to personal characteristics, my academic background and my role as a researcher from the university may have influenced the data collected. This is because it can be argued that academic researchers can be viewed as having an authoritative role, which can affect how participants view they should behave and interact within the interview setting. For example, Cornwell (1984) argues that the authoritative role of the interviewer may result in participants choosing to suppress information that they believe may not be socially desirable or acceptable to the researcher, or choosing only to disclose things that they believe the interview wants to hear. I cannot state equivocally that this did not happen within any of the interviews as all of the participants knew in advance of their interviews that I was coming from the university where I was undertaking a PhD and their answers might have been influenced by this. Similarly, it should be noted that I was 'an outsider'; someone who came from outwith the social work department and didn't know much about the care system. Whilst I felt that my naivety was beneficial to the interviews as it allowed me to treat participants as experts, it is possible that participants, in particular the corporate parents, may have been less likely to vocalise negative opinions of the care system or their employers.

#### ***3.6.4.2 How participants view themselves and construct their narratives***

One of the potential limitations of qualitative interview data is that the data generated within the interview setting is based upon participants' retrospective accounts of their own thoughts, feelings and actions. As a result, it has been argued by Cornwall (1984) that interview data is limited by the construction of public and private narratives, with the interview setting not being conducive to the sharing of public accounts because the lack of relationship between interviewer and participant encourages adherence to socially normative constructions of behaviour. As a result, it would be expected that the data yielded within a single interview might be representative of well-rehearsed, well-constructed, socially acceptable reflections of the self rather than the private, more critical and potentially less socially acceptable views of the self and others. Whilst I cannot discount that the young people and corporate parents I interviewed provided me with well-rehearsed accounts of their thoughts, feelings and behaviours it could be argued that if this were the case I

would only have heard narratives that portrayed the participant or, in the case of corporate parents, their organisation in a positive light. For example, using the example of contraception it would be expected that the socially normative response to being asked about contraception would be to portray the self as a reliable and consistent user. However, this was not always the case, with several of the young people admitting to unprotected sexual behaviours and openly discussing how not using contraception had resulted in their being tested and treated for sexually transmitted infections. Similarly, it was common for corporate parents to reflect upon their practice when discussing looking after children. In doing so, the majority identified where they felt that they had made mistakes in the past, and how these impacted upon their interactions with young people in the present.

### **3.7 Data analysis and presentation**

In this section I use the data gathered using the short questionnaire (Appendix 6) to describe the characteristics of the sample. I then move on to discuss how the qualitative data was transcribed, analysed and anonymised, before reflecting on factors that might have affected my interpretation of the data; focussing in particular on how I presented myself to participants, and how participants' constructions of their narratives and my own interpretations of those narratives are socially constructed. I conclude this section by reflecting upon the reliability, validity and generalisability of qualitative research.

#### **3.7.1 Characteristics of the achieved samples**

Data from the short questionnaires on care histories were entered into an excel spreadsheet and descriptive statistics generated. In this section I briefly discuss the characteristics of the interview samples, beginning with looked after young people before moving on to discuss the corporate parents. Descriptive statistics on whether corporate parents had received sexual health training were also generated by reviewing email correspondence between me and the sexual health lead.

### 3.7.1.1 Looked after young people and care leavers

Interviews were conducted with 33 young people (girls n=19, boys n=14) aged 14-23 between August and December 2011. Table 9 shows that the mean age of first entry into the care system was 10 years of age (range: 0-15 years), with half (52%) of the young people reporting that they first became looked after when they were aged 11-16 and a third (36%) reporting that they had been aged 6-10. Girls were more likely to have been admitted to care during adolescence (58% vs. 36% boys).

**Table 9: Age of (first) entry into care**

Age at entry	All % (n)	Girls % (n)	Boys % (n)
0-5	12 (4/33)	-	28 (4/14)
6-10	36 (11/33)	42 (8/19)	36 (5/14)
11-16	52 (18/33)	58 (11/19)	36 (5/14)

Table 10 shows the reasons why young people became looked after. From this it can be seen that the most common reasons for entry into care were: physical abuse and neglect; parental drug and alcohol misuse; and young people stating that they had been outwith parental control. In a third (33%) of cases, abuse and neglect were experienced in conjunction with parental drug and alcohol misuse.

**Table 10: Reason for entry into care**

	All % (n)	Girls % (n)	Boys % (n)
Domestic violence	15 (5)	11 (2)	21 (3)
Physical abuse	52 (17)	63 (12)	36 (5)
Sexual abuse	12 (4)	16 (3)	7 (1)
Neglect	27 (9)	21 (4)	36 (5)
Absconding	9 (3)	11 (2)	7 (1)
Outwith parental control	21 (7)	16 (3)	29 (4)
Parental drug and alcohol misuse	39 (13)	48 (9)	29 (4)
Parental illness	6 (2)	11 (2)	-
Parental death	9 (3)	11 (2)	7 (1)
Parental imprisonment	6 (2)	11 (2)	-
Relationship breakdown	15 (5)	11 (2)	21 (3)
Prefer not to say	9 (3)	11 (2)	7 (1)
*Percentages sum to >100% due to multiple reasons for care entry			

Appendix 7 shows the placements experienced by young people. Their current care placement is in bold. From this it can be calculated that the mean number of placement moves experienced by the young people was four (range 0-12; due to the high number of placements experienced by Andrea her data has been excluded from this calculation.) and that whilst in care, half (52%, n=17) had experienced living in children’s units or residential schools. A fifth (22%, n=7) recalled being looked after at home, whilst a third (33%, n=11) had been looked after by relatives. At the time of interview three quarters (76%, n=13) of the looked after young people were living in children’s units whilst a quarter (24%, n=4) resided in foster care placements. Looking at those young people classed as care leavers, approximately half (44%, n=7) were living independently, a quarter were living with supported carers (25%, n=4) and a fifth (19%) were living in hostels.

### 3.7.1.2 Corporate parents

Interviews (n=21) were conducted with residential carers, social workers and foster carers. In total 23 individuals participated in the interviews. This was due to two foster carers who were recruited to the study asking if their husbands could sit in on the interview as they “fostered together” and wanted to discuss the issues in relation to how they “as a team” handled sexual health and relationships. In both cases the first I was aware of this decision was when I arrived at the household to interview the women, and as both men had taken time off work so that they could be available, I decided to adhere to their wishes. Table 11 shows the breakdown of participants according to interview type and the number of respondents interviewed. In this section the following characteristics of carers will be briefly discussed: gender, age and experience of sexual health training.

**Table 11: Interviews conducted with corporate parents**

	Individual		Partner interviews	
	Interviews(n)	Participants (n)	Interviews(n)	Participants (n)
Foster carer	5	5	2	4
ISMS worker	1	1	-	-
Residential carer	8	8	-	-
Social worker	5	5	-	-
<b>Totals</b>	<b>19</b>	<b>19</b>	<b>2</b>	<b>4</b>

The corporate parents interviewed were predominantly female (85%, n=24). That so few men were recruited and interviewed reflects the wider gender imbalance seen within social services in the UK, with McLean (2003) noting that men constitute only 14% of the workforce within social services. Although the exact ages of participants were not recorded, their ages ranged from the mid-twenties to mid-sixties. It was clear from the narratives of the participants that the residential and foster carers were significantly older than the social workers, with the majority (70%, n=12) of the residential and foster carers aged fifty plus whilst the social workers were predominantly (80%, n=4) in their late twenties to mid-thirties. Table 12 shows the number of workers who had received Talk2 training at the time of interview. From this it can be seen that all of the residential carers and two thirds (67%) of the foster carers had attended the Talk2 parenting course. None of the social workers had received training.

**Table 12: Interviews conducted with corporate parents according to Talk2Parenting training**

	Talk 2 Parenting	
	<i>Trained (n)</i>	<i>Untrained % (n)</i>
Foster carer	6	3
Residential carer	8	0
Social worker	0	5
<b>Totals</b>	<b>14</b>	<b>8</b>

### 3.7.2 Managing and analysing the qualitative data

I now move on to describe the processes used in analysing the qualitative data generated by the study.

#### 3.7.2.1 Transcription

As noted in section 3.6 the majority of the interviews were recorded using a handheld digital audio-recorder, with additional notes taken by the researcher throughout the interview. I listened to all of the recordings as soon as possible after the interviews. Four recordings that were conducted close together showed evidence of technical difficulties; two had static obscuring the beginning of the

interviews, whilst two interviews had recorded nothing but static. In each case I amended the notes that I had taken within the interviews with detailed notes of what I remembered having been discussed. I also obtained a replacement recorder as I was hesitant to reuse the recorder that I had been using given the problems that I had experienced.

Individual interviews were transcribed verbatim by a professional transcription agency with a longstanding history of conducting transcriptions for the MRC/CSO Social and Public Health Sciences Unit, University of Glasgow. Local dialects, pronunciations and colloquialisms were captured in order to avoid changing participants' meanings. As some of the tapes contained descriptions of child abuse and sexual exploitation I discussed with the head of the agency the procedures they had in place to minimise harm to their transcribers and was told that they were encouraged to stop transcribing if they became upset and to discuss their reactions to distressing information with the head of the agency. In addition to these rules, we agreed that recordings containing distressing descriptions would be flagged so that transcribers could be forewarned of content prior to agreeing to transcribe the recordings. Whilst in the majority of cases I was satisfied that the recordings wouldn't cause the transcribers distress, there was one recording that I felt was too distressing to release. This tape I transcribed myself over the course of a week; taking regular breaks, and talking to my supervisors and fellow students when I found myself becoming overwhelmed by both the narrative and the respondent's distress. After all of the interviews had been transcribed, each transcript was checked by me and where necessary I made corrections and undertook additional transcription of unclear sections. I also made notes about the emotive tone used by the respondents. The transcripts were then added to my own typed notes about the interview before each of the participants was assigned a pseudonym. Identifying data such as the names of people and places were removed from the transcripts prior to analysis being undertaken.

### 3.7.2.2 *Ontological positioning*

The qualitative data generated for this study was analysed thematically. Thematic analysis describes the process of identifying, analysing and reporting patterns that are present within the data (Braun and Clarke, 2006). These patterns, which are referred to as themes, are identified using one of three different approaches, namely induction, deduction and abduction. Induction refers to the interpretivistic process by which researchers derive and interpret concepts, themes or models through detailed readings of the raw data. This approach results in theory being derived from the data, rather than through pre-conceptions held by the researcher (Corbin and Strauss, 2014, Reichertz, 2007, Thomas, 2006). Deduction refers to the process through which researchers derive their findings by testing whether their data are consistent with *a priori* hypotheses and theories. The deductive approach seeks to apply positivistic and empirical approaches to qualitative data in order to test and confirm theories in a systematic manner (Hyde, 2000, Thomas, 2006).

Whilst the inductive approach is favoured within qualitative research, it should be noted that data analysis does not occur within a vacuum, and as such it can be difficult for researchers to free themselves of their *a priori* theoretical understandings when analysing data. Abductive inquiry offers a solution to the tensions between inductive and deductive approaches by combining the two approaches. Abduction is a type of inference that uses inductive processes to identify and collect pieces of information, whilst also using existing theories, concepts and ideas as heuristic tools to deductively develop, test and interpret ideas (Coffey and Atkinson, 1996, Richardson and Kramer, 2006). It can be thought of as a two stage process. First, the researcher uses the narratives of participants to describe the concept that is being studied. Second, they apply theoretical concepts and existing constructs to provide understanding or explanation of the actions being studied (Blaikie, 2004). The adoption of an abductive approach to analysing the data appealed to me as a researcher as it seemed to reflect my ontological positioning as a pragmatist; somebody who sees addressing the research problem as central to the line of enquiry, and is happy to use either deductive or inductive research tools, or combine deductive and inductive research tools, to understand that problem (Creswell, 2003, p11).

### ***3.7.2.3 Analysing and interpreting the data***

I now move on to describe the iterative process of analysing and interpreting the qualitative interview data that was collected. This process began by reading each of the transcripts in order to familiarise myself with the data. During this process I highlighted text, and made notes in the margins about ideas and concepts that struck me as I was reading the participants' narratives. These notes often consisted of words, theories or short phrases that attempted to sum up what I believed was being said in the text. This process, which can be thought of as open coding (Burnard et al., 2008), balanced inductively identifying themes that were 'emerging' from the data with deductively noting concepts that might be useful in interpreting the research findings. Initially my aim was to write a short summary statement or word for each section of the transcripts; however when participants had moved away from discussing the topic and there were no obvious or clear links to the research questions I chose not to code these segments as they could be viewed as constituting white noise or 'dross' (Morse and Field, 1996).

Figure 7 (overleaf) provides two examples of this process. From this it can be seen that reading through the excerpts generated a large number of potential themes. For instance, the excerpt on the left of Figure 7 predominantly focuses upon factors affecting young people's understandings of relationships, and highlights broad themes such as: the impact of trauma and abuse on young people's view of the self and others; risk behaviour as an indicator of trauma and poor attachment; carers' concerns about sexual exploitation and grooming; the role of monitoring and supervision within the care setting; and the importance of relationships. The excerpt to the right of Figure 7 focuses on the participant's experience of discussing sexual health issues with looked after young people. In reviewing this excerpt the following themes and ideas emerged: the importance of trusting relationships; recognising that young people may ask questions about sex in shocking or inappropriate manners, possibly to test how carers will react; the importance of corporate parents' reactions to questions about sex sexual health discussions; how corporate parents' gender and age may act as barriers or facilitators of discussion; and the potential for boys to be excluded from sexual health discussions.

Figure 7: Data familiarisation and theme generation

What do you think are the kind of main sexual health issues that young people in care face?

*own values about relationships?*

I think that maybe what they see as appropriate relationships, erm, I think sometimes they've got low self esteem, that they've suffered quite badly with a poor self image and unfortunately you know they'll kinda, maybe be drawn to people that will exploit that in them by saying the right things, by telling them what they want to hear and it's really hard trying to educate the young people that other people don't always have a clear agenda, you know they might have a hidden agenda and it's kinda inappropriate, what we see as inappropriate and the reasons why, behind that, and consequences, implications and what it would mean for them kinda long term, you know for their lives, so a lot of our work with young people, they come from very very, you know dysfunctional families and they crave the need to be needed and I think, especially with our females I would say, they feel that if they have a boyfriend, their status improves and sometimes they just don't make good choices, you know, and they don't see the implications, some people are kinda, especially online, we've got issues with kids online, and going to inappropriate websites and social websites and networking sites and it's trying to kinda educate them how vulnerable they actually are and be very careful what actually put on their site and how it can attract certain people to them, but, I mean in here, we're actually quite fortunate because our older ones are a wee bit more mature and they've got that kinda, they're a wee bit more sensible, but obviously our younger ones we're trying to educate right now and I think it's a big issue in the unit, exploitation and possible exploitation, and what's good for them, I just think that a lot of them are just kinda, really, they're ready to grow up, they want out of here, they want their own house, they want their own baby and maybe it's a kind of escapism you know from you know, from being in care.

*Attachment: baby → craving love & stability eg Chris/knight papers?*

You said the older ones are a lot, a lot more mature, is that something that you would expect compared to other young people that you've worked with in the past before?

Probably, yes, I think, you know, we're very open in here, you know, and the older young people, the older girls have been here a long long time - good relationships with staff, so when you've got good relationships with staff you get a bit more honesty cause they're not so fearful of being judged, so I think with our older ones there have been issues in the past, outwith in the community, drinking, being very vulnerable, but I think they've maybe just, yeah, grown up a wee bit, you know and they're maybe just a wee more stable in their lives, and I know that's not always the case in the different units, and I think we're just probably in a fortunate position just now in (), well apart from our younger ones.

So how do you develop those relationships with young people? Trust → secure base? Trust I think, trust, honesty. Erm, I think the kids, you know, they need to know that we are non-judgemental and that they can come to us and it's not a kind of, not a blaming culture. It very much depends on the young person as well, what they have been through prior to being accommodated, they're very kinda mistrusting of adults, because adults have let them down so much in their lives, they are expected to come into a group setting, so many

*Craving Attachment Self-esteem*

*Status → group living and identity?*

*Interact as a change → need for education*

*Monitoring and supervision*

*Emotional response to trauma e.g. use of alcohol to suppress feelings*

*CR*

*group culture re: being accepted?*

*Relationships facilitate communication*

- TRUST
- HONESTY
- JUDGEMENT
- BLAME

*Rejection as barrier to trust.*

residential when he turned 16 as well, like it's like you're there for a lot more significant events in their life, and trying to be as big a support as you can be, especially when they're, if that was, like, the only family they had. So I think that you're doing similar, like, similar things, but, like, your role's more intense, and they're, and if you're maybe only on wi' you and another member ae staff, like, you're, there's more chance of that person coming and speaking to you than there would be, like, someone else, like a family member or a friend or somebody at school, or, like, if you're there, then, like, you're their support, and they're more likely to use it.

Okay. And speaking of being that support, have you had any young people come to you specifically to ask you about issues around their sexual health and development?

M-hm.

Could you...?

I've had, like, young, like, girls, like asking me about, like, just, I suppose things I've heard at school, and, like, what's true and what's no true, about like sexual, their sexual health, and sexual positions, and different things like that, and, like, I think probably more so because, like, just being a younger female, that they're more likely to come and ask me and feel quite comfortable about it. And, like, I think more likely to come and speak to me about something like that than they would be, like, one of the older members ae staff, but, like, I'd always try to be quite open and... but I think, like, trying to discuss wi' them, like, what's appropriate in terms of like how they ask, and like no really like, cos like, they sometimes as you just to see what you... how you're gonnae respond, and they try and tell you things that they think you're gonnae find absolutely disgusting, or you're gonnae like react terribly to it, but like just being like really cool and calm and collected about it, and saying, "aye, well, it is this," or, "no, it's," or, "do you really think that," kinda thing, like, they'll... If you speak to them about it, just normally, then they're more likely to come and as you, and no really like blow things out of proportion as much. But I dinnae really think... I dinnae really think boys have really come and speak to ye as much as girls, but then again, they might be more likely to speak to ye like a male, like a male worker. But like I think girls are more, like more forthcoming in my experience what they want to know, and about asking, and they're more likely to come and ask in a group as opposed to just the one person. And I think that, like, once they realise that they can trust ye, and they can speak to you about it quite comfortably, they're more likely to come and ask ye more questions, and probably ones that are more serious. And even like, just having the conversations about, like contraception and things like that, or "can you come wi' me to the doctor, cos I'd really like to go on the Pill," or, like, and being, like, they're more likely to ask you, and I think that that's quite a good thing, because in your, you're being able to kind of give them an answer that's more educating for them than something that they've maybe just heard on the street or from a friend, or from a friend's friend. Like, you can go and then support them, and then you get a wee bit more knowledge out of what's happening wi' them as well, and then they build up that trust, to

*Parental role to supportive*

*Lack of choice for young people in residential care?*

*Young workers seen as more knowledgeable? Easier to approach?*

*Reactions are very important in building trust and facilitating communication*

*TRUST = importance of relationship*

*Shock factor? testing behaviour or lack of capacity to ask in way that adults would expect?*

*gender specific communication*

*boys more isolated?*

After reading through and annotating all of the transcripts I uploaded the transcripts into NVIVO version 8.0 and created tree nodes for each of the words and phrases that had been identified by annotating the transcripts by hand. This process allowed me to refine the coding process by deleting duplicate nodes or combining nodes that appeared to be describing the same thing. For instance, during the process of entering the emerging themes into NVIVO it became apparent that my coding of the excerpts shown in Figure 7 had generated two similar themes relating to communicating about sexual health and relationships, namely ‘the importance of relationships’ and ‘the importance of trusting relationships’. I also discovered that I had identified a number of similar words or phrases such ‘relationships’, ‘quality of relationships’, ‘trust’ and ‘trusting relationships’. In order to reduce the number of themes, and avoid duplication, I chose to consolidate these ideas into two nodes; one about relationships, and the other about trust. I repeated this process of deleting and consolidating themes that measured similar concepts until every theme identified had been entered into NVIVO. This helped to generate a shorter, more manageable list of themes. Table 13 shows an excerpt of the deletion and consolidation face.

**Table 13: Example 1: deleting and consolidating themes**

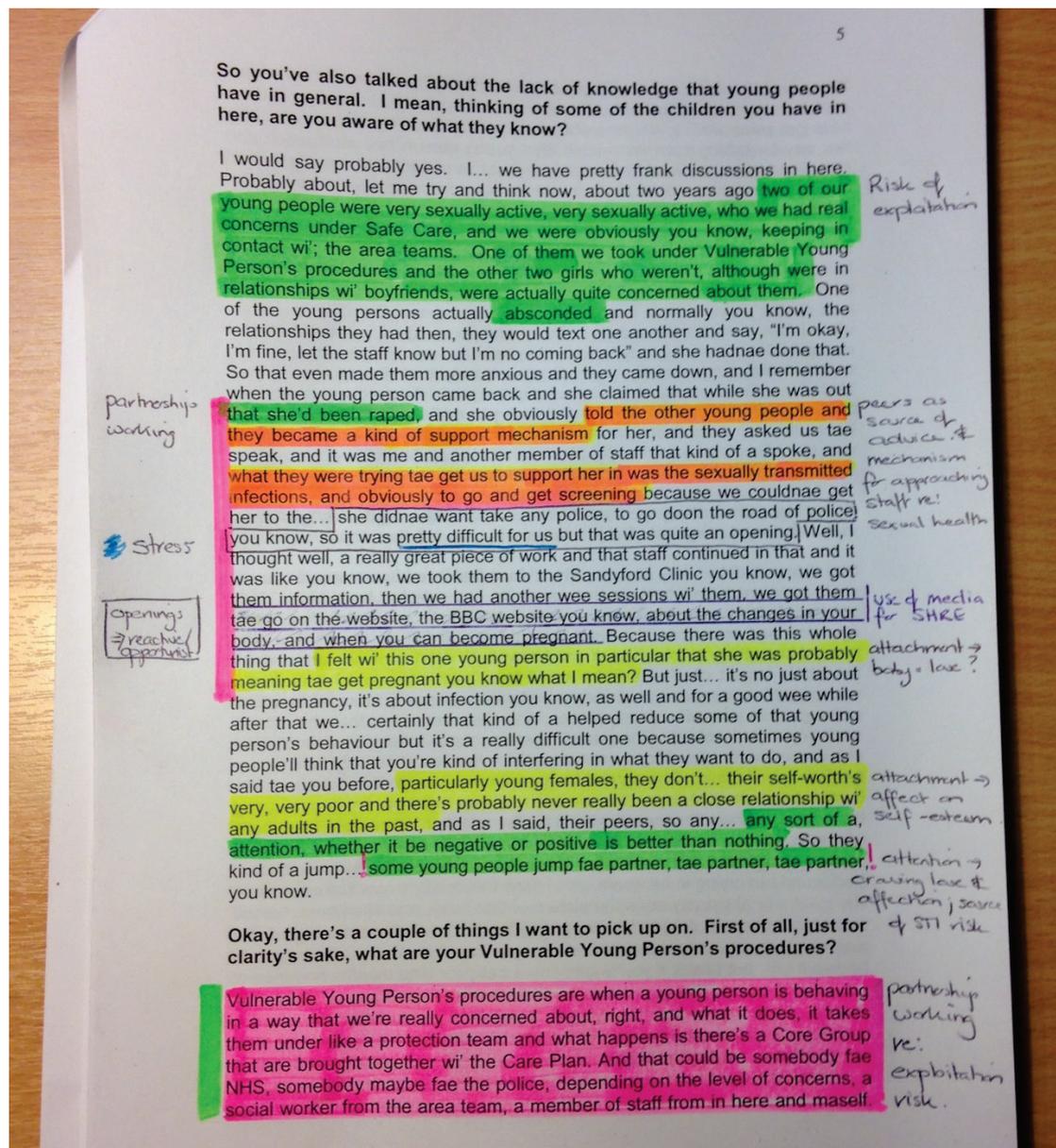
Sample of annotations identifying the importance of relationships in talking about sexual health and relationships	Initial coding scheme after removal of duplication and merging of similar concepts
<ul style="list-style-type: none"> <li>• Importance of relationships for communication</li> <li>• Relationships</li> <li>• Trust</li> <li>• Trustworthy</li> <li>• Openness</li> <li>• Responds with honesty</li> <li>• Safe to talk to</li> <li>• They’re like my mum or dad</li> <li>• Non-judgemental</li> <li>• Quality of relationships</li> <li>• Hard to form relationships</li> <li>• Listens to me</li> <li>• Supportive</li> <li>• Trusting relationships</li> <li>• Not ‘snobby’/looks down at me</li> <li>• Easier to talk to family</li> <li>• Find it hard to trust</li> <li>• Takes time to build up trust</li> <li>• They feel like family</li> <li>• Find it hard to trust other people</li> <li>• Listen to what you say</li> <li>• They don’t judge</li> </ul>	<ul style="list-style-type: none"> <li>• Trusting relationships</li> <li>• Openness and honesty</li> <li>• Safe to talk to</li> <li>• Feels like family</li> <li>• Supportive relationship</li> <li>• Non-judgemental</li> <li>• Listens to me</li> </ul>

Once I had finished abductively creating the thematic framework that would be used for the analysis I began the process of mapping the data to the nodes that had been created within NVIVO. Initially I systematically worked through interviews, broad coding sentences and paragraphs to the tree nodes. This proved to be a lengthy and laborious process so I decided to utilise NVIVO's query functions to search for combinations of words and key phrases that had been identified during the open-coding process. For example, in the excerpts shown in Figure 7 (see page 153) it was identified that the age of corporate parents could act as a barrier to communication about sexual health and relationships being undertaken. Thus, I created a query that searched for the presence of the terms: "age", "old", "older", "young", "younger", "closer to their age", "closer to his age", "closer to her age" to identify instances within the transcripts where participants had discussed age. The use of queries provided a quick way of coding the data, and at times allowed for coding across multiple nodes. For example, one of themes that I had identified during the open-coding process was 'the need to tailor discussions to biological, developmental and cognitive age'. As this theme shared the concept of 'age' with the theme of 'corporate parents' age as a barrier to discussion' I was able to modify and re-run the search to identify textual references that included: "age", "younger", "older", "young", "biological OR emotional OR developmental OR development OR cognitive" with "age OR for his age OR for her age OR age OR young OR younger". During this period I frequently cross-checked the results of queries against my own annotated notes in the transcripts to ensure that data were not being excluded.

Whilst the use of NVIVO provided a systematic approach to analysing the data I found it an extremely frustrating and clinical process that left me feeling so detached from my data that I found myself reflecting in analysis notes that "I couldn't see the wood for all of the tree nodes". Alvesson and Skoldborg (2000) argue that "insight is not achieved by laborious pondering but rather at a stroke, whereby patterns in complex data are illuminated by a kind of mental flashlight, giving an immediate and complete overview". For me, I found that the process of assigning quotes to tree nodes in NVIVO acted as a barrier to achieving this level of clarity and decided to return to coding the interview transcripts by

hand. This was something that I found much easier as it allowed me to treat the transcripts holistically and to begin mapping connections between participants' experiences by allocating each of the themes a colour and going through each of the transcripts and thematically marking it up. Figure 8 shows an example of this process. Once this was done, I returned to the computer and created word documents for each of the themes that had been identified. Once this was done, I began systematically copying the data relating to each theme from my electronic copies of the transcripts to the relevant word documents. This allowed me to group together all of the quotes that would be used for writing up each theme in one location.

Figure 8: Exemplar of colour coding themes by hand



After compiling these word documents I mapped each of the themes onto the research questions that had been identified for the PhD, see Figure 9 (overleaf) for the final coding scheme. This served two purposes. First it allowed me to assess whether I had collected sufficient data to answer the research questions outlined in the thesis; something that I felt was necessary to do at this stage in case the mapping revealed that additional interviews with young people or corporate parents were required. Second, doing this provided me with an opportunity to collate all of the data relating to each of the research questions and themes into a more manageable format for writing up. This exercise helped to organise and sort the data into a manageable format, and also highlighted where themes and concepts might be used to address both of the research questions.

Open-coding, refining the themes identified through reducing and synthesising the data, and mapping the data can be thought of as contributing to the first stage of the abductive process, in which the narratives of participants are used to illustrate the concepts being studied. This first stage of analysis can be thought of as generating insider, lay or emic knowledge insofar as the presentation of data in this way can illuminate “the subjective meaning, actions and context of those being researched” (Popay et al., 1998, p345). The use of emic knowledge is particularly useful within healthcare research as it can provide access to the views of service users who it can be argued are uniquely placed to identify barriers and facilitators of services use, and the strengths and weakness of the services that they use. For instance, the young person who states that they talk to their caregivers about sexual health because they “trust them” is providing a unique insight into a factor that might facilitate conversations about sexual health and relationships within the care system. Whilst it is acknowledged that the emic viewpoint has the potential to provide researchers and policy makers with a rich understanding of individuals’ experiences, Silverman (Silverman, 2011, p287) argues that researchers and policy makers who rely wholly upon emic accounts are “naïve”. This is because the descriptive accounts that respondents provide often fail to account for the impact that wider contextual factors may have upon their experiences.

Figure 9: Final coding frame

The screenshot displays a software interface for managing a coding frame. On the left, a vertical sidebar contains navigation options: Sources, Nodes (highlighted in orange), Classifications, Collections, Queries, Reports, Models, and Folders. The main area is titled 'Nodes' and features a search bar at the top with 'Look for:' and 'Search In' dropdowns, and a 'Nodes' button. Below the search bar, a hierarchical tree of nodes is shown. The tree is expanded to show several levels of sub-nodes. The 'Trusting relationships' node is highlighted in blue. The nodes are as follows:

- Nodes
  - Relationships
  - Node Matrices
- Nodes
  - Communication about sexual health and relationships
    - Child factors
      - Educational disengagement
      - Understandings of relationships
        - Domestic violence
        - Gender equality
        - Sexual abuse
        - Traumatic sexualisation
    - Corporate parent characteristics
      - Adopting parenting role
      - Age of carer
      - Gender of carer
      - Religion
      - Sexual health literacy
        - Embarrassment
        - Received SHRE as a child
        - Training
    - Doing 'sex work'
      - Partnership working
      - Resources
      - Role modelling behaviours
      - School-based SHRE
      - Training
    - Workplace factors
      - Culture shift - GIRFEC and corporate parenting policy
      - Culture shift - sex and taboo
      - Managerial support
      - Parenting values
      - Partnership working
      - Religious values
      - Risk management
      - Sexual health role
      - Sexual health training
      - Tensions between belief and practice
      - Workplace identity
  - Connectedness
    - Attachment
      - To people
      - To place
    - Trusting relationships (highlighted)
      - Placement stability
      - Placement type
  - Monitoring
    - Boundaries
    - Exploitation and grooming
    - Partnership working
    - Risk awareness and management

To protect against this, Silverman advocates that research findings should be analysed and discussed using etic constructs, which draw upon the wider empirical and theoretical literature to contextualise participants' experiences. This process is synonymous with the second stage of the abductive process, in which the researchers seeks to deductively identify theories and concepts that may be of use in explaining the subjective meanings and actions of participants. Returning to look at the importance of relationships in undertaking sexual health and relationships work it can be seen that the synthesis and consolidation exercise resulted in seven themes that could be used to describe particular facets of relationships that were perceived to facilitate communication. These included: having trusting relationships; the presence of openness and honesty within the relationship; feeling that caregivers were safe people to talk to; reporting that caregivers felt like family members; feeling supported within the relationship; caregivers being non-judgemental; and feeling listened to. What is striking about these themes is that 'trust', 'openness', 'honesty', 'safety' and 'support' are words that I would expect to see used within descriptions of attachment and attachment security (see section 1.4.2.1 for details).

It is widely reported that a parent who is sensitive, attuned and responsive to their child's needs teaches their child that they can be relied upon to protect and care for them. This in turn creates a safe and secure base that young people can use to explore their environments from, but return to when they become distressed or require help (Ainsworth et al., 1978, Ainsworth, 1982, Crittenden and Claussen, 2003, Isabella, 1993, Main and Solomon, 1986). Although this theory was initially derived to describe the mother-infant bond, the internal working models associated with attachment styles are believed to persist across the life course. Thus it might be expected that an individual who has a secure attachment style, insofar as their needs have been appropriately met by their caregivers and they have gone on to develop positive mental representations of the self and others, will feel confident asking for help and advice with regards to their sexual health. In contrast, an insecurely attached individual may choose not to seek out help and advice either due to the fear of being rejected, or believing that seeking help is not worthwhile because they have learnt that other people cannot be trusted to provide help and support. Within the sexual health literature attachment theory is reflected within the concept of parent-

child connectedness, with the research evidence suggesting that young people who have warm, close and loving relationships with their parents are the most likely to approach their parents for sexual health information and advice (Dilorio et al., 2003, Fullerton, 2004, Lezin et al., 2004, Jaccard et al., 1996, Markham et al., 2003, Miller et al., 2001, World Health Organisation, 2007). Given the emphasis that both corporate parents and young people placed upon the importance of relationships in facilitating sex talk it would appear that attachment theory could be used to provide a theoretical framework for the interpretation of results.

Whilst the emic viewpoint may help to facilitate understanding about the factors that may promote or restrict discussion about sexual health and relationships within the care setting, the etic view would seek to contextualise these findings. The etic perspective would argue that the presence of trust within the caregiver-child relationship is indicative of the quality of the bond that exists between the young person and the person who is caring for them. It would also argue that the security of this bond and hence young peoples' ability to trust other people reflects the quality of the interactions that occur between the caregiver and the child. For instance, the caregiver who is accepting of a young person's request for sexual health information, listens to the young person's questions and responds with openness and honesty will likely make the young people feel that they are a person who can be trusted to tell the truth and provide them with support. The etic view would therefore argue that the presence of trust within the caregiver-child relationship facilitates sensitive conversations by promoting comfort, and allowing discussions to be undertaken within the context of pre-existing, safe and familiar patterns of interaction.

Whereas the usage of attachment theory to interpret the research findings was deduced from my understanding of the literature, the potential relevancy of another theory was identified through discussing with my supervisors about themes that had emerged from the data. These themes are highlighted in Table 14, and highlight the tensions that existed between corporate parents' professional, parenting and personal identities. Through discussion with my supervisors it was identified that 'role theory' might be useful in interpreting

and explaining these tensions. Role theory is described by Stryker and colleagues (1980, 1985, 1994) as being useful to explain the notion that within society individuals occupy different positions; each of which have clear roles and expectations attached to them that help shape the attitudes and behaviours of that individual. These positions are often arranged hierarchically according to how salient the role is to that person's identity and the social position that they occupy. In essence, role identity can be thought of as the meanings that people attribute to themselves whilst operating within a certain role. For each of the roles that people adopt there will be a corresponding identity that underscores how that individual behaves and interacts with the world. This theory, which 'emerged' during the analysis of the data, therefore seemed potentially relevant to explaining the challenges that corporate parents appeared to be discussing in relation to incorporating sexual health and relationships education within their role.

**Table 14: Example 2: deleting and consolidating themes**

Sample of annotations identifying the influence of identity on sexual health and relationships work	Initial coding scheme after removal of duplication and merging of similar concepts
<ul style="list-style-type: none"> <li>• Not trained to talk about sexual health</li> <li>• Talking about sexual health is the role of the LAAC nurse</li> <li>• Co-ordination of care plan = social worker</li> <li>• Talking about sex = carers</li> <li>• Role of specialist agencies to provide sexual health</li> <li>• Those with training to talk about sex</li> <li>• Partnership working</li> <li>• Difficulties being a corporate parent not a parent</li> <li>• We take them</li> <li>• Informality</li> <li>• Professionalism</li> <li>• Foster carers are not professionals</li> <li>• Old-fashioned values</li> <li>• Religious (particularly Catholic) values</li> <li>• Never received sexual health education</li> <li>• Sexual health training</li> <li>• Reconciling different roles</li> <li>• Provision of managerial support</li> </ul>	<ul style="list-style-type: none"> <li>• Sexual health role</li> <li>• Sexual health training</li> <li>• Religious values</li> <li>• Parenting values</li> <li>• Workplace identity</li> <li>• Partnership working</li> <li>• Managerial support</li> <li>• Tension between beliefs and practice</li> </ul>

In addition to interpreting the data using the emic constructs of attachment and role theory, I explored whether being trained in sexual health and relationships affected perceptions of communication about sex and relationships within the care setting. The decision to look for differences in experiences associated with the provision of sexual health and relationships education improves the confidence of teachers to talk to young people about sex and relationships (Buston et al., 2002).

#### ***3.7.2.4 Presenting the data***

In the previous section I highlighted how the emic and etic can be used to present and interpret data. Given that there has been a recent focus within the NHS and social care services towards ensuring that the perceptions of service users are obtained and actively used to shape service provision this study will draw upon the emic view within chapters four and five to provide insight into the factors that influence and shape communications about sexual health and relationships within the care setting (Horsburgh, 2003). I will then move on in chapter seven to ground what the participants have said in terms of the wider empirical and theoretical literature.

### **3.8 Summary**

In this chapter I outlined the research questions and described the methods used to collect, analyse and interpret the qualitative data. In doing so I reflected upon the ethical issues that arose during the study, and the epistemological and ontological processes that contributed to generating and interpreting the research findings. I now move on to present what looked after young people and corporate parents told me about themselves, their communication about sexual health, and the factors they identify as promoting or restricting these discussions occurring.

## **Chapter 4: What shapes communication about sexual health and relationships within the care system?**

### **4.1 Introduction and aims**

The purpose of this chapter is to contribute to the understanding of the following research questions: what shapes communication about sexual health and relationships within the care system? The chapter is laid out as follows. It begins by discussing corporate parents' views on communicating about sexual health and relationships within the care setting, in particular focussing on the shift away from the belief that sex is a taboo topic that should not be discussed with young people towards the belief that communicating about sexual health and relationships should be a core part of the corporate parenting role. I then move on to explore whether attributes specifically relating to corporate parents, including gender, age and their role are thought to influence and shape sexual health and relationships discussions within the care system. The chapter concludes by exploring how young people's pre-care and care histories are perceived to shape sexual health and relationships communication; focussing in particular upon the perceived influence that pre-care and care histories have upon young people's understandings of relationships and their ability to trust and engage with other people.

### **4.2 Corporate parents' views on communicating about sexual health and relationships within the care setting**

In this section I present corporate parents' views on communicating about sexual health and relationships in the care setting.

#### **4.2.1 Sexual health should be part of the corporate parenting role**

Talking to young people in the care system about sexual health and relationships was identified by corporate parents, mainly residential carers and social

workers, as having previously been a “taboo” subject that was not discussed with young people. For example, Fiona (social worker, not trained in sexual health) stated that “in social services there has always been a lot of taboo discussing sexual health”. This was something that Jennifer (residential carer, trained in sexual health) echoed, recalling how she had been reprimanded in the past for taking a young woman to get the morning after pill:

“it was a few years ago... I was on holiday with a young person and I took her for the morning after pill and basically got my bum booted for that, you know, you shouldn’t have done that, it wasn’t your decision to take... fortunately we have progressed and we’ve moved on as a department”.

The progression that Jennifer alluded to was more widely spoken about in terms of there having been had been a significant culture change within social work services in the last few years that had resulted in it becoming acceptable to talk to young people within the care system about their sexual health. The change in attitudes was nicely contrasted by Patricia (foster care, not trained in sexual health) who recalled how sexual health had been this “big un-talkable thing... that wasn’t talked about” when she worked in residential care, but that attitudes within social work had progressed to reach the stage where talking to young people about sex was seen as part of their wider social development:

“children need to learn... and we need to stop making it this big thing that they need to find out about for themselves... our whole live revolves around sex and yet there’s so much made of it, it’s so taboo and it wasn’t talked about... and when I started working at the (residential) school I’m not sure I was that comfortable with that (talking about sex) but I’m hoping it’ll be better for them (children) today as it’s not the big ‘untalkable’ thing that it was before”.

The view that sex was not “the big un-talkable thing that it was before” was reflected in corporate parents’ views towards communicating about sexual health and relationships within the care setting. Two reasons were given for this. First, it was identified that by treating sex as if it was a taboo topic and something unspeakable corporate parents may be teaching young people that sex is something to be ashamed of and something that should be hidden. For example, Fiona (social worker, not trained in sexual health) said:

“I think if we make it taboo, where sexual health’s taboo, then the young person’s gonnae develop that way, thinking it’s taboo and something, d’you know what I mean, it’s no a dirty little secret, it’s a normal development, part of life”.

Similarly, Caroline (foster carer, not trained in sexual health) stated that she felt it was important to speak to her two foster sons about sex because:

“If it is a big, taboo subject, it becomes undercover. It becomes something that they experiment with that goes wrong and you know and they get all the wrong ideas about things”.

That corporate parents should deal with looked after young people’s sexual health issues was summarized by Morag (residential carer, trained in sexual health) who said:

“If that young person’s came and chapped ma door tae ask me a question, and it’s pretty personal about their relationships or their sexual health, then I shouldnae be saying to him, ‘och listen, I cannae help you. You need tae go and speak tae somebody else’. I’ll bring them in and I’ll talk tae them. If I’ve no got an answer for them or if it’s some specific agency, I’ll maybe say tae them, ‘we have got literature on that so just gie me a minute and we’ll go and get it and we’ll take five minutes and go through it’. I think that’s probably where we’ve got better whereas

before we'd maybe say, 'just go to [the sexual health clinic]' or whatever so I think that it's made us more aware o' how we dealt wi' it and how we're gonnae be dealing wi' it in the future".

That corporate parents shouldn't be turning away looked after young people's requests for information about sexual health and relationships was further evidenced in the fact that many of the corporate parents believed that sexual health should be seen as "a priority area" for practice, and should become "part and parcel" of the corporate parent role. For instance, Sarah (residential carer, trained in sexual health) argued that talking about sexual health and relationships with young people should "be part of our bread and butter", whilst Fiona (social worker, not trained in sexual health) stated that talking to young people about sexual health fell within the scope of the Getting It Right For Every Child framework and therefore shouldn't be ignored by workers:

"Getting it Right for Every Child focuses on a holistic perspective of assessment and intervention, and reviewing it as well, d'you know what I mean? Multi-agency working. So we would engage wi our, link in wi our link workers, but the GIRFEC model talks about a holistic perspective, so as corporate parents we need tae provide that holistic perspective - element, sorry - d'you know what I mean? And part of that is sexual health... we take on the whole role, and you cannae pick and choose".

The notion that talking about sex should be one of the responsibilities of a corporate parent was echoed by all of those interviewed, with the main sentiment expressed being that talking about sexual matters was something that a biological parent would be expected to do and therefore corporate parents should also be undertaking this role. For example, Fiona (social worker, not trained in sexual health) stated:

"as parents we're expected to do it, to discuss sexual health with a child... If it was one of our own children we would do it, so why not as corporate parents?"

This view was shared by both Jennifer and Dave (residential carers, trained in sexual health) who argued that talking to young people about their sexual health and relationships should be a part of the corporate parent role because “we would do it with our own kids”.

#### **4.2.2 Taking on the parenting role and filling in the gaps**

Many of the corporate parents interviewed felt that there was a necessity for corporate parents to talk to young people about sexual health and relationships. This was because it was widely believed that looked after young people were routinely excluded from both school- and home-based discussions about sexual health and relationships. Looking first at exclusion from school-based lessons on sexual health and relationships, many of the corporate parents (predominantly residential carers and social workers) highlighted that young people in the care system had a higher risk of being excluded from school-based health promotions as a result of truancy and school exclusion. For instance, Dorothy (social worker, not trained in sexual health) stated:

“nowadays there’s quite a focus on it [sexual health] in schools, in education on supporting children and educating them about all aspects of their health and how to keep themselves as well, and I think obviously a lot of kids, not all kids again, but a lot of kids we work with who are in care are school refusers or they don’t attend regularly or they dog off school and you know, that obviously means they are missing out on a lot of that traditional support”

Fiona (social worker, not trained in sexual health) agreed, stating that although she thought that although:

“schools were a good way ae getting the message across there is always that percentage of kids that are never at school, or have had really limited education, who dinnae learn”.

Similarly Alison (residential carer, trained in sexual health) stated that she felt that young people who missed out on their schooling would:

“maybe no have went through the kind of a sex education that’s started over the last couple of years... so they’ve probably missed a lot of that”.

Despite the view that looked after young people were at increased risk of being excluded from school-based sexual health and relationships education, 85% of the young people who were still looked after in local authority care stated that they had received sexual health and relationships lessons in school. It is worth noting, however, that a third of the care leavers reported that they had never received sexual health and relationships education whilst they were at school, with the main reasons cited for this being school truancy and school exclusion:

“I never got sex ed because I used to bunk off school all the time”

*(Catriona, 16, residential care)*

“if we weren’t at school we were drunk... I didn’t get any sex education”

*(Mike, 23, care leaver)*

Young people who were excluded from school-based sexual health and relationships education were viewed by corporate parents as having “very, very limited” sexual health knowledge. And, it was widely believed that this lack of knowledge was further compounded if young people were routinely excluded from discussions about sexual health and relationships within the home setting. For instance, Alison (residential carer, trained in sexual health) said that she felt that young people who became looked after:

“missed out on a lot of that [sexual health talk]... because you’ll probably find that there wisnae many discussions in the house about that [sex]”.

When asked why they thought young people were not receiving sexual health and relationships advice from their natural parents, the majority of the corporate parents stated that providing their children with sexual health advice would not be a priority for the birth parents of looked after young people. For instance, Laura (social worker, not trained) said:

“their parents wouldnae be the best person tae do it [talk to them about sex] as they wouldnae have the capability or the time or the kinda understanding tae really put forward that positive message. They’re focussed, I suppose, on the here and now and what needs done and meeting their basic needs as opposed tae trying to educate them on something else as well. So, I think there is, like, children that do fall through that crack, that never really find out and never really know and then it’s too late”.

That looked after young people are excluded from both home- and school-based sexual health and relationships education led to corporate parents identifying that they needed to become more proactive in discussing sexual health and relationships within the care setting. For instance, Claire (social worker, trained in sexual health) stated that there was a need for corporate parents to “fill the gap” because young people just:

“need someone that’s going to listen, someone that’s going to be there and not judge you. That’s the thing with young people. They need someone they can run things by, then they can get the support and advice. But the problem is young people in care miss out on all of that. Like they don’t get the education through school, through the normal route, and all that’s taken away and they don’t have someone, and we can be that someone”.

### 4.2.3 Who should talk to looked after young people about their sexual health?

Whilst corporate parents agreed that they should have the responsibility of talking to young people about sexual health and relationships there appeared to be some disagreement over who should be the main source of information and advice for young people in the care system. The majority of the corporate parents believed that residential and foster carers had the responsibility for talking to young people about their sexual health and relationships. For example, Mike (social worker, not trained in sexual health) agreed, stating:

“the best person to guide the young person in terms of their sexual development, sexual health, is the person that they trust, and that’s their carer. I think there may be a role for children who have good relationships with their social worker, in that there is a role there for a social worker to provide good support, advice and guidance to a young person”.

Although all of the social workers stated that they believed that communications about sexual health were best suited to residential and foster carers, it should be noted that half of the social workers interviewed stated that they were not only willing to talk to young people about sexual health matters but that they were already engaged in sexual health work with young people. For example, Laura and Mike (social workers, not trained in sexual health) both felt that social workers should be willing to talk to young people about sexual health and relationships, but that because this was something that was outwith their usual role, they should receive sexual health and relationships training to help facilitate this:

“if I was in that position, working with a young person who had a very trusting relationship with me, and who required support and guidance with their sexual health and development, then I would like to play a part in that... but I would like training as I see that as a gap in our development”.

Similar responses were given from the rest of the social workers who stated that they would be willing to talk to young people about their sexual health only they were reluctant to do so as they did not have the necessary training.

In addition to feeling that they lacked training, several of the social workers highlighted that their professional role could act as a barrier to their forming the close and trusting relationships that they believed were needed to provide young people with support and guidance about sexual health and relationships. For instance, Laura (social worker, not trained in sexual health) used her experiences of working as both a residential worker and a social worker to demonstrate that the individuals who care for looked after young people are often able to provide young people with advice and guidance that is better tailored to their circumstances:

“I think that, as a social worker, it’s a lot more difficult to assess if a relationship is inappropriate, and to really get to know that young person, because in residential you’re really, I mean, you really get to know the young people in terms of you see them for 24-hour periods, and you know a lot more about their life, and what’s happening on a daily basis. Whereas being a social worker, although you can have good communication with the school and health and the family, I think that there’s a lot more... there’s a lot more hidden, and I think it’s a lot more difficult to establish who is appropriate and who isn’t appropriate”.

In contrast, Laura felt that social workers, as a result of having limited time to spend time with young people, often found it more difficult to provide advice and guidance about relationships. The main reason given for this was that limited contacts with young people make it difficult to assess the appropriateness of relationships without relying upon information provided from a number of potentially conflicting sources:

“You’ve really got to use your knowledge, and your experience of that young person, or their family, on a first-hand basis, but then as well using

your other information fae other people that are working wi' them, and if it's through school or health or other family members, and sometimes you'd be getting information fae different sources that sorta forms your assessment as well"

Having to make rely upon multiple, and sometimes conflicting, sources of information was something that Laura felt made it harder for social workers to judge the appropriateness of young people's relationships:

"you've got to be quite careful ae that, because some people'll phone you up, and they'll say, "oh, this is happening wi' so-and-so," and it's a load ae nonsense, or ye dinnae know what's the truth, and somebody's got a grievance against somebody and they're just trying tae stir up trouble, and then, like, sometimes there is a lot ae truth in it as well, so... Or you maybe find out a month later that, actually, something did happen, and, like, the two-and-two go together then, and... so I think, like, it is more difficult tae establish what is an appropriate relationship and an inappropriate relationship"

Laura went on to state that she felt the only way for social workers to really understand what was going on in young people's lives was to:

"I think that... spend more time wi' the young people, and build up that relationship, it opens more doors to them speaking to you more directly about it, and being more honest wi' ye, and trusting about telling you that information".

Agnes (social worker, untrained) agreed with Laura about the difficulties that social workers faced in terms of being able to form close and trusting relationships with young people; stating that the main barrier to her being able to spend time with, and get to know, young people on her case load was not having enough time to do this. This lack of capacity was commonly cited as the

reason why social workers thought that their role should be to oversee and liaise with other agencies to provide young people with access to those services, and intensive supports if required. And, that residential and foster carers should take the lead on sexual health and relationships discussions because they were already known to the young person and had a relationship. I shall return to look at how the quality of the relationship that exists between corporate parent and looked after young person influences communication about sexual health and relationships in section 4.4, and in doing so will explore who looked after young people talk to about sexual health and relationships.

### **4.3 What factors relating to corporate parents shape communication about sexual health and relationships within the care setting?**

Given that it has been identified that corporate parents believe they should play an active role in talking to young people about sexual health and relationships, I will now move on to explore how characteristics of the corporate parent, including their age, gender and their attitudes and values towards sexual health and relationships, may shape communication about sexual health and relationships within the care setting.

#### **4.3.1 Corporate parents' gender**

Looking first at the gender of corporate parents it was widely perceived that the gender of corporate parents could shape communication about sexual health by acting as a potential barrier or facilitator of discussions. This was particularly true for residential care, with several of the residential carers acknowledging that a gender bias exists within the staffing of residential care units. For example, Alison (residential care, trained in sexual health) stating:

“there’s no a gender balance in residential... for every hundred applicants I can guarantee you about eight-four percent are females and there’s a small percentage of men”

The lack of male carers in residential settings was identified as a potential barrier to young men talking to their carers about sexual health and relationships. For example, Tricia (residential care, trained in sexual health) said that one of the things that worried her was that “if there wassnae a male on shift that the boys won’t come and talk to us about sex”. Similarly, Laura (social worker, not trained in sexual health) said:

“I dinnae really think boys really come and speak to ye as much as girls but then again they might be more likely tae speak tae like a male, like a male worker. Girls are more forthcoming in my experience about what they want tae know and they’re more likely tae come and ask in a group as opposed to just the one person”.

Agnes (social worker, not trained in sexual health) believed that this was because young men could find it “totally embarrassing” to talk to a female worker about their sexual health. Several of the young men interviewed agreed. For example, Darren (14, residential care), who had been having sex with older men for several years, said that he found it difficult to ask for help from members of the opposite sex, stating that he had been a number of times when he “had to push myself” to go and tell them that he was having “pains down below”. He went on to say that it could be really difficult because “there is not a lot of male staff to talk to” and sometimes he needs to see a doctor because of having “pain in [his] rear” and he finds it “really embarrassing” to ask the women. When asked why that was he told me that it was just more “comfortable” talking to the male staff because:

“they’ve probably experienced the same thing or they might have a better clue what’s going on... it’s because they’re the same sex really”.

This was something that several of the corporate parents felt should be acknowledged when talking to young people. For example, Fiona (social worker, not trained in sexual health) stated that she was currently working with a young man who had been sexually abused and that she had felt that before talking to

him about sexual health and relationships she needed to first find out whether he felt “comfortable talking to me because you’re a male and I’m a female”. Mark (residential care, trained in sexual health) agreed, but highlighted that comfort talking about sexual health to members of the opposite sex could also be seen in residential carers, in particular male workers, practice:

“I am fairly comfortable talking to a female about sexual health, but I know that I have got colleagues here in the unit who would not have those conversations with a female. They would be more comfortable having man to man conversations”.

On the whole, it was felt that female staff members do not feel embarrassed or uncomfortable when it comes to talking to young men about their sexual health. For example, Alison (residential care, trained in sexual health) said:

“the female staff arenae embarrassed tae talk about it wi’ the boys. We’ve got a young thirteen year old whose hormones are everywhere, going through puberty and they wouldnae have a problem with kind of a discussion about, well if there any areas of concerns, or how he was talking about a female or if he was talking about sex. They wouldnae have an issue going in and discussing that wi’ him”.

This was echoed by the female foster carers; however, those who were caring for boys revealed that they would often leave the sexual discussions with boys to their male partners. For instance, Caroline (foster carer, not trained in sexual health) said that although she “can talk to the boys about anything” her foster son Matthew (15, foster care) feels more comfortable talking to her husband about the things he experienced before coming into care, how they make him feel and what he feels towards other people:

“talks more about these things to my husband... my husband is absolutely brilliant at speaking to Matthew about these kind of things... like whether

you're interested in girls or boys... and Matthew listens to him even though he doesn't really like talking about it... and after he's had these chats you just see a different wee boy, he's all relaxed and easy, and things come easier for him".

Acknowledging that boys can benefit from talking to male carers was something that Tricia (residential care, trained in sexual health) highlighted using the example of teaching a young man to shave during puberty:

"that's not something I can do. So, if we have boys in placement that is going through puberty and I have a male worker, then I get him to come into work unshaven so that he can show the boys how to shave properly".

Whilst the majority of the corporate parents were concerned that gender acted as a barrier to young men receiving sexual health and relationships education, it was noted by a few of the residential carers that young women could also have problems approaching male carers about their sexual health. In particular, the difficulties young women might have with regards to talking to male workers about menstruation or asking for emergency supplies of sanitary towels or tampons were highlighted. Several of the young women interviewed agreed, stating that they had felt really uncomfortable talking about intimate problems such as menstruation and genital pain to staff members who were of the opposite sex. For example, Karen (17, care leaver) recalled how she had been living in a residential unit when she started her periods and:

"there was like four men on at the time and I was like 'oh man, I've got tae tell them' but I was like.... I didnae know what was happening tae me and they were like speaking tae me about how tae put a pad on and how tae put a tampon in and all that and I was like 'nae bother... they've obviously dealt wa lassies before', but I had tae really pluck up the courage tae ask them".

### 4.3.2 Corporate parents' age

In addition to corporate parent's gender acting as a potential barrier to sexual health communication being undertaken in the care setting, corporate parent's age was also identified as a potential barrier to such discussions being undertaken. For example, it was believed by several of the corporate parents that older workers were more likely to view talking about sexual health and relationships to be a taboo topic, and one that should not be spoken about with young people. Andy (residential carer, trained in sexual health) stated that:

“for the older staff group it is an issue that is very taboo for a lot of them. I just think they feel really uncomfortable having that discussion... it's an area that they would rather never ever have to talk about with young people”.

This was because many of these workers had grown up in an era where sexual health was not openly discussed. For instance, Margaret (foster carer, trained in sexual health) whose latest role was as a peripatetic foster carer stated that one of the foster carers that she worked with was seventy and “quite elderly” and had “never been used to talking to children about sex in any way” so had asked her if she would be willing to talk to the boy that she fostered because she felt unable to do so. That age could act as a barrier to talking about sex was also reflected upon by Laura (residential care, trained in sexual health) who felt that often there was a tendency for older carers to feel that it was inappropriate to talk to young people about sex because they themselves “had never been spoken to about sex”. This view was supported by young people who felt that not only could older workers be less willing to talk to young people about sexual health, but that the differences in their lived experiences as adolescents made them less understanding of the problems that young people faced today. For example, Nadia (23, care leaver) who felt that:

“generally the older workers are the ones that are very anti-talking about [sex] but it is possible that's because they live in their day and age. Things now are very different to sorta forty years ago, maybe even longer

when you were supposed to be married and it was the kinda done thing that you were married before you done anything. Now it's Friday night and people are out and [having sex] is their main aim".

Although Niamh (14) felt that her foster carer was really good at dealing with sexual health problems and had been willing to go to the local sexual health clinic to get condoms for her when she had been too embarrassed to go herself, she agreed with Nadia that her carer didn't really "understand that things have changed since she was younger", and that young people faced much more pressure from their peers about how they should look and behave. Niamh confided that because her carer didn't understand they frequently got into arguments about Niamh being "a ned"; something she had had to become when she was growing up in order to prove that she could "look efter herself".

Feeling that their corporate parents did not understand their point of view led to a third of the young people interviewed stating that they would prefer to speak to somebody their own age. This was discussed mainly in relation to adolescent romantic relationships and puberty, with the young people stating that talking to their siblings and peers was more appropriate because they had a better understanding of what young people were going through. For example, Tom (15, foster care) told me that if he was having a problem with his girlfriend he would talk to his "best mate" because "he's my age" and he "kinda has the same problems". Stephanie (14, foster care) agreed, and went on to describe how people "her age" were better to talk to than adults because they were better at handling things like relationship breakups. She told me that when she had recently split up with her boyfriend she had turned to her best friend for comfort because she was "able just to sit there with me while I just sat there and cried whereas my carer couldn't". She went on to state that whilst her friend had initially let her "sit... listening to this really depressing music going 'he's left me'" that by the end of the time she spent with her she was "laughing".

Being able to talk to other young people about problems was something that the young people found comforting. For example, Amy (16, residential care) described how her sister had reassured her that the changes in her body were normal when she had been upset:

“my pals were all like 'oh, I've got my period' and I actually I went in the house crying and everything and my sister and all my cousins back home asked me what's up and I was like nothing and everything so I never told her. And then I discovered that I had one breast bigger than the other and I just felt so abnormal and I showed my sister and she says 'naw, everybody's like that' and she said I'd grow out of it and I did”.

Similarly, Eddie (18, care leaver) told me that having people your own age to “bitch to” was quite helpful when you were having relationship problems because you don't want to “necessarily go and speak to somebody else about... having arguments and domestics” because it is “your business”.

Perceived differences in lived experiences was perhaps one reason why carers felt that young people in care would be more likely to seek out the support and guidance of younger workers when they wanted to ask questions about sexual health. Certainly, several of the corporate parents highlighted that young people could be dissuaded from talking to their carers if they felt that they were too old. For example, Margaret (foster care, trained in sexual health) stated that she had been told by a teenage boy that she was working with that he felt that his “carers were too old to talk about sex” and that “he felt he couldn't talk to them because they were in their fifties”. That young people were more likely to approach younger workers was a view supported by Laura (social worker, untrained), who had begun her career working in residential care, who felt that being “a younger female” had made her more approachable to “the young people she had worked with in residential settings” who were:

“more likely to come and ask [her] and feel quite comfortable about [asking] something like that then they would be [asking] one o’ the older members ae staff”.

In addition to the feeling that young people would be more comfortable talking about sex with younger workers, there was also a feeling amongst older workers that newly qualified workers were much more knowledgeable about sexual health than they were. Laura (residential carer, trained in sexual health) reflected that “the older” workers “are more out of date”, whilst younger workers are the more “relaxed” in their knowledge of sexual health. One reason that was suggested for older workers being less comfortable talking to young people about sexual health was that, unlike younger workers, they had not received sexual health education when they were younger. This meant that carers often felt that they did not know the language and terminology they should be using when talking about sex. Margaret (foster care, trained in sexual health) felt that it was difficult to know the words and phrases that young people used to describe sex and sexual acts. She stated that being fifty-five she just “doesn’t know” the “words that [young people] use” and because of that it is difficult to know what the boy she is working with “hears round about him”. She went on to reflect that when she had attended the sexual health training session organised by the social work department that there had been phrases used like “tonsil tennis” and “jumped her bones” which she had never heard before. She went on to state that she honestly thought that having your bones jumped meant “being mugged or something like that”.

Jean and Ian (foster carers, trained in sexual health) commented that it wasn’t just the language that older carers did not know about it was also the range and availability of contraceptives and the different types of “diseases of the flesh” that young people were to be educated about. They spoke about how they had attended the sexual health training session offered by the council and had been really surprised at the range of contraceptive choices available to young people, including the female condom which Jean “never knew” existed. Margaret (foster carer, trained in sexual health) also spoke of this, stating that she had found the training very “educational” and that “there were some forms of contraception

that [she'd] never seen or heard of". Similarly Ian reflected that whilst he "knew about gonorrhoea" he "didn't know about Chlamydia" and the training had provided him with an opportunity to become more knowledgeable.

In addition to not feeling secure in their own knowledge, Laura (residential carer, trained in sexual health) felt that some of the older workers might not feel comfortable using the correct names for parts of the body or the correct terms for things to do with sex, relying instead on euphemisms and metaphors in their discussions with young people. As an example of this she told me about a worker she had worked with recently who had been "quite a bit older" and "nearing retirement age" and how she "talked about your flower" and how "if you needed anything sorted you would go to the flower shop". Using euphemisms was something that she didn't think was very helpful when talking to young people about sexual health clinics as some young people can take comments made by their carers very literally. As such she believed it was best to use the correct terminology:

"so that everyone is quite clear what is meant because she could have some people thinking 'oh right, I need to go buy some flowers'".

In addition to believing that some carers didn't understand what young people were going through, several of the young people felt that corporate parents not having specialist sexual health training acted as a barrier to them being spoken to about sexual health and relationships. For example, both Alan (18, care leaver) and Eve (16, care leaver) told me that they felt that young people in care would be better speaking to LAC nurses about sexual health because "they knew about the birds and the bees", "they knew mair than the staff" and they had: "got actual qualifications under their belts so they knew whit they were daeing and how tae deal wi' weans".

In addition to seeing LAC nurses as knowledgeable, Alan felt that because they were "professionals" it was easier for young people to listen to them and take their advice on board. He went on to tell me that he felt that if "you don't hae a

proper professional talking to weans [about sex] then they're no gonnae get very far". The view that LAC nurses were professional was shared by all of the young people. When asked what this meant, the young people stated that it meant that they were willing to listen to what they had to say, allowed young people to speak to them at their own pace and treated what they shared as confidential. Eve (16, care leaver) highlighted that going to the LAC nurse was "just like going tae see a doctor" and that you could talk to them "if you had any problems or anyhin' you were concerned about". Tim (16, foster care) and Darren (14, residential care) felt that the fact that LAC nurses were like doctors made it "easier" to talk to them because you knew that when: "they would come in and talk about sex wi' ye that they would keep [what you told] them to their sel'", that it would be "confidential" and that if anything needed to happen as a result of talking to the nurse she would "deal with it for you herself". In addition, LAC nurses were commonly described as being "nice" and "pleasant". For example, Darren (14) was one of the young people thought that his LAC nurse was "nice" because when you're talking to her "she doesn't really push things" if you don't want to talk to her about them. Sophie (17, residential care) said that this made LAC nurses "just dead easy to talk to" because they "gie [you] the time to talk" and make it really easy to "tell the truth". Similar opinions were expressed about discussing sexual health and relationships with GPs and sexual health nurses.

Just as young people were hesitant to talk to their corporate parents when they perceived that they lacked sexual health knowledge, in the previous section it was demonstrated that corporate parents identified their own lack of knowledge about sexual health as a barrier to talking to young people about sex. Being offered training and support in relation to talking to young people about sexual health was seen as one of the main ways in which carers' knowledge about and confidence in discussing sex could be improved. Amongst those residential and foster carers who had received sexual health training there was a general feeling that although they still found it "embarrassing" to talk to young people about sex that being trained had made them feel more confident in their own knowledge. For example, Jean (foster carer, trained in sexual health) told me that her husband Ian was "not really one for being quite open about anything to

do with sexual stuff. I think he just finds it embarrassing”. When I asked Ian if that was the case he nodded, whilst Jean contributed that he must find it embarrassing because his “face goes red”. Despite Ian’s embarrassment around discussing sexual health he reflected that having received sexual health training had helped his confidence and he proudly stated that even though he had been embarrassed at the time the training had given him the confidence to “stand up and talk about a female condom” to a room full of people.

Having increased confidence in their ability to talk to young people about sexual health was reflected in how carers compared their experiences of discussing sexual health with young people both before and after being trained. Margaret (foster carer, trained in sexual health) stated that before she had received sexual health training she used to think:

“Oh God, what if they ask me this or ask me that? I know, I’ll make a joke of it. I’ll tell them but I’ll make it funny... to cover my embarrassment and to cover his embarrassment”.

Whilst she acknowledged that prior to being trained she would still be “telling the facts” she felt that her own lack of confidence made it much easier for her to make talking about sex “a laugh”. She went on to reflect that since she had attended the sexual health training she can still “have a laugh” with young people if either she or they “says something silly” but that she now has “the confidence to say, no, wait a minute, that’s not really what’s happening” and is then able to “tell them exactly what’s happening or show them a passage in a booklet”. Laura (residential carer, trained in sexual health) also commented that since she had attended the training she had made an effort not to make a joke out of sexual health topics in case it made the young people she was talking to feel as though sexual health was something that she didn’t take seriously. She went on to state that one of the main messages she had taken away from the training was that:

“the most important thing for them to know is that there are people that they can talk to and people that they can ask that aren’t going to get embarrassed”.

In addition to providing carers with the confidence to overcome their embarrassment, having attended sexual health training was seen as improving carers’ confidence to tell young people that they “didn’t know” the answer to a question. Ian (foster care, trained in sexual health) told me that whereas previously he would probably have told the young person to “go ask Jean” when he didn’t know how to answer a question he would now be more likely to tell the young person that he didn’t know but that there is “a phone number that I can phone” and we can ask for information and advice. Alison supported this view, stating that the training had given her workers “the tools” they needed “tae go in there and have discussions wi’ young people”. From the perspectives of carers, those tools largely referred to their increased knowledge of the resources that they could use to help them talk to young people. I shall return to discuss how corporate parents talk to young people about sexual health and relationships in section 5.4.

#### **4.3.3 Tensions between parenting, personal and professional identity**

In the previous section it was identified that the gender and the age of corporate parents can both shape sexual health and relationships communication through lack of knowledge and embarrassment. Furthermore, it was demonstrated that not only did young people often display gendered preferences for who they spoke to about their sexual health, but they also to some degree preferred to speak to younger workers as they were seen as being more knowledgeable and in-touch. I now move on to discuss whether the construction of professional, and personal values and identities shapes communication about sexual health and relationships; drawing in particular upon the effect that religious and parenting views have upon communication about sexual health and relationships within the care setting.

#### ***4.3.3.1 Tensions between professional and parenting identities***

In section 4.2.3 it was identified that there was some disagreement as to which corporate parents should be responsible for talking to young people about sexual health and relationships. From this it was seen that there was some reluctance on the part of social workers to undertake direct communication with young people about sexual health and relationships. One reason that was cited for this reluctance was the need to delineate between the roles of the parent and the professional, with social workers, and to some degree residential workers, viewing their role as being to oversee and orchestrate access to sexual health services for young people based upon their needs and the role of foster carers and key workers being to engage in in-depth discussions with young people about their sexual health and relationships. For instance, Sandra (residential care, trained in sexual health) stated that when it came to choosing who to undertake a piece of sexual health and relationships work with a young person it was important to “take it back to staff using their relationships with young people” and “matching in with key workers and who is best to do specific pieces of work with individuals”.

Similar views were expressed with regards to the existence of specialist sexual health services, with many of the residential and foster carers stating that they felt it was more appropriate to let individuals who had received specialised training take the lead on talking to young people about sexual health and relationships. For instance, Joanne (residential care, trained in sexual health) discussed this using the example of a 12 year old girl who was demonstrating sexualised behaviours towards older men; had been emailed and texted sexually explicit photos by older men; and was suspected of being in a sexual relationship with a 14 year old boy living in the same children’s unit:

“if we think they are highly vulnerable then we get involved with the young women's project who do particular pieces of work with them. The 12 year old I was telling you about, we think she may have been abused, but we don't know, she's never disclosed that. The project worker is covering a lot of that groundwork with her and sexual health would be included in that. We've had reports in from them, and I know that they

are doing, that most of their work with her is concentrated on that, so what we kind of tend to do is we back off a bit and let one person, one person do that work and someone else does the work about keeping herself safe and making safer choices on the PC... but they would be doing the kind of specific work on the sexual health and keeping herself safe. I mean obviously we would pick it up once the young woman's project backs out but that's what they are doing with her right now".

Similarly, Fiona (social worker, not trained in sexual health) stated that she was currently working with a young man who had been sexually abused and had gone on to sexually abuse another boy in placement. To address his sexual health needs required using specialist services:

"the young person I'm working with, his needs are quite different so we've got [a specialist service] involved coz there's problematic sexualised behaviour... and they do this life path thing, which is brilliant. It's a very simple, pictorial thing that they do, and they talk about where the child was at then, where the child is at now, and the two paths that they could go on, and one's, although it's no said tae them, the right path and the other the negative behaviour path... and he's working them to learn and reflect on that, and it's reassuring him and reinforcing to him that even though that [the abuse/abusing] happened, that doesnae mean that you cannae go on to develop positive sexual relationships".

Where corporate parents were using specialist services to address the sexual health needs of looked after young people they identified that it was important to ensure that they worked together to "get the balance right" between what the specialist workers were talking to the young person about and what they as workers were talking about. In all of these cases it was felt that if specialist sexual health work was being undertaken, it became the responsibility of carers to focus upon working upon young people's self esteem, building up their confidence and talking to them about relationships.

There was some evidence that parents who were employed in a professional role but were then asked to adopt a corporate parenting role found it difficult to reconcile their dual roles of parent and corporate parent. This was because, although the social workers and carers interviewed recognised that their role as a corporate parent was to “act like a parent” it was also recognised that both social work policy and the behaviours of children in the care system meant that tensions existed between their views on how young people should be parented and how they were parented. For instance, one of the foster carers revealed that his views on appropriate parenting behaviour differed from that of the social worker in charge of one of the young men he was looking after. Ian (foster care, trained) recalled how he had been spoken to by the social worker of one of the children he was caring for because he thought that he was “too informal” in his interactions with the young people in placement. This informality included laughing, joking and teasing the young people he cared for in the same way that he “would laugh and joke with [his] own kids”. He went on to give an example of this from a conversation he’d recently had with a social worker:

“I remember saying to one social worker who came in, as he said he was a bit late and the child hadn’t had his tea yes, and I said ‘what, do you expect us to feed him?’ It was just a joke. It didn’t go down well. ‘Yes I do expect that’ he said and I was like ‘it’s alright, I’m only kidding’. You know, the poor guy just didn’t know us. I mean we’ve got one wee boy that goes on contact every fortnight and the deal is that if he has something to eat out then that is fine, but if he doesn’t there’s food here for him. End of story, but that guy took that so seriously”.

Ian appeared visibly upset when he went on to say:

“you’ve now got to the point where you’re having to think what you’re saying because it seems you can’t joke about anything... and it’s taken the niceness away, you know, the niceness of just being normal and doing the stuff you would do with your own kids. I mean we’re not idiots. We

know what they're worried about, but if they just let us live a wee bit, things would bounce along a lot better".

Later in his interview Ian apologised, and explained that he found it quite difficult as a foster carer to accept criticism of his parenting style from a newly qualified social worker who had no children when he had raised three children, and had been successfully fostering children for over twenty years.

Caroline (foster care, untrained) expressed similar feelings about social work policies designed to make the running of the "family home" run more smoothly, including the provision of taxis for young people travelling to and from school. Using taxis was something that she felt acted as a barrier to her being able to foster a sense of security in her foster son, Michael. She told me that she had refused the use of the taxis because:

"when Michael first came to live with me, school was far away so we had an hour's drive, in the morning, to take him to school, and I refused to use taxi services for children. I just absolutely refuse. If I can't take them to school, they need to be put in and collected from school from - it's part of their security, you know? I remember, myself, as a child, if your mum wasn't standing waiting at the school gate - so it's just small things like that that I put into, so I insisted on taking him to school myself, dropping him off at school and then going back and picking him up - which was horrendous in my day, but we got there. We moved his school after a while, as well, once we knew he was gonna be here permanently. We moved him school, and I think these kind of things were very important to Michael's security because he had been removed by the police from home. It was, you know, they kind of raided the house early one morning and took all the children away, and he remembers the trauma of this".

Several of the corporate parents stressed that they found it quite difficult to provide sexual health and relationships education to young people who had been sexually abused and then went on to demonstrate sexually abusive behaviours

towards other children and young people. This was because a tension existed within their recognition that the young person sexual health advice to was both a victim and a perpetrator. For example, Alison (residential care, trained in sexual health) discussed having a young man in placement that had been referred to the procurator fiscal for the suspected rape and sexual assault of a toddler. She told me:

“you’ve got tae kind of no look at that young person as a predator. You look at him as the victim because we don’t know what’s went on in that family home... the three year old had syphilis but it was only when she went intae hospital, because she’d been seriously no well, that they knew that’s whit it was, and thankfully they caught it in time because she’d had it like for eighteen months right. So then it was testing the whole family and two came up positive... the young person was then questioned and he admitted it, but he was the scapegoat you know? The sacrificial lamb”.

Alison went on to describe the difficulties that she had reconciling the need to protect and care for this young person with the need to protect the rest of the young people in placement:

“there’s that whole element there that you need tae keep at the back of your mind... because you’ve got tae look at the medical evidence which tells us he had syphilis after the three year old right, so he wisnae the first person, d’you know what I mean? So it’s a whole complex case that you have tae work wi’ and you have tae protect him but no tae be judgemental but you also have tae be dead aware cos you cannae let him run about just down the road because there’s a wee nursery doon the road. I cannae just let him go tae swimming, so there’s a whole protection risk assessment to do... but the Procurator Fiscal looked at his case and says ‘no, this young person has been as much of a victim... but you still cannae take your mind off the possibility o’ him being a possible predator”.

I shall return to discuss how corporate parents use monitoring and supervision to mediate the behaviours of young people who have problematic sexual behaviours in chapter five.

#### ***4.3.3.2 Tensions between professional and religious identity***

Moving beyond the tensions that existed between corporate parenting and parenting identity, it was also clear from the interviews conducted with the corporate parents that religion and faith often shaped corporate parents' ability to talk to young people about sexual health and relationship was discussed by several of the corporate parents, including Sarah (residential care, trained in sexual health) who reflected that she found the difference between what carers were supposed to be able to talk to young people about and her own familial and religious upbringing "challenging". She told me that sometimes she "really struggled" with separating out the things that she would feel comfortable discussing with her own children and being expected within her role to be able to discuss sexual feelings, masturbation, contraception and sex with young people. She told me that the way in which she learnt about sexual health when she was younger had influenced the way in which she as a parent talked to her own children, reflecting that:

"I know this sounds as if it's so traditional and old fashioned, but I was never brought up with all this input of you can go get the pill here, you can go get the jag here and here's what all that's about in such graphic detail. I was brought up with, you know there's something there and then when you asked a questions and your mum's face went red and they tellt you a wee bit about it"

Maria (foster carer, trained in sexual health) agreed, stating that because she had a "very strict Catholic upbringing" she found it difficult to talk to young people about being sexually active because when she was growing up "it was very, very strict and you didn't do anything until you were married". This resulted in her finding it hard to discuss sex:

“I’ve been known to say, if you love the person it’s very enjoyable, but I wouldn’t go into... well, you know”.

Being raised in a Catholic household affected how the women chose to parent their own children, with Sarah (residential care, trained in sexual health) stating that although she had been very comfortable talking to her children about “the birds and the bees” she viewed them as “naïve and innocent” young people who had “never had to know about jags and contraceptives and teenage pregnancies”. These were things that she had “never tellt her lassies” about and things that she “wouldnae tell” her children about because she felt that they had a right “not to lose their childhood”.

For three of the foster carers, being raised in a Catholic household facilitated the discussions that they had with their own children and foster children about puberty and reproductive health. This was because they had never been spoken to about these issues by their parents, and had only found out about periods when they started or how babies were born when they came to have their own children. For example, Patricia (foster carer, trained in sexual health) said:

“I was brought up in a Catholic family where it wasn’t talked about, and nothing was talked about and I wasn’t even told about periods. I was told about nothing. I went to college at sixteen and was sitting in a classroom doing childcare at college at sixteen, and I’m sitting in a class and I’m looking at this film on childbirth and I see where a baby’s born from. I thought that they untied your tummy button, took it out, tied it up again and stuck it back in and I’m finding out where this baby comes from. Now I did bring my children up... I brought them up from an early age, from when they were wee tots, I would get them to go and get my sanitary towels and whatever and I would tell them what it was”.

Similarly, Maria (foster carer, trained in sexual health) said that:

“we got told nothing, absolutely nothing to the stage where the first time I took a period I thought I was dying. And then when I had my first baby I didn’t have a clue what was happening or what was going to happen to me so I always thought that if I had children of my own I would prepare them, which I did hopefully”.

Despite talking to their own children about sexual health, the four women who had been raised Catholic reported finding it difficult talking to young people in the care system about sexual health. When I asked Sarah (residential care, trained in sexual health) about the conflict between her views on sex, and the expectation that corporate parents should talk to looked after young people about sexual health and relationships, she told me that having received sexual health training had helped her as it had provided her with an opportunity to question her values and to do “a lot of self reflection” about her role and responsibilities as a worker. She told me that during the training she had told the trainer that she didn’t feel comfortable with the idea of talking about sex with her own children and that they should be learning about those things in school and was gently reminded that looked after young people “are getting what her kids are getting” in terms of school based sex education. She reflected how this statement had left her thinking about how the children that she works with come from different backgrounds to her own children, had often been exploited and had very different experiences and expectations of relationships than her own children have.

Although the other women talked about their sexual health training experiences in terms of making them feel more comfortable talking to young people about sex, Sarah said that she thought that she would never be fully comfortable talking about sex with young people, but because she takes her role as a carer “really really seriously” she had had to accept that there will always be a difference between what she believes and what she discusses with young people in practice:

“it has took me an awful long time tae do all my challenging in myself and being on these courses and asking and prying about how does that fit with my psyche to sit here and talk about things that I ordinarily would not talk about outside of [the unit]... I think I’ve managed that quite well and... I’m not in conflict with myself about what I should be doing in my role”.

She went on to highlight that children in care “need people that they can turn to” and even if she still wonders whether discussing sexual health with young people borders on being “exploitative” and feels that there is no “difference between me talking to a wean and showing a wean explicit pictures under the guise of education and showing them a dirty picture in a magazine” that there is a genuine need for her as a carer to be the person who talks to them about these issues.

Whilst Sarah was able to reconcile her views on religion and talking to young people about their sexual health needs, Jennifer (residential care, trained in sexual health) recalled how she had been placed in a situation where the religious beliefs of a fellow residential carer had acted as a barrier to them addressing the sexual health needs of a young woman. She recalled an instance where a worker that she had line-managed had really struggled with the fact that one of the girls in the unit that she had a close relationship with had approached her and confided that she was pregnant and wanted her advice about terminating the pregnancy. The worker was Catholic, and she recalled the worker had come to her to ask her if she could talk to the young person because she didn’t agree with abortion and was having a hard time reconciling her own beliefs towards pregnancy and abortion with the need to support and provide advice to the young person.

When asked how she had handled that situation as a manager, Jennifer told me that she had felt it was extremely important for the worker to continue to be present at any discussions that were had with the young person because she had been the person the girl chose to approach. Although Jennifer recognised that she was asking a lot of the worker in terms of potentially supporting a young

person through a termination of pregnancy, she felt that the worker had been approached by the girl because “she could be trusted” and that by allowing her to excuse herself from supporting the young person might damage that trust. She went on to state that in cases like this it is really important that managers be available to workers to help and support them in talking about difficult issues. In this case, Jennifer told me that she had worked with the worker to explain to the girl what her options were, what each of those options would involve and to accompany the girl to the sexual health clinic. Throughout that process she felt that it had been her job as a manager to gently remind the worker that they had to “keep the child’s view at the centre of any decisions that were made” regardless of how they themselves may feel about those decisions.

Jennifer (residential care, trained in sexual health) also felt that the role of managers was important in supporting staff members to overcome any difficulties they were having in reconciling their values and experiences with what was expected of them in their role. Where workers felt “uncomfortable” talking to young people about sex she felt it was important “not to force” staff members to have those discussions but instead to focus on ensuring that they didn’t “react with shock and horror” when faced with questions about sex. As with older workers, Jennifer felt that it was very important that staff received sexual health training in order to prepare them for the possibility of being asked questions about sex and to allow them to learn methods of positively responding to young people rather than stating “I’m not talking to you about that!” and leaving young people in the position of feeling that they couldn’t open up to and ask questions to staff members. This view was supported by Laura (residential care, trained in sexual health) who felt that one of the advantages of residential workers now being trained in sexual health was that it allowed them to learn to talk to young people “from a knowledge base and not from [the] value base that [they] are trying to project” in their daily lives. I shall return to discussing how the transmission of values occurs within the care setting in chapter five; in particular, focussing upon how corporate parents’ views on sexual behaviour are communicated and what role if any, the communication of religious and tradition values have upon young people’s engagement with discussions about sexual health and relationships.

## **4.4 How do young people’s pre-care and care experiences shape communication about sexual health and relationships?**

Having demonstrated that gender, age and professional and parenting identities of corporate parents can influence communication about sexual health and relationships within the care setting I now move on to explore whether the pre-care and care histories of young people shape communications about sexual health and relationships. In doing so I examine how young people’s understandings of sexual health and relationships are shaped by their pre-care and care experiences.

### **4.4.1 How do pre-care experiences shape young people’s understanding of sexual health and relationships?**

In chapter one it was demonstrated that young people entering the care system are often raised in households characterised by social exclusion, poverty, mental health difficulties, drug and alcohol misuse, domestic violence and child maltreatment. All of the corporate parents that were interviewed identified that young people who were raised in households where these problems were present were likely to have experienced significant levels of instability prior to being admitted to care. For example, Jennifer (residential carer, trained in sexual health) stated that she thought a lot of the young people that they work with:

“have been passed from pillar to post.... because the relationships wae the adults that have been taking care of them – whether that’s been grannies, grandas, mums, dads, aunts and uncles – is sometimes no very positive”.

The lack of stability that young people could experience prior to entering the care system was identified by all of the corporate parents as having an adverse effect upon young people’s ability to form secure, trusting relationships with other people. For instance, Sandra (residential carer, trained in sexual health) stated that she felt that:

“with young people coming from some of these backgrounds there’s huge attachment issues, huge nurturing issues, and this idea that, you know, you can just form relationships in an easy way isn’t really the kind of norm because consistency and nurturing are really important elements of building up trusting relationships”.

As to how a lack of stability in the birth family affects young people’s relationship development, many of the corporate parents utilised attachment theory to demonstrate that being exposed to trauma during childhood adversely affected the developing bond between parent(s) and child. For instance Karen (social worker, not trained in sexual health) stated:

“the risk taking behaviour we see and the you know, just lack of, they just don’t care about what happens to them, don’t look to the future, don’t see a future you know, and it can be...it’s the effects of early trauma, the effects of whatever they’ve been through, that rejection, poor attachments is I mean, it’s just all-encompassing I think you know, just all these behaviours we see and it all boils back down to that you know, lack of a stable you know, secure base with parents or with a parent and a carer at home”.

Fiona (social worker, not trained in sexual health) agreed with this assessment, stating that:

“what I’ve found is that young people who’ve been at home in scenarios where they’ve experienced really neglectful or abusive situations...children that have been at home more, or for longer periods in these situations, tend to have the more problematic difficulties in terms of their attachment and their ability to function and develop appropriate relationships”.

Two thirds of the corporate parents interviewed agreed with this sentiment, stating that they thought that many of the young people they cared for believed that being treated or treating others with violence was a normal facet of human interaction, and that this in turn affected how they interacted with other people. Looking first at being treated with violence, Jean (foster carer, trained in sexual health) stated that she had cared for a number of young people over the years that had witnessed domestic violence within the home and expected that their carers would “call them names” and physically “hurt them” because they thought that violence was a normal form of interaction within relationships. She went on to recall how one young boy had expected to be hurt when he misbehaved because his father: “used to lift him up and bang him against the wall” when he did something wrong:

“when he first came to us he would get so angry he would say ‘go on, hit me. Hit me! Throw me against the wall! Throw me against the wall! Throw me up the stairs! Throw me down the stairs!’”

This was because his experiences had led him to believe that physical violence was a normal facet of relationships; something that Jean and her husband had had to spend a lot of time trying to redress by “sitting him down and explaining that that won’t happen here because hurting people isn’t nice”. She went on to state that it had taken a lot of “time and patience” for her and her husband “to build up his trust” and “get him to believe that he was safe” and “wouldn’t be hurt here”.

In addition to believing that young people who had been exposed to domestic violence were more likely to expect to be treated with violence, corporate parents also stated that young people who had witnessed violence were also described as being more likely to get into regular fights, react hostilely to other people and to use physical violence within their relationships. For example, Sarah (residential carer, trained in sexual health) described how she was currently caring for a 16-year old woman who, in addition to being exposed to drug use and domestic violence within the household, had witnessed a family

member being murdered. Amanda was described as being extremely defensive and hostile towards other people, with Sarah commenting that she would practically “growl” at people if they “looked at her the wrong way”. Sarah told me that she thought being exposed to violence within the household had made Amanda “very mistrusting of others” and that because of this she often reacted with suspicion and hostility to other people’s social cues. This in turn resulted in her “regularly getting into fights” with other young people, and “getting battered a lot”.

Fiona (social worker, not trained in sexual health) and Sandra (residential carer, trained in sexual health) both highlighted that it was important to remember that young people who are displaying violent and aggressive behaviours within the care system are enacting “learned behaviour”. For instance, several of the residential and foster carers highlighted that they thought that young people got into fights because they believed that “hurting” people was how arguments and differences between people were resolved; a message that had been learned through watching their parents use violence to resolve conflicts. For example, Chris (social worker, not trained in sexual health) discussed how he was currently supervising a 13 year old boy who had grown up in a household where there was violence, and dad carried a knife and had previously been to prison for racially-motivated assault. This was something that he felt had a negative effect on the young person’s understandings of relationships, leading to him to believe that violence was normal. Chris stated that the young man had started adopting his father’s views on race, and was recently discovered “carrying a knife” in the community.

Stories such as these were repeated by the majority of the residential carers, with Joanne, Laura and Sarah (residential carers, all trained in sexual health) highlighting that witnessing domestic violence, and “watching their mothers being battered” had resulted in some of the young men they cared for believing that “hitting women is normal”, that “it happens everywhere” and that “it is very appropriate to be hitting girls”. For instance, Sarah (residential carer, trained in sexual health) said: “they have seen domestic violence at home and they think that that is how you sort things out and that’s, that’s just how things

are". In addition, a few of the corporate parents highlighted that they felt that witnessing violence had resulted in young people not learning to regulate their emotions, with Laura (residential carer, trained in sexual health) stating that many of the young people that she had worked with who had witnessed domestic violence often had "poor impulse control". This resulted in them struggling to maintain relationships because they had a tendency to "hit out first and think about it later". Several of the young people agreed with this, stating that they had a tendency to react with anger and violence when stressed. For example, Alan (18, care leaver) who had grown up with an alcohol-dependant and violent father stated that:

"I just, like, I would always get in fights, man, and get in trouble aw the time. I'd take stuff the wrang way and stuff like that, man. I mean, I was a guid fitba player and stuff, and folk used to gie me heavy stick about being a fitba player and stuff like that, and they used to criticise me - no in a bad way, but they said, 'you know, you can dae this better, or you could dae that a bit better', and I used to crack up man, and say 'I'm fine the way I am' and stuff like that. So I struggled to take guidance an aw".

It was highlighted that reacting with violence often led to young people becoming excluded by their peers. This could happen in two ways. First, Caroline (foster carer, not trained in sexual health) and Danny (foster carer, trained) both discussed how they were caring for young people who were "aggressive", "loud" and "in your face"; behaviours which had led them to be excluded from their wider peer group because other young people found their behaviours to be "frightening". None of the young people interviewed discussed having no friends as a result of having violent behaviours. Second, several of the corporate parents felt that witnessing violence also affected how young people communicated with others. For instance, both Alison (residential carer, trained in sexual health) and Laura (social worker, not trained in sexual health) stated that young people who had witnessed domestic violence "dinnae know how to sit and talk" to other young people, and "do not learn how to discuss and argue in a more appropriate way". Alison went on to use the example of a 14 year old girl that she was currently looking after to demonstrate how lack of exposure to

domestic violence had affected her ability to communicate with other young people:

“she has no relationships wi’ anybody... she’s unable to form relationships. Whit she does is ‘buys’ people and relationships. Say for talking sake I bought new pens, she would come in and get two pens aff of me and she would go intae school and give two people they pens. She would try tae win them over that way because she doesnae know how tae sit and talk and build up relationships”.

When asked why this was she stated that she thought it was because the young woman had been provided with neither age-appropriate social interactions nor positive relationships that they can use to model their own behaviours on:

“I think because she’s never been allowed to be a child. Her mum and dad were both in care, and they had her when she was, when they were very young. Their relationship wisnae very positive; there was a lot of domestic abuse and her dad left her mum when she was about two. From then on she was never, never a child; she was mum’s companion. So she was probably around too much adult conversation; too much adult discussion”.

Being exposed to adult emotions and adult conversations was identified as adversely affecting young people’s development. This was considered to be particularly true when young people were identified as having been exposed to inappropriate, abusive and sexually exploitative behaviours during childhood. For example, Alison (Residential carer, trained in sexual health) said that:

“in care you’ve got a mixture of young people who’ve obviously been exposed to a whole range of different things, some of which have been very inappropriate sexual exposure... whether that be early exposure to pornography, or you know, parents who can be prostituting in the same house as children, parents who have perhaps, prostituted their children.

So it's about unpicking some of those things, and obviously the damage and distortion that that can cause, in terms of the pattern of development and the pattern of growth”.

Corporate parents broadly believed that young people's sexual development was affected by abuse in one of two ways. First, it was suggested that abuse and perceived parental abandonment could affect young people's feelings of self-esteem and self-worth; resulting in young people using relationships as a means of fulfilling a “need to feel loved”. Second, it was suggested that early and continued exposure to sexualised behaviour could result in young people either becoming sexually withdrawn or becoming over-familiar, and developing hyper-sexualised, inappropriate and problematic sexual behaviours or becoming switched off to sexual activity all together. Looking first at how abuse histories could result in young people sexual relationships as a replacement for love, Dorothy (social worker, not trained in sexual health) said:

“their experiences are quite awful and impact upon their ability to form relationships, and a lot of the young people don't have much self-regard or self-esteem, so you know, they don't consider themselves worthy of having what other young people have... they don't feel that they deserve to have that kind of nice, loving relationship so they will go do things, put themselves at risk because they don't feel that they are worth anything”.

As an example of the effect that low self-esteem and low confidence can have upon young people's sexuality, Wendy (residential carer, trained in sexual health) described a young woman that she had in placement who had bedded herself in, was refusing to go to school and was showing signs of being depressed. This was something that Dorothy thought had:

“huge implications, because you've got young people out there looking for whatever. We've got the young girl that I was talking about, in the dressing gown, she has very poor self-image, very poor self-esteem. She would avoid any sexual situation, and she would avoid, she would find it

disgusting. So her relationship with her sexuality and her sexual, you know, development is as damaged, in a sense, as the girl who's out there and exposing herself to all sorts of sexual dangers with sexually inappropriate behaviour and attaching herself to individuals who are behaving in a sexually inappropriate way towards her, and towards everybody. So I think, you know, we work with all levels of kind of sexual health, and clearly attachment has a huge issue, there. Sexual relationships will be a huge issue there, with the low self-esteem and the low self-confidence”.

The emphasis that Wendy placed upon the young woman's sexuality and understanding of sexual dangers leads on to the second point made by corporate parents; that early and continued exposure to sexualised behaviour can result in young people either becoming sexually withdrawn or becoming overly familiar, and developing inappropriate and problematic sexual behaviours. For instance, many of the corporate parents discussed how being sexually abused could result in young people becoming afraid of behaviours that would be considered normal within the context of a loving relationship. Marion (social worker, not trained in sexual health) and Dave (residential carer, trained in sexual health) told me that for many children who had been sexually abused it was the normal things like “giving them a hug at night” that could be traumatic because seemingly innocent acts could “trigger stuff fae their past”. Andy went on to say that:

“there's a girl that I have got here where it is a complete ‘no no’ for any physical affection to be shown because she has been physically and sexually abused in the past... and in the past that form of affection would have been used as a form of abuse”.

Three of the young women interviewed had been sexually abused, and all of them agreed with this. For example, Sophie (16, foster carer) confided that there was a member of staff that she “hated” because she was “constantly trying tae hug” her:

“I hate folk coming up and cuddling me. I need to get to know them. I thought I was going to crack. I wis. ‘Cause I hate folk that just comes up and cuddles me like that. Just stay away!”

When asked why she didn’t like being cuddled, Sophie ducked her head down and looked away before replying that it was because it reminded her of “what had happened” with her uncle; a man that she had early told me had raped her when she was living at home.

Whilst some young people became afraid of sex and things that reminded them of their abuse histories, several of the residential and foster carers stated that they had young people who had been sexually abused and had become over-familiar and had difficulties negotiating social boundaries. For, example Laura (residential carer, trained) and Danny (foster care, trained) stated that they currently cared for young people whose abuse histories had resulted in them having difficulty making friends because they were “overfamiliar” and so desperate to be liked that they “got in your face” and literally “shouted” for attention. Sarah (residential carer, trained in sexual health) agreed. She told me about a boy that she cared for called David (15, residential care) who had been “sexually active with older males” since thirteen years of age. David’s willingness to form relationships with older men was attributable to his having been exposed to “tonnes of pornographic material” and being “allowed unsupervised access to the internet” when he was nine years. This, in combination with being “thrown” between living with his mother, father and grandmother had resulted in him becoming a young boy who was highly “susceptible to compliments” and would “willingly” go with anybody that “smiled at him” or told him that he was “lovely”. This had allowed older men to groom him into sexual activity because he “wanted to please”, “wanted to be loved” and was “looking for someone to tell him that he was loved and that he belonged to them”.

To emphasise the extent to which David’s desire “to be loved” concerned the staff in the children’s home, Sarah told me about an incident where two men

had turned up at the residential unit stating that they were there to speak to David about joining their church:

“David was on a bus coming back fae school and his bus ride is ten minutes. I can’t remember the name of the church, it might have been Mormons or Evangelists or something like that, but there was two fellas and they smiled at David and he smiled back and before you knew it they had got in a conversation with him and on the Saturday they turned up at the door saying we’re here to talk to David... he wants to join our church”.

Although the incident was fairly innocuous and recounted in a humorous way, the point of the story was that David’s reaction towards other people left him vulnerable to being manipulated and exploited. This was in contrast to another 15 year old boy, Craig, who she felt would have been like “hoh youse! Youse are dodgy” if he had been approached by the same men. When asked why he would have reacted differently Sarah explained that, although Craig had been admitted to care because his mum was “a recovering addict” who had “neglected” her children to the point where they had experienced “a non-organic failure to thrive”, there had never been any concerns about his emotional and sexual development:

“There was neglect... He and his younger sister just weren’t getting fed and watered. He’s not a street urchin, but... he knows his way about his ain community and he’s in with his ain community and he’s got great patter and a great sense of humour. He’s funny and at times he gets himself into bother, nothing major, and he’s a school dogger. But, he’s doing no different in here other than he’s getting fed, he’s getting watered, he looks healthy, he’s grown in height and he’s put on weight. So, for that young man to live here and go to his ain community there is absolutely no issue. He waves to you and he’s offski, he’s away. He’s gallus and he’s one of they cocky self-assured wee guys and he’s confident”.

In Craig's case, not being exposed to sexual behaviour in childhood and having a continued and stable relationship with the people that he grew up with where seen as being protective and minimising his "level of risk and vulnerability".

Turning to look at hyper-sexualised and problematic sexual behaviour, many of the corporate parents felt that young people often modelled the sexual behaviours displayed by their parents within the home setting. This was viewed as being potentially damaging, with a third of the corporate parents interviewed stating that if young people entering care had been exposed to sexually permissive or "promiscuous" behaviours within the family home then this could have an adverse effect upon their understanding of relationships. For example, Laura (social worker, not trained in sexual health) agreed, stated that she believed that young people in care learn about relationships "fae their own experiences" and that:

"in a lot ae my experience the Mum's had like more than one partner, or the Dad's had more than one partner, and that's changed over a period of time, and they've built a relationship wi, like, a partner for maybe five years, and then that relationship's broke doon, and then Mum's had another partner, and they've got a relationship wi' that male in their life, and then that's broken doon. And that's like been the kinda pattern... and that really affects their understandings of relationships".

The view that parental role modelling of behaviours could have adverse effects upon young people's development was most commonly expressed by residential care workers, who frequently commented on the fact that the parents of the young people they cared for often had a history of multiple sexual partners, violent partners and multiple children to multiple fathers. For example, Alison (residential carer, trained in sexual health) said that in order to understand the behaviours of children:

"you've got to look at some of the relationships maybe their parents had. You maybe, you could maybe have a mum whose had seven kids and

maybe seven different partners, d'you know what I mean? Or else you could have a mum who's been very, very badly domestically... you know, domestic abuse. So they've seeing a lot of violence along wi' the you know, sex and whatever".

Chris (social worker, not trained in sexual health) agreed, stating that he believed that the development of one of his clients "sexual morals" had been affected by the home environment:

"I've previously worked with a 14-year-old girl who was a parent at 14, and the kinda activities around the house were consistent with problematic lifestyles. I know that there were inappropriate adults accessing the house. There was a lot of alcohol use and probable substance misuse at home, and as a social work department we had little knowledge of what adults were accessing that house. But we were aware that there was violence in the house, there was domestic violence, there was alcohol use, and obviously that, in my view, had an impact on that young person's kinda moral development because she was unable to state who the father of her own child was; indicating that she was very sexually active".

That Chris emphasised the impact of young people's pre-care histories upon the young people's moral rather than sexual development was at odds with some of the views expressed by residential and foster carers, who discussed their beliefs that young people exhibiting highly sexualised and age-inappropriate behaviours could be markers of both previous and current sexual abuse/exploitation. For instance, Wendy (residential carer, trained in sexual health), described how she was caring for a young woman who was demonstrating sexually "predatory" behaviours towards other young people in placement; something that she felt was reflective of:

"her background... four children were born in the space of five years when mum was twenty-one. Mm hmm.... so you're beginning to think, wait a

minute. Different partners, four children within five years... you know? We need to protect them from the kind of inappropriate exposure to the damage that's been done to others. So I suppose, in that sense, it's a case of trying to protect their innocence, at the same time as trying to educate about the possibility of what can happen in different situations... it's also a case of trying to reduce the impact and trying to educate young people about the dangers that are out there in society, and to try and protect young people from each other”.

That some young people who had been sexually abused or exposed to sexual behaviours in early childhood seemed so eager to please others concerned corporate parents. Patricia (foster carer, trained) described how she had fostered a 5 year old girl (Katie) whose mother had sexually abused her by “putting her fingers into her vagina” and “allowing schedule one offenders to rape her”. She told me that how this girl had interacted with adults, particularly men, had been quite frightening because her understanding of the adult-child dynamic was so heavily influenced by sex. As an example of this she told me:

“her needs were always different. She'd have been trying to sit on their [men's] knees and there was a whole load of stuff about safe keeping. My brother, he'd maybe come to mine for a cuppa tea and I would go and make him a coffee and she would make a beeline for his knee and start rubbing herself on him sexually. She didn't know any better. She had been sexually abused, horrendously sexually abused, so it was just wee things like that that would be different with regards to her and her needs and keeping men who might come into the house safe.

Behaving in this way was something that she felt Katie couldn't be blamed for, but it concerned her because not only could those behaviours place her at risk, but they could also jeopardise the reputation of friends and family who were innocent bystanders:

“I was grateful that he (her brother) was able to say to me in the early stages, ‘I don’t feel comfortable with what she’s doing’ because I could have left the room and she might have been sat on the couch and the next minute she’s on his knee so it was about keeping her safe and keeping everybody else safe”.

The sexualised behaviour of young people they cared for was something that foster carers found particularly difficult to deal with when exposed to. For example, Ian and Jean (foster carers, trained in sexual health) told me that they had cared for a number of young people who had been sexually abused and went on to demonstrate sexually inappropriate behaviours within their household. Jean described how in one case they had had a boy come to stay with them who had been molested by his father and that they had first become aware of this when they noticed that he had opened his pyjama bottoms and was fondling himself whilst curled up on the couch next to Jean watching television. She went on to say that she had gently asked him what he was doing and he had told her that he was “counting the balls”; a game that he and his father used to play whilst they were cuddled up together on the couch watching the television.

For some children it was felt that the concepts of abuse and love were perceived as being so intertwined that carers felt that the only times those young people felt wanted or loved was when they were being abused. For example, Morag (social worker, not trained in sexual health) told me that:

“they might not have had somebody to talk to and listen to them, or the people that they have had to talk to and listen to them have been abusers and the information that they have got has been skewed, so in the case of that young boy, when you were sitting listening to him and talking to him, he was clearly sexually aroused because that was the only adult contact he had, the only positive adult contact he had had was with people who had been abusing him so, when you were being nice to him and talking to him and listening to him, he was getting aroused at that”.

Young people's desire to be loved and to please was something that corporate parents felt was exploited by adults, with many of them stating that they had witnessed young people's affections being "bought". For example, Dave (Residential carer, trained in sexual health) told me that: across Glasgow we've had a number of issues in terms of young males using local shops to entice girls, mainly girls, using cigarettes and mobile phone top ups in return for sexual favours". Alison (residential carer, trained in sexual health) agreed, stating that when she had worked in a children's unit located near to a park she had noticed that it as being used as "a kind of gravitation point" in that:

"young people would go there, meet their pals and it wisnae long before they were being picked up by men. You would have men saying 'well if ye dae this, if you dae that' and it was like they were pimping them, you know? So in other words they would go in the cars and they would get the money and they would get money for a pack of cigarettes or a wee bag o' sweeties and they would be happy".

This concerned carers because if they couldn't find out about shops and individuals grooming young people and share that information with other carers and the police they couldn't protect children from being groomed into prostitution. Mark (residential carer, trained in sexual health) further illustrated the problem that corporate parents were experiencing with sexual grooming, stating that:

"in Glasgow we've had a number of issues about networking, in terms of young Asian males using local shops to entice girls, mainly girls using kind of cigarettes, and mobile phone top ups in return for sexual favours basically".

I shall return to discuss how corporate parents oversee and monitor the behaviours of young people involved in problematic sexual behaviours in chapter five.

#### 4.4.2 How do care experiences shape young people's understanding of sexual health and relationships?

Moving beyond pre-care experiences, many of the corporate parents identified that difficulties trusting others could have adverse effects upon young people's ability to settle into placements and form attachments with their new carers. Underscoring this was the belief by all of the corporate parents that perceived rejection by the birth family and grief associated with the breakdown of those relationships adversely affects young people's ability to build trust. For example, Fiona (residential carer, trained in sexual health) felt that:

“if a child is born intae a family and they build up a relationship wi' their mum and dad, and then that breaks down or a child's at risk and they have to move tae another family member or they move to a residential unit or foster carer then they're no going tae have that same intense relationship wi' their parent or carer. I think that they tend tae kinda lose out on maintaining that relationship, and keeping that closeness and that bond”.

Furthermore, she believed that where young people experienced multiple rejections they were less likely to build secure and trusting relationships with their carers:

“they've maybe lived wi' their mum or wi' a gran and then an auntie, and they've moved fae place tae place so their relationships have broken down and then they've had tae start another relationship wae somebody else... but the chances of them building a really secure, long-term relationship wi' another carer can be quite difficult unless it's somebody that's been quite close tae them before”.

Sarah (residential care, trained in sexual health) agreed, stating that young people who had experienced multiple rejections took “a long time to form their relationships” and “seek trust”. Within the care system, placement moves were

viewed as promoting rejection and lack of trust. Marion (social worker, not trained in sexual health) told me that she thought “moving fae place tae place tae place must be really, really difficult” for young people especially if they had “experienced a lot ae sexual abuse and neglect in their life”. In those situations Marion felt that young people had never had the chance to “really build a good relationship wi’ somebody that they can trust”. Claire (social worker, trained in sexual health) felt that one of the reasons why young people didn’t form trusting relationships with their carers was that they knew that “they were not going to be somebody that [was] going to be there forever”. This was something that she could understand because:

“as soon as that (young) person leaves that unit or that member of staff leaves that unit, that relationship’s over. They’re not mummies, daddies, aunties and uncles that can be there forever”.

That the care system wasn’t able to provide stability and continuity of care to young people was something that Claire (social worker, trained in sexual health) felt “caused serious damage”, especially in situations where young people had grown up with carers and “called them mum and dad”. She felt that long-term placement breakdowns were extremely common once children became teenagers because this was a period where young people were undergoing significant change, their hormones were “running wild” and many of the young people she had worked with had found it difficult to cope with their past. When this happened Maggie (social worker, trained in sexual health) felt that it was often too easy for carers to hand children back to social work departments on the basis that “they are not my child”. Whilst she could understand that carers could often be pushed to the position of giving up a child by increasingly troubled behaviour, she expressed anger on behalf of those young people she had worked with who had experienced:

“being swapped with other children” or who had thought that their relationships with their carers would be there forever only to wake up one

morning and realise that “it’s over, it’s finished and they don’t [get to] see them again”.

Lack of stability, loss of relationships and the accompanying rejection that young people felt when placements broke down were seen as being “all encompassing” in the damage that they caused to young people’s understanding of relationships and the behaviours that they exhibited. Where young people were in “stable, secure placements” corporate parents felt that they learnt to trust people because the “uncertainty [was] totally removed”. For example, Katherine (social worker, not trained in sexual health) stated:

“if they’re in a stable placement... maybe a foster placement where they know that it’s not going to break down and that the carers aren’t going to give up on them, and they know that they’re going to stay there, then that can make a huge difference to their behaviour because it’s about a lifetime of rejection and them knowing that somebody’s actually going to keep [them] and treat [them] properly”.

Being in a secure placement helped young people to feel “settled” and “safe”; words that were commonly used by the young people I interviewed when talking about placements that they had been in for a long time or had formed a good relationship with their carers. Feeling safe and settled were seen as being key ingredients for young people developing positive relationships, with many of the corporate parents arguing that when uncertainty is removed young people learn that they can trust the people caring for them. For instance, Caroline (foster carer, untrained) stated that it was really important for young people to “be claimed” and to be allowed to form a relationship with “their own special person” who would “be there for them”. To exemplify this she described the experience of caring for Matthew (15, foster care) who had come to live with them when he was 8 years old. At first Matthew was “withdrawn”, “isolated” and “very unsettled” because he had been “bounced from foster carer to foster carer” with each placement breaking down quickly. She recalled that once he was placed within their home it quickly became apparent that Matthew had

decided he didn't want to move again and that he "belonged" to their family. As he became more secure within the household he went from being a "very unhappy" boy who was unable to talk to them about any of his experiences to a "happy" child who started to trust them enough to talk about "the demons" in his past.

Where young people couldn't find their "own special person" within placements, Sarah (residential care, trained in sexual health) felt that they often "looked for love" elsewhere. This was something that many of the corporate parents acted as a barrier to young people having "healthy" and "appropriate" relationships with peers, romantic and sexual partners because they were "forever searching" for the love and nurturing that they craved. Claire (social worker, trained in sexual health) told me that in the years she had spent working with adolescents who had missed out on nurturing as children she had witnessed a lot of them "desperately searching" for that one person who would "nurture them" and who "they could identify with as a mother or father figure". This was something that Laura (residential care, trained in sexual health) felt often undermined young people's expectations that relationships should be loving and respectful; resulting in them placing themselves at risk of being "used" and "exploited". Claire (social worker, trained in sexual health) agreed, stating that she had worked with a number of young women that had experienced instability and rejection, and that when it came to romantic and sexual relationships they became:

"very desperate to form those relationships because they are meeting a particular need at that time coz they're desperate to have a connection with somebody. They're looking for that stability and they rarely find it. They're looking for that connection and finding it in people they don't know, that they've just met on the bus, somebody that seems kind, somebody that's got a kind word for them, seems to like them and they're like 'that'll do for me, and then they put up with stuff that they wouldn't normally put up with. They know it's not right but they'll put up with it because we've not offered them an alternative. It's because they're so very lonely".

The emphasis that corporate parents placed on describing how pre-care (e.g. maltreatment, domestic violence and lack of stability) and care (e.g. lack of stability) histories affected young people's understandings of relationships was based on the belief that relationships, in particular secure and trusting relationships, were a necessary component of talking about sexual health and relationships. In addition, reflecting upon the effect that attachment difficulties had upon young people's risk of being exploited and/or exploiting others in order to feel loved and accepted led to corporate parents discussing how risk management and monitoring of young people's behaviours affected their ability to talk about sexual health and relationships. I shall return to discussing these issues in chapter five.

#### **4.5 Summary**

The data presented in this chapter has been used to address the following research question: what shapes communication about sexual health and relationships within the care system? In answering this question it has been demonstrated that there has been a perceived cultural shift within social work services that has resulted in communications about sexual health and relationships no longer being viewed as a taboo subject but rather as an acceptable and important part of the corporate parenting role. Underscoring this change of attitude was the belief that a good parent would talk to their child about sexual health and relationships; therefore, the good corporate parent should be willing and able to hold such discussions with the young people they cared for. The shift in attitudes that was discussed by the corporate parents interviewed in this study may be attributed to the emergence of a wider discourse on parenting within social work practice. This discourse, which has been spearheaded by the Scottish Government (2008c) emphasises that all practitioners involved in providing care and supervision to looked after young people have a parental responsibility to looked after young people and should, be "seeking the same educational and health outcomes for those young people as any good parent would want for their own children". It was therefore not surprising that corporate parents often contrasted their views about good corporate parenting with the view that looked after young people's birth parents, as a result of the additional health and social care needs, often failed

to fulfil to talk to young people about sexual health and relationships; thus necessitating corporate parents to step in and fill this gap.

The emphasis that was placed upon sexual health and relationships discussion forming part of the parenting process within the care system resulted in corporate parents questioning their ability to undertake such discussions with young people. In particular, it was shown that communications about sexual health and relationships were believed to be shaped by the gender, age and knowledge of corporate parents, with looked after young people preferring to discuss sexual health and relationships with corporate parents who were of the same gender, were similar in age and who were perceived to be knowledgeable about sexual matters. That sexual health and relationships discussions were patterned by gender was viewed as being problematic as it was felt that having to talk to somebody of the opposite gender promoted embarrassment and could act as a barrier to young people seeking out help and advice. This was particularly true in residential care where it was noted that there was a significant shortage of male carers. That younger corporate parents were identified as preferred sources of sexual health and relationships advice reflected the belief that younger corporate parents were more likely to have received sexual health and relationships education themselves, and would be more “in touch” with young people’s experiences and thus better placed to give advice. This was clearly demonstrated by older corporate parents expressing frustration at not knowing about the different types of contraception available to young people and being confused by sexual colloquialisms being used. Training in sexual health and relationships for corporate parents was identified as increasing knowledge, reducing embarrassment and increasing corporate parents’ confidence about talking to young people about sexual health and relationships.

Corporate parents discussing sexual health and relationships discussions as being a parental responsibility resulted in a notable tension emerging within corporate parents’ narratives. This focussed mainly upon the conflict between professional and parenting identity, with social workers and some of the residential carers interviewed adopting a very professional oriented attitude towards discussions

about sexual health and relationships discussions within the care setting that resulted in their believing that their role was to oversee and liaise with other corporate parents and agencies to ensure that young people's sexual health needs were addressed. In contrast, the foster carers and some of the residential carers identified that their role was more that of a parent than a professional. These corporate parents often stated that they found it difficult to reconcile their traditional and religious views on parenting (views that would have usually resulted in their not talking to their children about sex and contraception) with the professional recognition that looked after young people need to be spoken to about these issues because of their increased vulnerability.

Moving beyond the tensions between professional and parenting identities, it was demonstrated that corporate parents felt that they should be routinely talking to young people in the care system about sexual health and relationships, because pre-care experiences such as exposure to parental promiscuity, domestic violence and sexual violence, could adversely affect young people's understandings of relationships. For instance, many of the corporate parents used the example of young people witnessing domestic violence to explain how repeated exposure to violence can result in young people believing that anger, hostility, arguments and physical violence are normal facets of relationships. Furthermore, it was believed that exposure to age-inappropriate and sexually violent behaviours, including child sexual abuse was particularly damaging for young people; resulting in young people being at increased risk of early sexualisation and developing problematic sexual behaviours. Together these factors were identified by corporate parents as promoting social isolation, adversely affecting young people's self esteem and, in some cases, resulting in young people entering into unhealthy and exploitative romantic and sexual relationships through their desire to feel wanted and loved.

The perceived impact of pre-care and care histories on young people's understandings of relationships was identified as a potential barrier to sexual health and relationships discussions being undertaken. This was because of the strong role that carers felt trusting relationships played in their ability to talk to, and have young people approach them about, sexual health and

relationships. In addition, corporate parents identified the increased risk of exploitation associated with poor understandings of relationships as a factor that necessitated their providing young people with additional monitoring and supervision. I now move on to discuss these issues in chapter five, and in so doing address the question of whether connectedness, monitoring and supervision mediate discussions about sexual health and relationships within the care setting.

## **Chapter 5: How do connectedness, parental monitoring and supervision mediate communication about sexual health and relationships in the care setting?**

### **5.1 Introduction and aims**

In the previous chapter it was demonstrated that communicating about sexual health and relationships should be considered to be a core part of the corporate parenting role. However, it was also demonstrated that corporate parents believed that there was a range of factors that shaped the likelihood of such discussions occurring, including: the age and gender of corporate parents; corporate parents' own views on sexual behaviour; and, the effect that lack of stability and being exposed to physical and sexual violence prior to entering the care system had upon young people's understandings of relationships. Moving beyond these factors, the literature review conducted in chapter two demonstrated that communication about sexual health and relationships is mediated by family processes such as connectedness, monitoring and supervision. In this chapter I explore whether corporate parents and looked after young people believe that these factors mediate communication about sexual health and relationships within the care setting. In doing so, I explore how the quality of relationship or connectedness that exists between looked after young people and their corporate parents mediate communication about sexual health and relationships. I also explore some of the other issues that were raised in chapter four, including how values about sexual health and relationships are communicated within the care system and how monitoring and supervision are used to try and protect young people from being sexually exploited. The chapter concludes by discussing how corporate parents and looked after young people talk to each other about sexual health and relationships.

### **5.2 Connectedness as a potential mediator of communication**

In chapter two it was argued that communication about sexual health and relationships is best undertaken within the context of warm, loving and trusting

parent-child relationships as this helps facilitate open and honest discussion (Wight and Fullerton, 2013). This belief was shared by the corporate parents interviewed as part of this study, with the majority of those interviewed stating that trust was a significant facilitator of communication about sexual health and relationships and that the individual best placed to talk to young people about these issues was their carer or key worker. In this section I explore whether connectedness and trust mediate communications about sexual health and relationships. I then move on to explore how corporate parents attempt to influence young people's sexual health behaviours by promoting connectedness.

### **5.2.1 Does connectedness mediate communication about sexual health and relationships within the care setting?**

All of the looked after young people interviewed believed that trust was a significant facilitator of discussions about sexual health and relationships; emphasising that it shaped communication about sexual health and relationships by identifying the person that they would approach to seek information and advice. This person was not always a corporate parent. For instance, several of the young people stated that they preferred talking to their birth parents about sexual health and relationships because they made the young people feel comfortable. For example, Tim (17, care leaver) stated that when it comes to talking "about mad stuff" like sexual health that you "just want tae sit doon wae yer ma and da... no somebody you don't even know". This sentiment was also echoed by Stuart (20, care leaver) when he said that he "didnae really want tae talk" about sex with somebody that he had only known "for a couple of months or about a year". He went on to say that because of that, whenever he had had any questions about sexual health whilst he was in care, he would just "wait to see [his] dad and talk to him about it" because his dad "was always there for him" and he knew that he would give him the advice he needed.

Trust was strongly associated with the length of time that young people had known somebody for. For example, Eve (16, care leaver) stated that she would only "talk tae the wans I trust the maist" and, although she was talking about discussing sexual health with her peers rather than her carers, she went on to

clarify the statement by saying that this would be the “wans I’ve known longer”. Amy (17, residential care) expressed a similar view when she said that she would “never talk to them (her residential carers) about private things” but she would be very happy talking to her supported carer about sexual health because she had known Amy since she was a little girl and “knows [her] full life story”. Similarly, Tim (17, care leaver) and Josh (14, residential care) described how they would only really want to talk to people who knew them really well. Tim described how if he was having relationship problems then he would talk to the residential worker that was married to his social worker:

“she was awright. She was an older woman and she was just sound man, and her husband was my social worker and she was my key worker in the home so I knew her and her husband. I thought they awright”.

Furthermore, Josh (14, residential care) told me that he would only want to speak to the residential staff member that had been allocated to him as a key worker because he “gets on wi’ him better”, had “been to aw ma meetings” and knows him really well.

For other young people, it wasn’t just how well they knew their carers that mattered but the feeling that they were like family to them. For example, Kim (22, care leaver) told me that the only member of staff in her unit that she would have considered talking to about sexual health and relationships “was just lovely” and “was kinda like my papa or something”. Alan (18, care leaver) agreed with this view stating that although he would never speak to residential staff members about anything to do with his sexual health he would “feel really comfortable” talking to his key worker. When asked why he felt this way Alan explained that it was because she was “like [his] mammy” and “the next best thing tae a mum [he] ever had”. He went on to state that his key worker had known him since he was “about five... or maybe about six or seven” and “knows about everything that has happened [him]”, and that that means he “doesn’t hae any problems about going and telling her stuff” because he knows that “she will be understanding”. As an example of this he confided that he had “tellt her

about twenty minutes ago ‘oh by the way, I’m gay and that’s my boyfriend next door’” and that it didn’t “phase her”.

That young people felt they needed a relationship with their carer before talking to them about sexual health also highlighted the importance of trust. For example, Darren (14, residential care) told me that you have to be able “to trust” your carers before having discussions about sex. Unfortunately, being in residential care was something that Darren thought acted as a barrier to this because there are “different people on different shifts all the time and you’re getting to know them much slower”. Whilst “the trust does come along and you do build relationships up with the staff” he highlighted that it took longer than if you were just living with one person. Where young people felt that they couldn’t trust their carers they often stated that they thought it would be easier to discuss sexual health and relationships with their parents. The main reason for this was sexual health was part of young people’s “private lives” and they felt that family members “knew you the best” and wouldn’t “judge you”.

Corporate parents who were viewed by young people as being open, honest, non-judgemental and were sensitive in their parenting were identified by looked after young people and care leavers as being those they would approach for help about their sexual health and relationships. For instance, young people identified that they were most likely to talk to carers that were “not phased” by anything and who were open, “in touch” with young people and “non-judgemental”. For example, Niamh (15, foster care) told me that she could talk to her foster carers about anything. When asked why that was she told me that although she knew that her carer “doesnae really want it [sexual activity] happening” she is “really open about that kinda thing” because she “would just rather I be safe”. She went on to tell me that because her carer was open to talking to her about sex that they had had a number of conversations about contraception, and not only had her carer taken her to the sexual health clinic, but had even gone in to get condoms for her when she had been too embarrassed to go herself.

Amy (17, residential care) and Tim (17, care leaver) both agreed that it was best to have carers that were open and non-judgemental. For example, Amy told me that this was one of the things she liked about her supported carer, saying that it was easy to talk to her because:

“she [will] sit and listen to you until the sun goes down, she’s just... see even her giving you advice, you just feel as if she’s helped you a lot. Just her telling you something and you feel like she’s really helping you. I’ve had loads of conversations with her, and I just feel as if she’s the only person I can go to... coz she wouldn’t judge you or nothing... she wouldnae judge you on anything”.

Similarly, Tim told me that it was important to have carers that didn’t judge you and that that was why he liked talking to the carer who was married to his social worker because “she wasnae a posh cunt or anything” and she had “never done anything wrang tae [him] so [he] just spoke tae her”. He went on to say that the main reason he wouldn’t want to talk to the rest of the staff “about stuff [he was] daen” was because “they were too snobby” and “think they are better than us”. Finally, Alan (18, care leaver) said that he could talk to his key worker about anything because:

“she was understanding and aw that. Liz has known me since I’ve been about five, six, maybe even a wee bit older - aye, maybe about six, seven and stuff. I mean, Liz is like my Mammy, Liz knows everything about me, stuff like that, she knows about everything that ever happened to me. So I mean I don’t hae any problems about going and telling her “like Liz...” I telt her about 20, no even ten minutes afore “by the way, Liz, I’m gay, my boyfriend’s next door,” she was like, “aye, that’s fine.” Stuff like that. I can tell Liz anything and it willnae phase her”.

In contrast, where carers were viewed to be judgemental, young people often stated that they didn’t feel comfortable approaching them to talk about sexual health and relationships. Several young people discussed this. For example, Alan

(18, care leaver) felt that young people in care could “tell staff nothing” because some of the:

“maist judgemental people that you will ever meet are ressie staff. They judge you about everything. Your family, your past, your future, your present and even what type of person you are. Ressie staff will judge you coz they work wi' you 24 hour, seven days a week”.

Several of the young people believed that their corporate parents would be judgemental stating that they would rather ask family members, in particular parents, about sexual health and relationships because it was easy to discuss “private lives” with family members because they were “family”, they “knew you the best” and they wouldn’t “judge you”. For example, Darren (14, residential care) said that if he wanted to ask questions about sex he would “feel more comfortable” talking to his mum and dad because “they knew him” and they wouldn’t be “looking at him” and “judging him” in the way that he felt other people who are “not family” tend to do. Kim (23, care leaver) and Amy (17, residential care) agreed, with Kim stating that she thought talking about sexual health was “a definite no go” because although carers might not say anything to you “the way they look at you” makes you know that they are judging you. Amy agreed going on to say that she was put off talking about sexual health with the staff because although they “won’t always say anything” it “sometimes feels like they are judging me” when they make “wee snide remarks” about things:

“I came in from being like out myself, and this happened last year, they would call you like ‘a dirty stop out’ and I’m like ‘I’m no like that’ and it’s just things like that. And, even if something did happen, I wouldnae tell them... I’d hesitate to tell them anything... coz they would judge me. They always make wee snide remarks about everything”.

Even where young people hadn’t experienced their carers being judgemental to them, just the thought that they may react judgementally was enough to act as

a barrier to them approaching their carers about sexual health. For example, Darren (14) stated that he didn't like "not knowing what they're saying and if they've got personal views and judgements on it", whilst Eve (16, care leaver) told me that she had tended to avoid conversations with her foster carers about sex in case "it caused problems" and you don't know how they will react and then "you've got to live wi' that person every day". It is however worth noting that young people reported similar levels of discomfort talking to their biological parents about sexual health and relationships. For instance, several of the young women interviewed stated that they wouldn't ask their parents questions about sex because they were scared of how their parents would react if they thought they were sexually active. For example, Niamh (15, foster care) stated that when she had wanted to go onto the pill she had been "scared to tell my da cos he's my da" because she couldn't "remember [her] dad ever telling [her] anything" about sex and she didn't know how he would react. She described how on the day she went to get the pill from her GP she met her dad in the surgery waiting room and he asked her why she was there, to which she repeatedly replied "I'm just here to see the doctor". When asked why she hadn't wanted to tell him, she told me that although her dad knew she smoked "he didn't have a clue about anything else" because she "hid everything" from him in case "he would be angry". She went on to say that when she finally confided in her dad about being on the pill she had been surprised at his reaction:

"a couple of weeks [after I went on the pill] I says to him 'I was going to get the pill' and he went 'what d'you no tell me for?' and I was like 'cos I thought you'd be angry cos I'm under 16' and my dad's like 'no', he's like 'you're making the right choice' and I was like (shocked expression) 'oh, well, fair enough'".

Kim (23, care leaver) told a similar story with regards to telling her father about her pregnancy. At the time of her interview Kim was three months pregnant with an "unplanned" pregnancy. She told me that the day she found out she was pregnant she was like "oh my god, I'm gonnae die" and had "sat on the toilet pan greeting coz [her] dad was gonnae kill [her]". She went on to say that the reason she had thought that her dad would react negatively was that when her

younger sister had come home at the age of 15 and announced that she was pregnant her dad had “went mental at her”. Looking back on the day she built up the courage to confide in her dad she revealed that he wasn’t angry but was actually “quite happy” and thought it was “great” that she was going to have a baby. In some cases, young people being hesitant to talk to their parents about sexual health and relationships matters were justified. For example, Mike (23, care leaver) and Katie (15, residential care) described having good relationships with their parents up until the point that their parents discovered their homosexuality. Katie told me that her grandmother had started looking after her after her “maw saw a picture on Bebo” in which Katie was “wae a lassie” and “was kissing her or something like that”. This had resulted in her mother becoming like “a raging bull”, going “aff her nut, pure aff her heid” and becoming physically violent. Katie told me that at first she had tried to deny that she was gay by telling her mum that the person in the picture “clearly wisnae [her]” but that in the end she had made the decision to pack her bags and go live with her grandmother. Mike confided that his father had thrown him out when he discovered that he was bisexual. When asked what happened he told me that he had been living with his dad for three years when he had told a friend that he thought he might be bisexual:

“I done that whole thing of telling one of my friends and thinking ‘oh well he’ll be grand about it, he won’t tell anyone and then he blabbed his mouth to the whole school so not only was I getting beat up when I was leaving school I was gonna go home to get beat up by my dad for it. He wasn’t violent or nothing but I knew he was gonna crack me for it. He was gonna hit me because I hadn’t told him first... then he kicked me out”.

Alan (18, care leavers) also experienced negative reactions to revealing his homosexuality; however, in his case the reactions came from his residential carers:

“a lot of the staff gave me a lot of bullying and that because they found out I was gay. They really made my life miserable and impossible... they

just, I don't know, they just bullied me. Slagged me, had a pop at me any chance they could".

As Alan reflected on the experience of being bullied he highlighted that he hadn't told anybody whilst he was in the care system about the bullying, but had since confided in the workers at the care leavers charity that he went to:

"I didnae go tae anybody, I kept it quiet. Only like, there's only a few staff in here [care leaving charity] know what happened. I kept it, I kept it to myself as I didnae want anything done aboot it, because I wasnae, I didnae move oot so I didnae want it worse, and then they found oot I was seeing one of the guys in the school, or I was allegedly seeing one of the guys in the school - the guid thing was they couldnae prove it at the time, but I really, a lot of the staff really, efter then found oot that, I really got a hard time fae all the staff. Male, mair the male staff than the female, but a few females as well... they were just like slagging you if they could get away wi' it... even the managers joined in... the man who ran the place I stayed in, he gave me a really difficult time".

That Alan had confided in the workers at the care leavers charity reflected his earlier assertion that the people who worked there were "like family" to him, and further emphasised the notion that trusting, non-judgemental relationships were necessary for facilitating discussions about sexual health and relationships both within and outwith the care setting. Whilst the evidence presented thus far highlights the importance of trusting relationships for discussing sexual health, the evidence presented in chapter four demonstrates that looked after young people may, as a result of their pre-care and care histories, experience difficulties forming trusting relationships with their carers. This led to a number of corporate parents, mainly those in residential and foster care, identifying that promoting connectedness and building positive relationship understanding should be a central part of sexual health and relationships education within the care system. These issues shall now be discussed.

## 5.2.2 Promoting connectedness

In this section I discuss how corporate parents attempted to promote connectedness within the care setting by: promoting consistency and routine, encouraging young people to become engaged with education; and, role modelling positive and trusting relationships within the care setting. How corporate parents undertook these tasks will now be discussed.

### 5.2.2.1 *Promoting connectedness within the care setting*

In chapter four it was demonstrated that lack of stability in the pre-care and care histories of looked after young people was believed to adversely affect young people's ability to build trusting relationships with their corporate parents, and that all young people in the care system needed to have their own "special person" who they could approach for help and guidance whilst in the care system. It was recognised that young people entering the care system for the first time, as well as those young people who have experienced multiple placement moves, need to be provided with both space and time to settle into their new placement and start building connections with carers. This is because entering the care system was described by all of the looked after young people as being a stressful and scary time. For example, Tony (care leaver, 20) said:

“you obviously get scared coz you don't know what you're doing and there's all these other people... that bit [is] scary. It's just a new place, new area, different people. You get scared. You don't know what you're daen so you just stay in your ain room because you feel mair safe”.

Alan (care leaver, 18) agreed, stating that his first night in residential care had been “heavy going”, “terrifying” and “a big change fae sleeping in [his] own bedroom to sleeping in some children's unit”. This notion of change was reflected by a number of the young people, with the overall consensus being that being taken into care was like “being taken oot of your comfort zone” (Tony, care leaver 20) and “entering a whole new world” where you “don't know the rules” (Kim, care leaver 23) and there are “hunners o' weans running

about... and it feels crowded... and there are people just coming in, flinging off their clothes and making themselves at home” (Sophie, residential care 17) and being “dead cheeky all the time” (Catriona, residential care 16).

All of the residential and foster carers interviewed identified handling the transition into a new placement as a means of trying to ameliorate the fear that young people felt upon entering the care system. However, it was recognised that this process needed to be undertaken slowly in order not to further traumatise young people. For instance, Alison (residential carer, trained in sexual health) said that she felt that rather than bombarding young people with a lot of information when they first became looked after it was important to just “let the young person just be their self for a few weeks” before starting to slowly work with them to form routines:

“initially we don’t have this big thing about come and sit round the table because these kids have never done it. Can you imagine sitting with six or seven total strangers and having your dinner? They eat on the run, grabbing something and off to play... off to play until twelve o’clock at night. So I think it’s just about doing it slowly and then building up your relationship and building up trust”.

Wendy (residential carer, trained in sexual health) agreed. She went on to describe how they had one young woman in placement who had “bedded herself in” and had “turned night into day” and was refusing to settle into the routine of the unit. This was something that the staff had allowed to occur for a few weeks, but they felt it was now time to integrate the young person within the unit. When asked how they were going about this Wendy explained that they were using “baby steps” and appealing to things that she liked doing. For example, Wendy told me that the young woman liked to read the newspaper so the first thing that they had done was encourage her to get up every morning and to give her money so that she could go to the shop to buy the newspaper. For now they were allowing her to take the newspaper back to her room to read,

but in the long term the goal was to get her to a place where she felt safe enough to sit in the lounge or dining room to read the newspaper.

#### ***5.2.2.2 Promoting connectedness to education***

Encouraging young people to return to or remain in education was seen as one of the main ways that corporate parents could promote routines for young people. It was also seen as a way of enhancing self esteem. For example, Joanne (residential carer, trained in sexual health) told me that she was currently caring for a 16 year old boy who, until he was 14, had not attended school for two years. During that time he had become “more and more withdrawn”, “very socially isolated”, “violent with the staff” and took less and less interest in his personal hygiene... he didn’t want to bathe, wasn’t interested in how his hair looked or how his clothes looked”. When asked what they had done with regards to his education Joanne told me that the residential staff had started to take him to the library to try and encourage him to learn “without a jotters open approach”. This was something that he liked, and as he started reading they asked him if he would be willing to try going to a school that had an “activity based approach to learning”. He agreed to try the placement and since starting there had only missed two days of school. The most dramatic change for Joanne was watching him becoming more settled and seeing his self-esteem improve:

“this is a boy who is now extremely happy and takes pride in doing his hair and wearing good clothes. Instead of coming home from school angry he comes home tired and exhausted from spending a day really engaging with the curriculum. He’s always desperate to tell us about his day and what he’s been up to”.

When asked why routines and self esteem mattered, many of those interviewed stated that they felt that lack of routine, low self-esteem and low self-worth were often to blame for young people engaging in risky relationships. For example, Claire (social worker, trained in sexual health) told me that she felt a lot of the relationship choices that vulnerable young people make are based upon the fact that they have got “really low self worth”. This was something

that Joanne (RW, trained) agreed with, stating that often when young people had low confidence and low self-esteem they tended “not to value themselves” and entered into relationships “with people who were no good for them”. That education could be used as a means of enhancing feelings of self worth and reducing young people’s exposure to risky behaviours was echoed in the experiences of young people, particularly those who had been placed into residential schools. For example, Ali (16, residential care) and Jack (20, care leaver) both described how being made to live in the same place that you attended school had resulted in them becoming much calmer and reduced the amount of trouble that they got into. Ali told me that before she went to live in a residential school:

“I didnae go to school. I refused to go to school every morning. I used tae skive off it. I didnae do nothing. I just sat and boozed every day of my life, just got a drink and that was me sorted. I didnae care about anybody else apart fae my pals and then, just all of a sudden I got moved and I went tae school every morning. I used tae get dragged oot my bed to go to school. I hated it, but efter a while I started liking it. I started going to school and the only thing I used tae get in trouble for was probably running oot for a fly fag, but everyone done that! I got myself a job and that, and I was daein well for myself”.

However, she went on to say that she had complained so often about the fact that she was living so far away from Glasgow that the decision was made to move her to a children’s unit within the city. This was something that she felt had been “a bad idea” because she knew that she wouldn’t be able to resist going out with her friends and falling back into her old behaviours:

“it all came downhill as soon as I got telt ‘oh no, I have to move back to Glesga again’. I didnae want tae move back to Glasgow. I know what I’m like. I know what I’ll do. I willnae pay attention tae things. I willnae dae nothing... it’s a bad idea sending me to stay in Glasgow because I’m telling you, I know what I’m like. I know what I’ll do. I know I’ll just go

right doonhill and do everything I used tae do before I came to this place, and then what do you know, as soon as I come back what's the first thing I dae... lift a drink and think wahey I'm partying".

Jack told a similar story in relation to his experiences after his father was murdered. He began by discussing how his father's death had resulted in him feeling stressed, angry and lashing out at other people:

"I was just leaving primary school and being told my dad's been... that my dad had been murdered and going into high school which is already enough for a young boy that's going into like first year ae school. You know what I'm talking about? Obviously it's stressful. You're like 'what's it gonnae be like?' And, when I went in there it was obviously a class of twenty-two or whatever, a class of twenty, and if somebody said something to me I would... I don't know what it was, but I just used tae lash oot at them because I was so angry at the fact that that [dad being murdered] had just happened. I couldnae get it oot ma heid".

He went on to describe how living in a residential school had been really good for him because it had been a "really good support", and how routinely attending school had helped him to feel safe and secure:

"efter aboot nine month of me being in the residential school I felt comfortable there, like this is the place for me. I've got my ain room, I've got my ain living room, I'm starting to get tae know the boys. I was settled in the wan unit. The boys were gonnae be there for the same amount of time as you are because they're in the exact same position and you're no gonnae be getting flung about fae here tae there tae there. You're in the wan place go to school, you come back fae school, you're daeing what yer daeing at night - your football training, whatever, blah, blah, swimming - whatever you're daeing, you're daeing. And then, the next day, you're going to school. And I started tae get intae that routine, which I did for aboot three year".

### ***5.2.2.3 Promoting connectedness with birth families***

Many of the carers felt that in addition to supporting young people back into education, promoting relationships with birth families, where it was deemed safe to do so, helped to promote a sense of security amongst young people and could help to overcome the difficulties that they had trusting other people. For example, Sarah (residential carer, trained) felt that regardless of whether carers “judged” the backgrounds of young people as being “chaotic” and “unstable” they had to remember that maintaining a relationship with their parents was often something that made young people “feel secure” because it is “what they know... it’s their parents, their mum and dad”. Mike (social worker, not trained in sexual health) agreed stating that he felt that it was “really important to liaise with family members, good or bad” about what was happening with their children, and that he was very much of the opinion that they should encourage contact with parents at every opportunity:

“If somebody’s doing well at school the parents get phoned. If they’re doing well at sports they get phoned. It’s about building those relationships. We have birthday parties here for the kids where the family are part of that and we have been to birthday parties for kids at family homes. These things are all really good and really critical because it’s what is best for the kids. If they are absolutely craving family contact, and it is appropriate and it is safe then we have to encourage that even if we might think they’re terrible parents”.

Caroline (foster carer, untrained in sexual health) agreed stating that she viewed contact between children and their parents as “valuable” because it provided them with an opportunity to “get some time alone” with their parents, and they as carers could encourage parents to engage in their children’s lives by inviting them to attend school prize giving and, where appropriate, come over to the house to just generally spend time with their child. She went on to state that how corporate parents managed contact between parent and child could also help improve young people’s understandings of respectful behaviour:

“his mum had a real problem with previous foster carers.... She used to throw water at them at (children’s) panels and could be quite aggressive. She didn’t think that when Matthew came to us it would be a permanent arrangement. I felt that we had to break down some of those barriers with her and that she had to understand that we were all on the same side and that was to do what was best for Matthew. So, I arranged through the social work to have a meeting with her and I spoke to her about how I was going to care for him and what role she would have and how we could work together, and ever since that day she’s had the utmost respect for me... anything that I’ve asked her to do, she’s never out stepped the mark”.

Having a positive relationship with Matthew’s mother was something that Caroline felt had made it easier for Matthew to “relax and become part of the family” because he not only felt he had his mother’s “approval” to be part of their family, but was able to see her on a regular basis.

Whilst for some young people promoting contact with parents was viewed as being appropriate, for others the chaotic nature of their parents’ lifestyles or previous histories of abuse removed this option. In these cases corporate parents felt that it was important for young people to be allowed to form relationships with their own “special person”, with Mike (residential carer, trained in sexual health) stating that as carers they are often “trying to fill that gap” by providing young people with a “really strong, positive role model and relationship” and allowing them to see that that adult will not just be “another adult who may let them down”. This was something that Catherine (social worker, untrained in sexual health) agreed with, stating that she was currently working with a young woman who “was craving for that affection and attention” and that:

“it was now about trying to give her what’s she’s missing. The relationship with her parents has completely broken down and it’s about trying to build that relationships back up and maybe giving her that attention, and to fulfil that need, because she has been rejected by her parents”.

Having a secure relationship with another person was something that Catherine hoped would allow this girl to go on and address that “craving” that she had in a healthy manner rather than making “unsafe choices” in the future.

#### ***5.2.2.4 Role modelling respectful behaviour***

In section 4.4.2 it was demonstrated that many of the corporate parents felt that young people modelled their romantic and sexual behaviours upon those that they had observed within the family home, and that in certain cases this could result in young people pursuing relationships that placed them at risk of being sexually exploited. As a result of this, corporate parents identified that role playing and modelling respectful behaviour should be a core part of any sexual health and relationships work undertaken within the care setting. In particular, it was emphasised that role modelling could be used to improve young people’s understandings of gender equality, respectful behaviour, and help instigate rules about privacy and respect.

Looking first at modelling gender equality, Alison (residential carer, trained) and Sarah (residential carer, trained) felt that it was important that corporate parents consciously move away from the days when male carers “didn’t do the dishes or make the beds”. This was because they believed that creating gender roles within care placements had only served to reinforce the belief that some young men had that men “were dominant” and “the wumman would do as she was told”. For instance, Alison (residential carer, trained) told me that in the children’s home she worked in they tried to show the young people that men and women were “equal partners” and that it didn’t matter whether it was “a male or a female who goes up the stair, checks the rooms. tidies up, puts in washing or helps wi’ the supper”. Similarly, Ian (foster carer, trained) said that he and his wife made a conscious effort to share the household chores so that the young people “see me ironing and doing the dishes”. Sarah (residential carer, trained) agreed that it was important for young people to see men doing traditionally female roles, stating that she thought it was:

“important to talk about equality and to tell kids that equally the man should be doing the hoovering... I’m quite blunt in here. No. You’ll get the dishes done just the same as she’ll get the dishes done”.

As an example of how modelling gender equality could affect young people’s behaviours she recalled how she had cared for a young man who had grown up in a household where the women did all the work. This had resulted in him “walking past the male members of staff” when he needed a shirt ironed and saying “gonnae wan of youse iron that” to female staff members. This was something that he had eventually stopped doing after she had started “telling him to go and get a male member of staff to iron his shirt” every time he did this.

In addition to modelling gender equality, it was felt that it was important for carers to provide children with “family values and teach them social skills so that they could progress and move on in life”. The main reason for this being that many of the young people they looked after had missed out on nurturing within their early lives. At the heart of this process was teaching young people about privacy and respect, through modelling positive behaviours within the care setting. How corporate parents went about this appeared to differ slightly by type of placement, with foster carers focussing their lessons about respectful behaviour around notions of privacy and personal boundaries whilst residential carers focussed more frequently upon modelling respectful behaviour towards the self and others. Looking first at privacy, several of the foster carers interviewed stated that one of the most important things they could do was to help young people establish personal boundaries and promote understandings of privacy. For instance, Patricia (foster carer, untrained) said:

“things change when you foster. The wee things that you don’t actually think about change, because, you know, it was quite natural for our boys to come down in the morning in their boxer shorts maybe wae a dressing gown in the summer, maybe not. That changes. That stops. All that stops. You, you have to look at all the risks there are, and your, your children’s

life changes. Our seven-year-old couldn't come and jump into our bed in the morning because I couldn't allow the other two children to do it - so I couldn't allow him to do it because I didn't want them to feel that he was special".

Furthermore, Bernadette (foster carer, untrained) stated that one of the first things they teach young people in placement is that:

"it is not appropriate to be showing your (body) off" and ensuring that young people realised that it was "not appropriate to be going into the toilet" together. This was something that she felt was particularly important where young people were demonstrating sexualised behaviours; recalling how they had cared for a young boy who "would take other boys into the toilet and expose himself and want them to touch him and vice versa".

This had resulted in their having to:

"keep reinforcing what is and is not appropriate behaviour... what is appropriate, where, and about giving them the privacy of their room and telling them that that is their private place, and what goes on in their private room is private and up to them. But it is not appropriate to be showing yourself off. It's not appropriate to be going into the toilet with other boys".

Similar beliefs about privacy were expressed by Caroline (foster carer, untrained) and Jean (foster carer, trained) who both argued that it was important to teach young people to cover up their bodies by wearing dressing gowns over their pyjamas and nightdresses, and that even when caring for younger children it was important to teach them that they "need to keep themselves more private", that "you don't go into a room when somebody's getting dressed" and that it is "not acceptable to come out of the bath and let

your towel fall off” in front of other people. Both Caroline and Jean felt that these messages could be reinforced by ensuring that young people were provided with “their own private place” and the “privacy of their own room”. For instance, Caroline said:

“we’re great believers in everybody’s got their own private place and their space and you don’t go into a room when somebody’s getting dressed and all that kind of thing. So everybody’s got their sense of privacy. We don’t flaunt things about or anything, and likewise, when you come out the bath - Michael when he was younger, I used to dry him, but not now. He’s ten and he gets himself dried and dressed in the bathroom and he comes out with pyjamas on”.

Caroline went on to reflect that creating boundaries needed to balance the individual right to privacy with teaching young people that they could approach their carers for help and support when they needed it. To demonstrate this she used the example of providing medical intervention for a young boy in placement:

“there has to be a level of appropriateness about your body... for example, Michael had a wee urine infection and his penis was sore, so it was a case of, ‘well, let’s have a wee look and see if it’s all red’ and I’m not gonna go into a room and close a door and have a look at a ten-year-old’s penis. I’m gonna have to say, ‘right, ok. Joe and I will sit on the bed and you touch it and you show me’, and then, ‘right, ok, now here’s some cream. Now, you put that on’, so that we’re not actually physically touching him... so there is, you know, you’ve obviously got that level of privacy, but he’s comfortable enough to be able to show us what’s wrong because this is a medical thing and you’re parents and you should be able to help me with it”.

That foster carers placed boundaries upon young people’s behaviours within the home was reflected in the narratives of several young people. For example,

Niamh (15, foster care) stated that the views of her foster carers towards respectful behaviour had resulted in her changing the way she dressed. She told me that before she had gone to live with her foster carers she had always worn low cut tops or t-shirts that were tied to show her midriff with tracksuit bottoms. This was something that her foster carers, in particular her foster father, disapproved of because it was “disrespectful”. As a result, she told me that she had changed the clothes that she wore and that she now “dressed like a girl” and had “nice clothes”. She also told me that after she and the other young people in placement had got ready for bed they weren’t allowed to come downstairs unless she was wearing pyjamas and her dressing gown. Sophie (16, foster care) also discussed privacy, stating that her foster carer’s bedroom was one of the few places in the house that young people weren’t allowed to go into, and that they “had a lock on the door” and “a cat flap fitted so that the cats can go in there and get some peace from us kids”.

Whilst foster carers discussed using personal boundaries and privacy to promote young people’s understandings of respectful behaviours, residential carers discussed how they modelled positive behaviours to young people. For example, Jennifer (residential carer, trained) told me that it might be considered “silly” but she had a number of rules that she asked staff to abide by when they came into work. These included not “talking about going for a sun bed” or “walking in with a can of red bull” because those little things can affect how young people “see you as an adult” and demonstrate the “respect you have for yourself”. In addition to demonstrating respect for themselves, Laura and Sarah (residential workers, trained in sexual health) felt that it was necessary to model respect for others in order to help people gain an understanding of respectful behaviour. For example, Laura told me that because young people had often not been shown how to “argue and discuss in a more appropriate way” she felt that it was the responsibility of carers to show them “that discussion” is how you solve problems and that “people are different” and “can make different decisions” or “have different opinions without disliking you or falling out with you”.

In contrast, Sarah told me that she used role plays to demonstrate how young people’s behaviours affected others. She told me that she would often walk into

the lounge, change her body language and screech at the top of her lungs “aw man, would you look at that” only for all the young people to look at her as if she was mad. This then provided her with an opportunity to say things like “you see how you reacted, that’s how you affected them out there in that street”. Mike (residential worker, trained) agreed stating that he thought it was important to teach “the kids about being respectful to their neighbours” and getting them involved within the community:

“It’s about using such events as Christmas and Halloween; you know these social events to speak to neighbours and be pleasant and have across the fence conversations. We have a couple of boys who play football out the back and we have neighbours who all play football so occasionally we get them round to play football”.

This was something that he felt was particularly important as there was a stigma surrounding children in care, such that when the residential unit he managed had been established there had been objections raised within the community about having a unit that provided care for “inmates and sexual predators on their doorsteps”. Mike also stated that he felt it was necessary to try and reach out to the community to reassure people’s concerns about residential care; stating that the managers of children’s units could, as he had done, “join the community council” and the “local neighbourhood watch” to try and reduce any possible hostility towards children in the unit, and to ensure that any antisocial behaviour young people in his care might be getting in to was being monitored and responded to.

That children in care were stigmatised was something that was frequently raised by the young people themselves as examples of how young people in the care system were not treated with respect by other people. For instance, Rebecca (14, residential care) stated that she didn’t understand how people could “judge you and be like pure mean to you just because you’re in care”. As an example of this, she told me that she had stopped going to the girl guides because the

woman running her guiding unit had told her that she was no longer welcome because she was in care:

“I went to the girl guides one night and the woman said the next week that I couldn’t go back because I’d obviously done something wrong to be in care and stuff and all the workers were trying to tell her I hadn’t, but like, some people are very judgmental”.

When I asked Rebecca why she had thought the woman had thought that she had done something wrong she wondered if she had “got mixed up” between secure units where young people lived if they had done something wrong and children’s units where you go to live if nobody is able to look after you. She was rather dejected when she went on to say that she believed that “some people just think young people that are in care have always done something bad when they haven’t”. Darren (age 14, residential care) agreed, stating that he thought that there is “a stereotype to being in care and people often think that you’ve done something wrong and treat you like menaces to society” when they found out you are in care.

Stigma relating to the care system was often reported as affecting young people’s education and ability to maintain friendships; thereby reducing their connectedness to the very things that corporate parents were attempting to promote connectedness to. For example, both Kacie and Rebecca (age 14, care leaver) stated that they had stopped going to school because they were being bullied as a result of being in care. For example, Rebecca told me that telling her friends that she was in care had resulted in them not wanting to be friends with her: “they just fuck off and leave you”, “say we’re no hanging about wi’ ye because you’re in care” and “we’re not being friends wae you if you’re in care”. Similarly, Ali (16, residential care) stated that she had been excluded from school as a result of getting into fights with people who “just slag you if you don’t have a ma and da and aw that shite... they make fun ae ye and they’re like ‘ha ha, you don’t have a ma’ or ‘ha, ha, you don’t have a da... so I just batter ‘em”. The stigma that young people in care experienced resulted in

corporate parents trying to normalise the care experience by allowing young people to invite their friends around to play or to stay for dinner. For example, Lindsay (social worker, untrained) said:

“we always try tae be quite open, and, like, people could come, like, I think... always made it, like, that you could come for your dinner, and you can come and spend some time wi’ the, wi’ people, and you can have friends over, and just - I suppose so you would getting tae see who they were kinda in relationship with, and who they were kinda friendly with, and so, like, they knew that they could feel that they could invite people to their home as well”.

Similarly, Joanne (residential worker, trained in sexual health) said:

“we actually encourage their friends to come here and visit, stay for dinner, and for them to go and visit their friends... we always encourage them to try and make friendships outwith the unit to try and keep things healthy”.

Despite this, several of the residential carers and social workers felt that it was difficult for young people to have ‘normal’ friendships because of the need for risk assessments and child protection checks to be undertaken when young people wanted to go and stay at another young person’s house. For example, Agnes (social worker, untrained in sexual health) thought that the experiences of young people in care were often “limited” because of this:

“a parent for example can make the decision to allow a child to go and stay at a friend’s house because they know the friend and they know their mum, but in a unit where you’ve got five or six children and they say I want to go to my pals or have a sleepover, well nine times out of ten we’re having to say actually no we need to check that person out and do disclosures”.

This impacted upon young people's relationships because it removed their ability to "do things impulsively or in a normal way that other kids can do". As a further example of this, Agnes stated that:

"most children who are responsible, they get to go out to their pals house and go out with their pals to the pictures and do this and do that and it's obviously different... I mean we try to make it a normal life and try to make it normal, but a lot of the time it's not possible to make it that normal because there's always got to be some kinds of checks, there's always got to be monitoring".

Patricia (foster carer, untrained) agreed, stating that one of the barriers to her fostered and adopted children having normal peer relationships was the increased level of vigilance that was needed when they wanted to do things like stay over at a friend's house. For example, she recalled how Jenny would ask "can I go to my friend's house" and she would find herself replying "I don't know her mum" and then having to be introduced to the friends parents and go to their house and check that it was safe for Jenny to spend time there. She went on to say:

"if she was biologically mine or even if she was adopted I could make that risk assessment myself but because she's still under the social work the whole thing about the safe keeping has to be so much more vigilant than you would be normally. You would say 'oh I've seen that mum, that child's a lovely girl and she's been dropped off here by her mum and been picked up here by her mum and I know roughly where they live'. But, I don't know where they live and I don't know if it's a nice house and a clean house, whereas (if it was your own child) you would likely make that assumption based on Anna presents well and speaks well, you know what I mean?"

In addition to acting as a barrier to young people experiencing normal relationships with their peers, many of the carers felt that the additional checks

that were needed to allow a young person to go and stay at a friend's house identified them as being looked after and thus increased the likelihood that they would be bullied or losing friends. For example, Claire (social worker, trained) told me that:

"we had that quite recently. A young person wanted a sleepover and it took weeks and weeks to do a police check on the one family and now they're not friends any more so it's too late. And, once that family's name and address is somewhere, every time that young person goes missing the police will turn up at their door at three in the morning so then they're like I don't want you hanging about with her because she just causes all sorts of trouble. It's awful".

Whilst the narratives of corporate parents highlighted the need to be vigilant, in order to ensure that the health, wellbeing and safety of children within their care was maintained, it should be noted that the need to conduct police background checks on friends' families is not a legal requirement (The Scottish Government, 2008a).

### **5.3 Monitoring and supervision**

I now move on to discuss how monitoring and supervision of looked after young people's activities is undertaken. This section begins with an overview of the negative role models that young people in the care system can be exposed to, before going on to explore how corporate parents use monitoring and supervision to try and influence young people's sexual health.

#### **5.3.1 Negative role models as child protection risk**

Whilst many of the corporate parents spoke about the need for positive modelling within the care system there was also some recognition amongst social workers and young people themselves that young people in care, especially those in residential care, could be exposed to negative role models. For

instance, Laura (social worker, untrained) believed that residential care could result in there being “plenty of opportunity” for young people to become “involved in a lot more kinds of dangerous, risk taking behaviour”. In particular she highlighted that the behaviour of young people she had supervised who had been placed into residential care sometimes “nose dived”. When asked what she meant by this she said:

“just getting involved in kind of relationships within the unit, with other young people you know, kind of maybe becoming involved in a relationship like between kind of, a kind of boyfriend, girlfriend scenario in the unit. I mean, I’ve had like knives, young people with knives and you know, lock back knives and fighting and obviously drinking alcohol just whenever they... smoking, it seems as though the unit staff just don’t have any power to sort this. Drug-taking as well and just, you know, a blatant disregard for rules and boundaries”.

This was something that many of the young people who had lived in residential care had experienced. For example, Karen (17, care leaver) was nine years old when she went to live in a children’s unit and she was terrified. She told me that:

“it was like a horrible place. There were folk coming in steamin’ drunk and oot their faces and it was terrifying. I was nine or summat like that, a wee lassie, and there’s like 16 year olds in there, 18 year olds in there and they’re coming in steaming and you’re like a wee lassie pure shitting yourself, you’re like ‘oh ma gawd’, and there were folk coming in and there was a bathroom doon the stairs where they smoked joints and aw that and people just getting steamin’ and the polis coming in each day and I was like a terrified wee lassie”.

Andrea (16, care leaver) had had a similar experience. She described being placed into a unit at the age of 11 with other young people who were much older than her and witnessing a lot of things that she had never seen before in a

very short space of time. Although Andrea didn't like to describe the unit that she had been living in as being the unit where all the "bad weans" were sent to live, she acknowledged that the unit had been full of all the "people wi' behaviour problems" who "couldnae deal wi' life and took drugs and drank". She described the unit that she had been living in as a "crazy" place where people would turn "up at the door with samurai swords... wanting tae chop up folk in the units because of stuff that had happened at the weekend". Andrea told me that she thought the unit she had lived in hadn't been a suitable place for an 11 year old girl as when she first arrived the things that she saw terrified her.

Laura (social worker, untrained in sexual health) thought that there were two reasons why young people in residential care were at increased risk of being exposed to negative peer influence, namely wanting to fit in with their peers and residential workers not having sufficient powers to control young peoples' behaviours. With regards to the first of these she told me that she thought that sometimes units could have either very positive or very negative effects upon young people's behaviour depending upon what the behaviours of the wider group were:

"I think if it's a really settled unit and she, you know any young person goes into that and you know, all the young people go to school and you know, they're all quite settled as can be the case, then they're more likely to conform with that kind of norm within the unit at that time but all it takes is for someone else to be moved in and just completely you know, blow the lid off it and then one decides they're not going to school and one decides they're not conforming, then the rest of them kind of just join in and unfortunately the two young girls I've worked with have been the ones that have went into the unit and probably been the ones that weren't wanting to go to school and weren't wanting to do anything you know, and maybe start to tip the balance you know, in the units".

There was certainly evidence of this within young people's narratives, with young people often describing how they had started to adopt the behaviours that

they witnessed either as a way of protecting themselves from being bullied by others or because they wanted to “fit in” with the other young people. For example, Andrea told me that she had started getting into fights on a regular basis as being able to fight demonstrated that she could look after herself and prevented the other young people from hurting her:

“you could climb the ladder... the more and more fights you got in, the more and more you could handle yourself the more and more you could handle yourself and the bigger the reputation you had and the more people werenae gonna hit you”.

Similarly, Stuart (20, care leaver) stated that he had started drinking alcohol and doing drugs because he was worried about what the other young people would do to him if he didn't. He told me that he had been “papped oot” of his foster care placement when he was eight or nine after being accused of “daen stuff that [he] shouldnae be daeing like going out, fighting, drinking and aw that” which he didn't like being accused of because “I didnae drink back then... Aye I smoked, but that was it. It's no like I was going about taking drugs and drinking”. This resulted in him being placed into a residential unit, which exposed him to a lot more things and led to him adopting those behaviours at a young age:

“you always get one or two people that start things that you just don't want tae be a part ae, but because I was only ten I got intae smoking hash. I got intae drinking. I was getting in trouble wae the polis for hinging about wae the wrong people but it's just wan ae they things.

Stuart when on to reflect that being in residential care can expose young people to peer group settings that are not those that they would usually be part of if they weren't in residential care, and that this can expose young people to peer pressure:

“you cannae actually help that if you’ve been in care and you’re hanging about wae the wrong people... people who were older than us, and I felt more fallible so I thought ‘if I don’t dae this I don’t know what they could dae to me so I’ll dae it wae them”.

Whilst some young people reported that they had adopted risky behaviours because they were worried about being hurt by others, a small number of young people stated that they had done things that they wouldn’t have normally done because they wanted people to like them. For example, Tony (16, care leaver) told me that being in care had been a “time of [his] life when [he] was stupid”, “didnae gie a fuck” and just wanted to do what the other young people were doing:

“you just don’t gie a fuck. I went and ran away on the Monday wi’ another girl from the unit and we stayed oot all Monday night and stayed in some random person’s house and that’s heavy dodgy in itself. We got picked up on the Tuesday at four o’clock in the afternoon and then we got dropped back aff at the home and then on the Wednesday we were oot again. It wasn’t good. I just wanted to follow the groups... but it was dead stupid and that. Anything could have happened to me. We went to that guy’s hoose and he had a hatchet and a baseball bat and you’d shit a brick right?”

Moving on to the second reasons stated by Laura, namely that corporate parents didn’t have sufficient powers to control the behaviours of young people in placement she argued that:

“unit staff just don’t seem to have, aren’t able to stop it [negative behaviours] because there’s very little they can do. I think the only thing they can really do is withhold their pocket money, but they can’t even do that because they’ve got to let them have their money so all they can do is supervise them spending it so that they don’t have the money in hand to go out and buy drink and cigarettes and things like that”.

Several of the young people supported the notion of residential carers having no power to stop young people's risk taking behaviours. For example, Tony (16, care leaver) when asked about why he had taken some of the risks he had taken stated that he had done it because "when you are in care you can get away wae a lot mair than you can get away wae in (your own) hoose". For example, he told me that because he knew he wouldn't get into the same amount of trouble that he would have at home he had had started "smoking weed" and "dogging off" school. He went on to say that when you're in care and you get caught smoking a joint you just "go tae your room" whereas at home he would have been "papped oot" onto the streets. For him, knowing that he wasn't going to be asked to leave the children's unit if he did something wrong allowed him to become "a bit of a rebel" and "dae stuff" that he wouldn't normally have done like "shout and swear at the staff" because ultimately he knew that they "couldnae swear back". Amy (17, residential care) agreed, stating that:

"in here it's not like your family. They're not scared... they wouldn't be worried. It's not as if I was scared of my family but I wouldn't let my family worry, so I wouldn't run away, but in here I would just run away. I would smash a window and I wouldnae care because it's no my family. It's just people that need to look after me. You get away wi' a lot more in here than you would at home".

It is worth noting that once young people had started using substances and getting involved in aggressive behaviour they often reported that they had found it difficult to stop. This was because using substances and getting into fights proved to be effective ways of getting rid of their pain and anger, and allowed them to forget what had happened to them in the past. For example, Stephanie (14, foster care) told me that she started using drugs and alcohol to forget about all of the physical abuse perpetrated by her mother and being raped by her stepfather. This had resulted in her:

"getting in with really bad people who were drinking and going out every weekend and taking drugs and things like that... half the time I was always

like out of it. I'd just take anything, anything we could get our hands on we'd smoke it all and snort it all or whatever and you used to feel really good, but then the next day you'd just think 'why am I doing this?', but it was really, I just think it was getting away from everything that made it worthwhile."

Andrea (16, care leaver) had had a similar experience. She told me that:

"at first when I moved into the unit it was cannabis, poppers, aerosols, all the kind of stupid stuff but then I started going out with a few of the people when I moved into (this one unit) and you started going out with people at the weekends and there was eccies flying about and there was cocaine flying about and speed, I mean I was only 12 year old and I was taking them all just to show I wasnae a daft wee lassie I was a lot more mature at the time ay, but obviously I was a daft wee lassie but I was just trying to act the big hard brass Andrea which I was at one point but that's what everyone thought but I was a vulnerable wee lassie on the inside who just wanted to go out and drink and dae drugs tae just try to block it all oot".

### **5.3.2 Monitoring and supervision as a child protection tool**

Despite it being demonstrated in the previous section that looked after young people may be particularly vulnerable to engaging in antisocial and health risk behaviours, including sexual risk taking, the interviews conducted with both corporate parents and looked after young people suggest that communication about sexual health and relationships is still largely reactive and based upon child protection concerns. This issue, along with how monitoring and supervision of young people's activities is undertaken within the care system will now be discussed.

### ***5.3.2.1 Sexual health and child protection concerns***

Although it was noted that talking about sexual health and relationships within the care system had previously been a taboo subject, it was widely accepted by all corporate parents that talking to young people about their sexual health had always been “on the agenda” when young people were engaged in risk taking behaviour. For example, Agnes (social worker, not trained in sexual health) stated that social workers had:

“always had a duty to consider it [sexual behaviour]... but there wouldn’t always be a major sort of in-depth discussion of it if there weren’t any major issues; however, if a child was sexually active and they were underage and there were concerns about their activities and they were putting themselves at risk then it would be very high on the agenda”.

Concern and worry about young people’s activities was also highlighted by Laura (social worker, untrained) who discussed how she had experienced young people in residential care:

“just disappearing, walking out the unit and not giving any sense of where they were going or who they were going with and the unit staff really being at a loss to know who they are with and where they’re going. And you know, they kind of met up with people I don’t know, through social networking sites or anything like that or just people they know, or associates and disappearing for days and nights and you know, staying out all night and just offering no explanation as to where they’ve been and then go back out the next day and staying out all the night again and I mean, that’s a common theme and the police obviously are out looking for them and bringing them home and that’s I think, in my experience, that’s been a huge worry because they don’t know where they are, who they’re with and obviously as we spoke about earlier you know, about getting money and older males and things like that, it’s a real, real worry”.

Agnes (social worker, not trained in sexual health) discussed her beliefs that communicating about sexual health and relationships were particularly important for young people who were absconding from placement:

“I had a young woman who was absconding from her foster placement, what had been a stable foster placement, she began at a certain age absconding, she wasn’t happy there, there were issues with the foster carers, they were very religious and she felt she was being forced into doing things she didn’t want to do, like going to church and stuff like that, and she started to rebel, like most teenagers do, her behaviours were she was running away, having sex with men she didn’t know, and coming back the next morning covered in mud because she’s been having sex or she said she’d been having sex, but whether she’d been having sex or being forced to have sex we don’t know but this was happening on a regular basis, she was drinking and just really, really very vulnerable, but you know I think, but in her case, that [sexual health] was very high on the agenda”.

The emphasis placed upon risks by corporate parents suggested that conversations about sexual health were often reactionary rather than preventative and that staff members refrained from “major, in-depth discussions if there weren’t any major issues”. This view was echoed by several of the young people, all of whom were care leavers. For example, Andrea (16, care leaver) said:

“you were getting up in the morning... say you’d absconded on the Friday, you’d come back on the Sunday. You wouldnae talk to them all day on the Sunday because you’re hungover but on the Monday you’d have them all in your ear. “Did you use protection? Do you know the risks? All these leaflets, big packs of leaflets like this (indicates about a cm thick with hands) and dragging you to the clinic to make sure you’re alright. And it was constant. My sexual partners were always over the age of 16 so really they could’ve got done wae it (charged by the police) and they were

constantly phoning the polis and the polis were coming out and then they'd make you go to the family planning clinics and all that kinda stuff".

Similarly, Tim (17, care leaver) said that "they only talked to you about it if you was daen stuff and if you werenae daen anything then they wouldnae say anything to you". This was further demonstrated in an example provided by Mike (23, care leaver) who said that none of his carers had spoken to him about sexual health until he "came home after 'the big night' and "told the staff" that he had had sex at which point they "got all panicky" and "asked lots of questions" such as "were you safe? Did you use a condom? Did you make sure she was clean?" before making him "go to the clinic to get checked".

Many of the corporate parents identified that they had a responsibility to record and share information about discussions they had had with young people about their sexual health and relationships. How corporate parents recorded and shared this information was identified by some young people as shaping their decisions to seek support about sexual health and relationships. For example, Freddie (18, care leaver) felt that conversations with carers were only partially confidential; this meant that young people could "trust [staff] to a certain extent but that if you say something and they think you're putting yourself in danger then they'd have to tell other people". He went on to say that although this meant that "you could talk tae them" you would never be able to "fully trust" them. This view was also shared by Darren (14, residential care) and Amy (17, residential care) who felt that although staff "needed to pass info on" information if there was "a danger" to young people there needed to be limits to what staff were allowed to share and what they weren't. When asked what things staff members "need to pass info on" about Amy replied that if something "was a worry" then staff should "pass on" but that if it was something "more personal" then they just shouldn't be sharing it.

Mike (23, care leaver), Mary (16, residential care) and Darren (14, residential care) agreed, confiding that they had all experienced "personal" information

being shared in sensitive ways. For example, Mike recalled how on one “embarrassing” occasion he had got thrush and “told one member of staff because [he] needed help” only to have “other staff showing up at his room and going ‘I heard you had this’”. As it was something to do with the health of a young person in care he told me that he knew they had to share the information and that “they’ve gotta log it”; however, he couldn’t help but think that it would have been more appropriate for “just one member of staff to deal with it” rather than everybody becoming involved and making an already embarrassing situation worse. Mary shared a similar experience describing how a few weeks earlier she had been in bed with period pains only to discover the next day that the staff had written in the unit’s log book that “Mary was in bed with period cramps”. She went on to ask “Why? Why did it need to be written in the book?” When asked how she knew it had been written in the book, she told me that it was because she had gone into the office and had seen it, and if she could see it then “anybody could have seen it”.

Darren told me that seeing personal information “written down in the diary or the books” and then seeing “all the staff read the book” was something that didn’t make him feel good”. He felt that if he “told one staff member” about a problem he often “just want[ed] them to know” and “not everyone else”, and that “if someone came to like one staff with a problem they should just deal with it like when they are on shift rather than going to different shifts and telling them”. He went on to say that:

“whatever is in the book should be like really important, you know, like stuff that’s going to affect your life constantly, like daily. Stuff that shouldn’t be written in the book is something more personal to you that you don’t want to feel everybody else knows”.

Whilst it appeared to be widely accepted that confidentiality could be broken under certain circumstances, young people often expressed concerns about how staff members used and shared information, with many feeling that the way in which staff did so was akin to “gossiping” about their problems. For example,

both Sophie and Amy (both 17, residential care) described how staff in their units would often talk openly about the problems young people in their unit were having. Sophie told me that staff in her unit often “talked about aw your problems in front o’ the other young folk” whilst Amy stated that “staff will just bring up things in front of other people”. Amy went on to say that she often “heard [staff] gossiping about other young people” and that she didn’t think it was right for staff to be doing that because:

“some of the people in here have come from quite a bad background and staff, like one of the staff in here will just say things right in front of like me and they’ll put that person down in front of the other young people. I don’t think that’s right”.

However, Nadia (23, care leaver) didn’t think that staff would stop talking about young people “any time soon” because she felt that the lives of children in care were “often better than gossip magazines to them”. Mike (23, care leaver) and Rebecca (14, residential care) both agreed about the extent to which staff gossiped about young people. Mike felt that that staff members gossiping happens “quite a lot” in residential care and that whilst he was there the one thing he was always guaranteed to be able to talk to female staff about were his relationships because “they loved his relationships because they were all so complex” and they would be “all over it” whenever some “new drama” arose in his life. Rebecca (14, residential care) went on to say that if there was a boy that you liked then to avoid being the “gossip of the week” you just “don’t tell them anything about a boy fancying you”.

Whilst some young people were concerned about how confidential the conversations that they had with their carers were, other young people talked about how they felt that sometimes staff crossed personal boundaries when talking to them about things they had told them in confidence. For example Stuart (20, care leaver) told me that he had found it really hard having a girlfriend whilst he was in care because the “staff were always telling wee jokes... and trying tae have a laugh with us” but it felt “like they were trying

tae bring in wee digs and wee sly comments all the time”. Although Stuart went on to reflect that he could now see that the staff weren’t trying “to pick on him” and were just “having a wee laugh” when they acted like that, the effect of those interactions when he was in the care system was him deciding not to talk to staff about his relationships.

### ***5.3.2.2 Monitoring peer and romantic relationships***

Earlier in this chapter I highlighted that many of the corporate parents, in particular the residential carers believed that inviting young people’s peers and romantic partners into the care setting provided corporate parents with an opportunity to monitor these relationships and assess any potential risks associated with them. For example, Marion (social worker, not trained) described how she actively encouraged young people within her unit to bring their boyfriends/girlfriends into the unit so that:

“you would be getting tae see who they were in a relationship with... and you get a wee bit more of an awareness ae what the situation is wi’ people. That sound terrible, but it’s true. Just getting to know their partners a wee bit and they’re more likely tae kinda sit and chat tae ye and talk tae ye and tell ye where they’re going and what they’re up tae... and at least you get tae kinda know what they’re up to”.

Mike (residential carer, trained) agreed, stating that he felt that:

“as a parent you would want to, you know, you are trying to encourage the young people to discuss with you that they’ve got partners, that they are engaged in maybe a sexual relationship that they have got a girlfriend or a boyfriend or whatever it may be, and that they feel comfortable about talking about that person roundabout, so that it gives us an opportunity to say ‘well, why don’t you invite so-and-so over for some dinner’ you know or ‘come and use the meeting room and you could spend some time in the unit’. Just so we can get a sense of where the

relationship's at and what you know how serious it is I suppose for the young people. And again, that backs onto relationship building. If you have good relationships with young people then you can have those conversations and it is not about prying, it is about talking to young people, and letting them know that I am asking the exact same questions I ask my own daughter or my own son so they don't feel that they are being treated any different because they live in a unit".

Mike (residential carer, trained) went on to describe how they currently had a 16 year old girl in placement who was pregnant, and:

"her boyfriend lives locally and he had been over for dinner and he has been involved in the unit and staff have met him and we are clear what our role is and he is quite clear what his role is to this young girl.. and it works... the young girl is 16 and the boy is 23 so it was quite clear for us the best way for us to deal with that was to be part of the relationships in terms of we could have made it taboo and went 'well I'm sorry we're totally against it and we want nothing to do with it'.

Instead, Mike described how they had taken the decision to allow the young women to bring her boyfriend back to the unit so that they could monitor and assess the relationships:

"I could be quite clear in my role in safeguarding this young woman and find out if there was any ulterior motives or whether there were any other reasons why he was interested in this young girls other than just you know being in love with each other... so we have engaged with this young man and invited him to come round to the unit so that we could get to know him".

Despite feeling this had "worked well" this time, he went on to acknowledge that introducing a 23 year old into a children's unit created additional risk that

had to be monitored: “it is very difficult to manage. It is about again about awareness about where there are young people in the unit and it’s something that we dictate when it happens, it’s not something that the young girl and the young male decide for us, they don’t just appear on spec and say “can we come in and have dinner or come in and sit in the front lounge and watch telly”. It is something that we have to dictate”.

Joanne (residential carer, trained) agreed, stating that because she had young people in placement aged 12 to 18 it was important that when the boyfriend of the older girl in placement came in to the unit they were allowed to spend time together as long as they “did not shut the door” and “did not go into the bedrooms”.

The importance of risk assessing and monitoring young people’s behaviours was also evident within the narratives of carers who had experience of young people within the care placement encouraging other young people to engage in risk taking behaviours or who had alleged that another child in placement had abused or was abusing them. Looking first at the importance of monitoring young people encouraging engagement in risk taking behaviour, Patricia (foster carer, untrained) recalled how strict monitoring had been when she had worked as a residential carer, stating that:

“after working seven years on night shift I felt as though I was no longer a care giver - I was a security guard, at night, keeping young ones out of other ones’ rooms that weren’t supposed to be there, through the night, hauling other ones in windows that were trying to get out of windows in the middle of the night, keeping ones out that didn’t belong to the unit that were trying to get into the unit to be with some of our young ones and we had alcohol brought in, we had drugs brought in, we had children that were abusing gas and glue and all sorts happening”.

She went on to say that the unit she had worked in had also had problems with young people in placement being involved in sexual relationships with each other:

“we had a lot of sexual relationships going on within the unit... and... that was dealt with as it happened, and it was dealt with in a way that you would have stopped it. If you knew it was going on, you would have stopped it. That was what was done. You would sit down and talk with them and basically tell them this is no the place - but then, it was their home. I don't know what the place was for them... because then they do it outside... well, they didn't always do it outside. We had to phone an ambulance one night for a girl as she had been giving one of the boys a blow job in one of the bedrooms and had caught her brace on his penis and the blood was everywhere... so no, they did do it in the unit, and as I say, I would be in, hauling kids - I mean, we had fifteen-year-olds that we were hauling out of one room, into another room, saying ‘no, you're not on’”.

### ***5.3.2.3 Risk awareness and planning in the care setting***

In addition to monitoring young people who were encouraging risk taking behaviour, several of the corporate parents specifically discussed how they had to monitor the behaviour of the young people within the placement because they had alleged that another child in placement had abused or was abusing them. In particular, Joanne (residential carer trained) described how the physical layout of the children's unit she managed made it difficult for staff to know where all the young people are at anyone time because of the number of “hidden corners” within the unit. Thus, the unit had a policy of locking communal areas when not in use and ensuring that the bedrooms that were located closest to the staff office were allocated to the young people who required the most supervision. To place this in context, she described how the bedroom closest to the office had been allocated to a young woman who would “encourage the rest of the group to go out drinking, and would then make allegations of rape against one or more of the boys”. This young person was also

involved in an on-going investigation relating to being groomed by a gang of men, and was “suspected of having received money for taking another girl in placement to their flat”. Caroline (foster carer, untrained) described a similar experience of having to manage and monitor the space within her home, recalling how her oldest foster son Matthew (15) had alleged that her youngest foster son James (10) had sexually abused him. This was something that had resulted in the whole family being interviewed at the police station, only for it to transpire that Matthew had made up the accusation because he was unhappy that James didn’t always cover himself up after going into the shower. In order to try and alleviate the situation they had provided Matthew with a bedroom in the attic that James was not allowed to go into.

Beyond monitoring the space within care placements, several of the corporate parents highlighted the importance of carefully monitoring which young people they would encourage forming friendships, were allowed to go outside the unit by themselves and were allowed to go on trips with each other. For example, Laura (residential carer, trained) said:

“we’re also very careful about who goes on outings together, about who we would encourage to form friendships with, and who we would discourage from forming friendships. And that’s for very good reason, you know? So if we were, say, for instance, doing a holiday, we would be very careful who we were taking on holiday, where we were going - everything is risk assessed, in terms of what dangers are around, and sexual, you know, elements of that would be taken into, directly into consideration. And as I’ve already explained, bedrooms males not in females’ bedrooms, and all those situations would be risk assessed - where somebody’s placed within the building, where they’re sleeping, then where the night shift would be based, where the day shift would be based and managing the situations in those ways”.

In addition to managing the space within care placements, several of the corporate parents discussed having to establish rules with young people what

was and was not appropriate within the context of inter-personal relationships. For example, it was noted that because some abused children can be emotionally- and cognitively- younger than their biological age, the behaviours that they express in order to have their emotional needs met may not necessarily be appropriate. For example, Caroline (foster carer, not trained) when talking about Matthew stated that:

“there’s a lot of catching up to do... Matthew is, emotionally he is not fifteen. Emotionally he’s probably sitting around nine or ten years old”.

This was something that she felt had real implications for the way in which Matthew formed relationships with his carers and his understandings of age-appropriate relationship behaviours. For example, Caroline described how Matthew becomes very tactile when he is upset, and has a tendency to “want to crawl up on my knee for a cuddle”. This was something she found quite difficult to deal with because although Matthew has “the emotional needs of a nine year old” he “has a fifteen year old frame”, and it is not really seen as appropriate for “a fifteen year old to come and sit on my knee and cry”. Thus, Caroline and her husband found themselves having to place boundaries upon Mathew’s behaviours to ensure that nobody viewed his behaviours and their reactions as inappropriate:

“we’ve explained that to Matthew and we’ve said that we have to find other ways of meeting your needs, and he does understand that. He does know that wherever possible we will try to meet the need that he has but in a way that is outwardly appropriate because you know, somebody’s gonna see me standing in the street giving you great big hugs and think it is really weird so we’ll do it privately in the house”.

Caroline went on to highlight that being “very open” and “affectionate” in private had helped Matthew to grow emotionally from the child who “really struggled” with being affectionate and would “tense up when you went near him

to give him a hug” to the child who now “won’t leave the house in the morning to go to school without getting a massive hug”.

Similarly, Patricia (foster carer, not trained) stated that whilst physically a child can be “tall and look his age” it is not uncommon for them to be “mentally and emotionally stuck” at a different age. She went on to describe how she currently provides respite care for a 13 year old boy who is cognitively and emotionally about five or six year old. This is something that she has found very challenging with regards to how he interacts with other young people because:

“he is very comfortable with little children. He’s not comfortable with teenagers and up until last summer, he is of the mental age where he loves nothing better than to run about in the park and on the play things at the park and to go to a soft play, but he goes to younger children and he wants to lift them and he wants to help them on and off things and he wants to pat them and cuddle them”.

Whilst Patricia felt it “very difficult to say whether his behaviour is sexualised behaviour” or “if he is sexually aware” she was certain that there would come:

“a point when he will have sexual feelings and the people that he is most comfortable with is these young children... he’s almost compelled to go to them, and will sneak about to try and get a wee one to give a wee pat to”.

When asked as a carer how she dealt with those concerns Patricia told me that she had discussed her concerns with his foster carers and social worker, and that it had been decided that she should try to talk to him about how he interacts with other children. This was something she found frustrating as although they had frequently talked to Paul about his behaviours, they weren’t sure whether he understood them. For instance, she stated that Paul could “get quite agitated” when spoken to about why he likes to play with the younger children

as he “doesn’t know why he goes to younger children” and can’t articulate whether “it’s because he’s comfortable [with them] or because it gives him a good feeling”. I shall return to discuss the effect of cognitive and emotional delays on sexual health learning later in this chapter. Not being certain that young people understood their concerns about risk resulted in carers placing restrictions on young people’s behaviours. For instance, Patricia stated that her concerns about Paul’s friendliness towards young children had resulted in her making the decision to “stop taking him to play parks and soft plays” because she was very aware that parents could be concerned about an older boy approaching and touching their children.

Placing restrictions upon young people’s activities, and the effect that it could have upon their wellbeing and autonomy was something that was highlighted by a number of carers. Sarah (residential worker, trained in sexual health) told me about her experiences of caring for Darren (15) who had been being sexually exploited by older men for the last 2-3 years. Knowing where Darren was, what he was doing and who he was doing it with became extremely important tools in keeping him from being at harm. For example, Sarah (social worker, trained) stated that because Darren had been groomed via the internet and then met the adults at a later date they consciously monitored all of his email communication and accompanied him wherever he went. This was something that Sarah announced was “restricting his freedom” and “his right to be a normal child” because he didn’t get to do all of the things other young people did, like get on a bus in the city centre and go anywhere; the main reason being that when Darren was left to his own devices he would end up contacting men through the internet and “be found having sex with older men in parks”.

Alison (residential carer, trained), Joanne (residential carer, trained) and Agnes (social worker, trained) also discussed placing restrictions upon young people’s behaviours to minimise their contact with older, exploitative adults, namely screening all communications that the young person received by letter, email and text messages in order to ensure that young people were not having contact with exploitative men. For instance, Joanne (residential carer, trained) discussed how they currently had a 12 year old girl in placement who was

demonstrating signs of early sexualisation and had been emailing and texting naked photographs by an older male in a position of power:

“We’ve got a twelve year old girl who is, I don’t want to say obsessed, but when we first got her in about six months ago, all her talk and her chat was about paedophiles, and how she can say who paedophiles are, and she was going on to websites and there was inappropriate material found on her phone and different things like that... we’ve still not got feedback from the police about what was on the phone so we’ve given her wee trust exercises to get back on the computer as we don’t want to ostracise her from the group, but then she’ll go onto these certain website and she’s had images sent to her from people in the past that are in my opinion grooming her... so it’s a difficult one”.

When asked how they were trying to protect the young woman, Joanne went on to say that they were working with an outside agency who were focussing on “work about keeping herself safe and making safer choices on the PC”, and that they were strictly monitoring her email and phone communications so that they could be aware of any problems.

Caring for young people who had problematic sexual behaviours was something that appeared to cause corporate parents distress. For instance, Jean and Ian (both foster carers, trained) became quite upset when discussing how they had provided care to five siblings who all demonstrated problematic sexualised behaviour, including incestuous relationships that had developed as a result of the abuse they had experienced within the home setting. What was evident from their narratives was the fact that despite doing their best to monitor and keep the young people safe, they found themselves having to witness and intervene in acts of incest on a number of occasions. For instance, Ian recalled one incident where he had taken two of the young people to the hospital for a scheduled appointment and had been asked to leave the two young people sitting in the waiting area with the receptionists so that the consultant could talk to him in private. He went on to recall how he had returned to the waiting area to find

the two young people missing. After a quick search of the department the two were discovered in a toilet cubicle: “he had her stripped down in the toilet and was having sex with her”. This incident served to highlight that the young people could not be left unsupervised in public.

Similarly, Jean discussed how these young people required additional supervision within the home environment; recalling an incident that had happened when she had gone out for the day, leaving Ian to look after three of the young people and had come back to find him “standing doing the ironing... whilst one of the children was sat watching telly in the room”. He went on to say that the first thing his wife asked was:

““where are the other two children? And I said, ‘they’re just up the stairs playing... and the other boy who was watching television just seen me and goes, ‘I think you should go up the stairs’. Now this has happened on a few occasions where one of us has been out and they would use that moment, and I ran up the stairs and there was child A and B in the sliding wardrobe, a pillow put down on the inside of the sliding wardrobe to mask the noise and he had the girl on the floor and he was on top of her... and I’m just doing the ironing... that’s how quickly... I never even twigged”.

Jean and Ian went on to say that after that point they realised that they had to “work as a team” because they “had different radars” and would pick up on things that the other wouldn’t.

#### **5.4 How do corporate parents talk to young people about sexual health and relationships?**

Thus far, it has been demonstrated that corporate parents play an active role in trying to influence looked after young people’s sexual health by trying to promote connectedness and playing an active role in the monitoring and supervision of their peer and partner relationships. I now move on to discuss

looked after young people's and corporate parents' experiences of talking to young people in the care setting about their sexual health.

#### **5.4.1 Talking about sexual health and relationships**

Many of the residential and foster carers had experienced talking to young people about their sexual health and relationships. Those corporate parents who had received sexual health and relationships training discussed how they had a greater awareness of the resources that they could use to enable them to discuss sexual health and relationships with young people, and how they had used these in practice. For example, Margaret (foster carer, trained) stated that:

“after I went to the training I found that I was really more confident and I had all the information on hand and booklets to show the boy. I was able to sit with all the booklets and just speak about it without having to put humour in”.

Being able to draw upon printed sexual health materials, books and other forms of media were seen as valuable tools that carers could rely upon and which made it much easier for carers to sit down and discuss sexual health and relationships with young people. This view was shared by staff that had and hadn't received training. For example, Laura (residential carer, trained) told me that she had given a young girl in placement a book to read about puberty and sexual behaviour. After reading the book, the young woman asked Laura how she could find out “what all the parts [of the vagina] looked like”. Laura told me that she had suggested that the young woman “use a hand mirror” in the privacy of her bedroom “to look at her private parts”, and that this conversation had then evolved to talking about masturbation and how it could be used to “learn how you like and don't like to be touched”.

Alison (residential carer, trained) stated that prior to having received sexual health training the residential carers in her unit had often relied upon materials

printed by the NHS to help guide them in talking to young people about physical changes that were happening within their bodies:

“we as a staff team got some great stuff off the NHS for working wi’ five, six, seven and eight year olds and we did a great book that illustrated the changes in their body because obviously when they go in and they have baths and they have showers they’re noticing their body changing and they become more inquisitive”.

Drawing upon the support of outside agencies was something that she thought helped staff initiate conversations with young people. For example, she stated that the previous unit she had worked in had “got the family planning team to come doon and do some work” with the young people “around sexual health, contraception and sexually transmitted infections”. The staff members were then able to build upon this by setting up a girls’ group and talking to them about relationships and problems that they might experience.

Residential and foster carers who had spoken to young people about their sexual health frequently highlighted that the internet was extremely useful as it provided carers with “a wealth of literature” that could be used in one to one discussions. For example, Alison stated that she had found the BBC website to be an “absolutely fantastic” resource when one of the girls in the unit had started her periods because they were able to go on and look at all the “different diagrams” and learn about the menstrual cycle and “when it starts and when it finishes” and how at certain points in the cycle “there’s the danger” of getting pregnant. Alison also illustrated the importance of having access to the internet using the example of a young man in placement who had been diagnosed with HIV at the height of all the “scaremongering that was going on wi’ HIV”. She recalled how she had been responsible for taking the young man “tae the Royal for the blood test”, and that when the results came back and the unit manager disclosed the young man’s HIV status “alarm ran through the whole staff team” because they had no knowledge about HIV and AIDS and how it was transmitted. Alison highlighted how if this incident had happened today they would have just

“gone on the internet” to find out information and to get advice about how to “keep ourselves safe”, but as this was before the internet was widely available they had ended up watching a BBC documentary about HIV to get more information. She recalled how at the end of the documentary a telephone number had been provided for people who wanted help and advice, and that because of this her manager had contacted the helpline. This enquiry for help resulted in three people from the NHS coming out to the unit to talk to the staff about how HIV was transmitted.

In addition to utilising the internet as a source of information on sexual health and relationships, many of the residential and foster carers talked about using other sources of media to initiate conversations about sexual health and relationships was something that corporate parents used. For example, Sarah (residential carer, trained in sexual health) described how in the girls’ group they had set up they had used problem pages within teenage magazines to prompt discussions of relationships amongst the girls:

“what we done was cut out problems in magazines, but what we cut out was the answers and not the questions so we were trying tae get them tae guess what was the question that young person asked”.

Caroline (foster carer, untrained) highlighted how kissing scenes and sex scenes in television programmes and films could be used to initiate discussions about relationships with young people. For instance, she told me that Matthew (15) often seemed quite distressed and frightened by witnessing sexual behaviours. In order to try and help Matthew become less frightened, she and her husband had made a point of “not turning a channel every time something that’s inappropriate comes on” and ensuring that they talked to Matthew about kissing scenes and sex scenes on TV and in film when they came on:

“we don’t shy away from something that if there’s a sex scene in a movie, or whatever, we’ll quite often discuss it, rather than say, “oh my goodness, we shouldn’t be watching that... we just relax about the whole

thing... it's not something that we try to pretend isn't there. It is there and it's life".

Discussing what was being seen on television was a way of trying to normalise sexual behaviours, and help Matthew understand that sexual behaviours are normal within the context of a loving relationship. This was something that she felt was very important as she and her husband didn't want to have to hide things like goodbye kisses on the way to work. Laura (residential carer, trained) also used television programmes to initiate conversations about sexual health and relationships; stating that she would get young people to reflect upon music videos and the "sexual messages" that they tended to convey.

In addition to using media, carers often reported using naturally occurring situations to discuss sexual health. These methods were often innovative. For example, Ian (foster carer, untrained) told me that he had been sat at the dinner table with three of his foster children when two of them had started daring the other to taste banana yoghurt. This flavour of yoghurt was identified as being "disgusting" and the young person didn't want to try it. He told me that after several minutes of pressurising the yoghurt was tasted, and he used the fact that the other children had encouraged this to happen to ask the question "why did you taste the yoghurt?" This led to the young people having a discussion about peer pressure which then allowed him to discuss issues such as smoking, alcohol use, drug use and feeling pressurised into having sex.

Meanwhile, Sarah (residential carer, trained) described two ways in which she had used naturally occurring events to discuss sex. The first was when she and a young person were playing Connect4 and the young woman asked "where do babies come from". She started explaining that "when a man and a woman have sex..." only to be interrupted by the young person who told her that they "knew that" they just didn't know what happened next and where the baby actually came from. Unsure of how to answer the question she told me that she had deconstructed the Connect4 game and used the grid as a uterus, the legs as the fallopian tubes and the counters to represent the sperm and the egg. After

explaining how sperm swam up the tubes and fertilised the egg she then found herself having to show the demonstration to other young people in placement as the girl she was talking to thought it was cool. Sarah confided that after talking to all the young people she had turned to her colleague and asked “did I get that right?” because even though she had had three children she wasn’t certain about the biology.

The second was an event that Sarah described as “mortifying” and made her want “to kill” the young woman that had instigated it. She described how she had been sitting at the dinner table “wi’ all the weans” having dinner when all of a sudden one of the young women had blurted out “see when you have sex wi’ your husband... do you cum?” Sarah confided that she had turned “bright red” with embarrassment, and that her first instinct had been to shout at the girl for asking such a personal and inappropriate question but that she had stopped herself from doing so as it was obvious that despite how the question has been asked the young woman had a question that needed to be answered. She went on to say that she remained seated and started talking to the young people present:

“about orgasms and how a man will feel when he ejaculates... and you were asking me about cumming, well whether I do or whether I don’t that’s personal; however, the sensation is a beautiful thing but it’s between two people and it’s private. We done this whole talk and by the end of it the weans were sitting [mimics head on hands looking enthralled], I would say it lasted about forty to fifty minutes”.

This was a conversation that Sarah was proud of because not only had she managed to control her automatic response, she had also been able to recognise that the young woman was “curious” and “testing” to see whether she would get an answer.

Recognising that the language young people use and understand is important when discussing sexual health and relationships was an issue that was discussed

by all of the corporate parents. For instance, Patricia (foster carer, untrained in sexual health) when reflecting upon her experiences of trying to talk to Paul about his behaviours towards younger children (see page 261) described becoming frustrated as she wasn't sure that what she was saying "was penetrating". This experience led to her reflecting that it was important to tailor language and content of discussions relating to sexual health to the emotional and cognitive stage that children appear to be operating at. Although not discussing sexual health at the time, Kelly (social worker, untrained) described how it was really important for carers to match the language they used to the "child's age and development" when talking to them. For example, she described how as a social worker one of her roles when a young person first becomes accommodated is to explain to them "why they were accommodated". During these discussions:

"you wouldnae want to use technical language with them" so instead, she explained, you need to "take the lead from them" and if they talk about "things not being right" you try to match your explanations to that level".

She felt that "reflecting and summarising" were two of the main communication tools that carers could use when talking with young people as it allows them to demonstrate that they are listening to the young person and attempting to understand what they are thinking and feeling. Most importantly, she felt that by talking to young people in this way carers could check that they're not "way off the mark" in their understanding of what is being said and thus avoid talking and working at cross purposes from the young person.

Engaging with young people at their level and on their terms was something that Caroline (foster carer, untrained) also believed was important and she described how sometimes children are only "able to talk" about what has happened to them in the past "in code", and whilst carers may know that the reason why a child has become accommodated relates to domestic violence and sexual abuse perpetrated by the child's father, the child themselves may only be able to tell you about the things that "the demons" did. She reflected that sometimes young

people feel unable to verbally communicate with adults for a variety of reasons, including feeling ashamed about what has happened to them and when that happens you have to let the young person tell you in their own way. For example, she described how Michael (10) when “he doesn’t really want to talk about things” that have happened can talk about them but only if he can “put a pillow over his face” or “talk to the back of your head” in the car whilst you are driving.

For other children who “can’t talk” about what has happened to them, Caroline stated that often they are able to write or draw what they are feeling and that carers should allow children the chance to express themselves in this way if needed. This view was shared by Janet (social worker, untrained) who felt that in order to talk to young people about sexual health and relationships it is necessary for carers to spend the time getting to know the child and learning how they communicate and learn. For her, there was only one way that this was possible and that was spending time with children and getting to know them. This view was shared by Kelly (social worker, untrained) who in her interview described how she had been working with a 15 year old boy who had been sexually abused and within the context of that work they have spent a lot of time talking about sexual health and relationships. She told me that through working with this boy she had come to appreciate that:

“you have to have an individualised [plan]. Depending upon their age, stage of development, their own needs, their own behaviours and what they’re liable to cope wi’ as well. I mean in terms of that 15 year old, when I started working wi’ him I could have started talking about sex, and he was aware of STIs, but I knew he wasnae emotionally ready for that so to do that would have been a really big error on my part. That could have had quite a traumatic effect on him”.

Instead, Kelly had found it particularly useful to think of discussing sexual health and relationships as if it was a “dripping tap”; something that could permeate every conversation in small ways and allow carers the opportunity to assess how

young people are responding to what is being said without being the “focus” of every discussion you have with that young person:

“If I started working wi’ a young person tomorrow that had been subjected to sexual abuse it would be away down the line before I’d even go near the sexual health subject. It would start off wi’ the dripping tap effect about relationships, positive relationships and seeing how they gauge what I am trying to say”.

Alison (residential carer, trained) felt that in order to be able to have discussions with young people about sexual health that you need to ensure that you develop a relationship with them first:

“It’s about relationships. If you go in aw guns blazing you’re no gonnae get anywhere. You have tae take it at that young person’s pace. They have tae be ready tae talk to you about their experience”.

Forcing sexual health onto the agenda was something that Alison felt was guaranteed to make young people disengage from those conversations, whereas she felt that if you can talk about relationships and sex within the context of a “normal conversation” then young people are more receptive to listening. Taking things slowly and getting to know whether a young person is emotionally ready to talk about sexual health was seen by carers as being particularly relevant for children who had experienced significant levels of abuse prior to becoming looked after. Margaret (foster carer, trained) stated that sometimes you find that children who have been sexually abused are very closed off to the idea of talking to adults about sexual health, and that “the very idea of sex” can make them feel very uncomfortable.

This sentiment was echoed by Caroline (foster carer, untrained) who described how Matthew would become extremely upset when he witnessed both romantic and sexual behaviour or heard sexualised language being used “he really

struggles with things. Even the mere mention of the word sex would send him into, you know, ‘oh don’t say that word, don’t say that word’”. She went on to describe how the extent to which Matthew was upset by sexualised language and behaviour had been highlighted by “a serious incident where Matthew (aged 13) accused Michael (aged 8) of more or less sexually abusing him”. When asked what had happened she went on to state that it had turned out that “nothing happened” in terms of molestation or physical contact, but that Michael had been “saying things to Matthew like ‘sex, sex, sex, sex’ and doing thrusting and things like that because he knew it was upsetting Matthew”. When asked how they discussed sexual health with Matthew given the discomfort he felt around sexual terminology, Caroline stated that they:

“try to use language that he’s comfortable with” because: “if I say the word ‘sex’ it just sends him curling up into a ball, wanting to die. So, we use words like ‘a couple making love’ because Matthew quite likes more elaborate... and colourful... words”.

For children who had been sexually abused, it was also felt that feelings of shame and a fear of being judged or not liked by adults acted as a potential barrier for engaging young people in discussions about sexual health and relationships. Margaret (foster carer, trained) stated that children who have been sexually abused often think that “once you know what has happened to them” that “you won’t like them anymore”. For such young people, Margaret felt that building a relationship and trust with that child was essential to be able to talk to them about sexual health:

“you’ve got to break down this barrier that they’ve got up that they’re such a terrible dirty person, and actually keep telling them, no, you are a really nice person and you can form relationships that are not sexual with both sexes. It’s a matter of just repeating and repeating and repeating... that what was done to you was wrong, that you’re not to blame in any way and that we can fix this through time if they allow you to help them”.

Being empathetic towards young people was considered one of the ways in which carers could help break down the barriers that sexually abused young people had constructed. Margaret (foster care, trained) told me that although her “understanding of it was never to show you were upset or shocked” that it is alright for carers to express their emotions to young people because: “If you are just turning up with a blank face and saying ‘oh my, that was terrible’ they look at you as if to say ‘you don’t give a damn’. She went on to say that if you can show young people that you can empathise with them and they can “feel that from you, that’s when you start getting the trust” and you can begin to work on repairing and rebuilding their understandings of relationships.

However, she cautioned that it is very important to reassure young people that even though she as a carer may be shocked by what has happened to them that it “hasn’t changed [her] relationship with them” and that she “doesn’t think they are dirty” or “that they caused” the abuse to happen. Kelly (social worker, untrained) felt that carers should be able to ask young people whether or not they “feel uncomfortable” talking to you about sexual health in order to find out why that is. Referring again to the 15 year old boy who had been sexually abused, she stated that when they were talking about “basic relationships” he was fine, but that “when we started talking about sexual relationships he felt quite uncomfortable” so she asked him:

“why do you feel uncomfortable? Is it because of the reason why you’re in here” And he kind of reluctantly, you know what I mean, coy - no coy, but - in an embarrassed way he said ‘yeah’”.

Once this had been acknowledged she felt that it then allowed her as a worker to slow the pace back down and spend time “reassuring and reinforcing” to that young person that “what has happened, happened” and that “even though that happened it doesnae mean that you cannae go on to develop positive sexual relationships”. When asked whether she handled conversations about sexual health with young people who had a history of being sexually abused any

differently from talking to other children, Margaret (foster care, trained) replied:

“no. I think because they actually know at a young age what you are talking about, you know, not the feelings and all that, but the actual actions, then it actually becomes that wee bit easier for you to describe then that ‘that was wrong and it should never have happened that way... and to go on and have those discussions about what relationships should be like, and that you would want them to be in a relationship with “a loving person who is age appropriate and relationship appropriate”.

#### **5.4.2 Partnership working**

It was recognised by all of the corporate parents interviewed that it was not always possible for them alone to provide young people with sexual health and relationships information, and as a result many of them emphasised the importance of partnership working. For example, Alison (residential carer, trained) stated “sometimes we can’t do all the work wirself”. When asked why this was, Alison stated that staffing levels could act as a barrier to carers talking to young people about sexual health and relationships:

“I think you’ve got tae remember that we’re limited wi’ staff and although our staffing levels... we should have two on every shift so if you had a member of the team who was out doing that particular work maybe two or three hours a week wi’ that young person then you have to think about the impact that would have on the other five young people that you’re looking after. So it’s about sharing you know as there’s specific pieces of work that they [other agencies] will do”.

She went on to illustrate the importance of working with other agencies to provide intensive support for young people by discussing the case of a young person who had been sexually abused by his father, and who had been charged with (but not convicted of) raping his sister (see page 189 for details):

“So for this young person we’ve got Barnardos and we’ve got Includem coming in. Barnardos are very much doing the risk assessment work you know, and the work wi’ that young person focussed on why it happened, his feelings and whatever. Then Includem work wi’ him through socialisation and taking him out, because obviously he’s no allowed out unsupervised, so they assist that way because I couldnae possibly have him oot ten hours in the day you know, so that’s where we kind of all come thegether (together)... and that’s how it’s really good if you’ve got a tight Care Plan as you can work out when they’re going (Barnardo’s), when they’re going (Includem) and then where we fit in? So that’s the importance of other agencies in the particular young person’s case”.

Where young people were working with specialist agencies, it was highlighted that it was important that residential and foster carers “took a step back” and allowed the agency to take the lead on providing help and advice. For example, Sarah (residential carer, trained) discussed this using the example of a 12 year old girl who was demonstrating sexualised behaviours towards older men; had been emailed and texted sexually explicit photos by older men; and was suspected of being in a sexual relationship with a 14 year old boy living in the same children’s unit:

“if we think they are highly vulnerable then we get involved with the young women’s project who do particular pieces of work with them. The 12 year old I was telling you about, we think she may have been abused, but we don’t know, she’s never disclosed that. The project worker is covering a lot of that groundwork with her and sexual health would be included in that. We’ve had reports in from them, and I know that they are doing, that most of their work with her is concentrated on that, so what we kind of tend to do is we back off a bit and let one person, one person do that work and someone else does the work about keeping herself safe and making safer choices on the PC... but they would be doing the kind of specific work on the sexual health and keeping herself safe. I mean obviously we would pick it up once the young woman’s project backs out but that’s what they are doing with her right now”.

Similarly, Fiona (social worker, not trained) stated that she was currently working with a young man who had been sexually abused and had gone on to sexually abuse another boy in placement. To address his sexual health needs required using specialist services:

“the young person I’m working with, his needs are quite different so we’ve got [a specialist service] involved coz there’s problematic sexualised behaviour... and they do this life path thing, which is brilliant. It’s a very simple, pictorial thing that they do, and they talk about where the child was at then, where the child is at now, and the two paths that they could go on, and one’s, although it’s no said tae them, the right path and the other the negative behaviour path... and he’s working them to learn and reflect on that, and it’s reassuring him and reinforcing to him that even though that [the abuse/abusing] happened, that doesnae mean that you cannae go on to develop positive sexual relationships”.

When asked what her role was, Fiona went on to explain that her role as the social worker was to monitor and evaluate the progress of the intervention put into place. This echoed the beliefs about professional roles that were discussed in chapter four. Alison (residential carer, trained) highlighted the importance of working with other agencies when young people at risk of prostitution because working alone to prevent young people becoming exploited could be “pretty soul destroying”. In particular, she emphasized that being able to “have the police involved, have the street teams involved and having vulnerable young people’s procedures” provides workers with support because trying to intervene when:

“young people are forced intae having sex, and they come in wi’ pretty bad brusing and you know faces have been punched but they willnae gie statements... that is very difficult... and it’s pretty hard and it’s quite frustrating at times, but you’ve got tae try to be professional and say ‘we’re trying our best’”.

In addition to specialist agencies, the NHS was identified as the main partner agency for young people's sexual health and relationships, with many of the residential and foster carers indicating the role that looked after children's nurses, sexual health nurses and sexual health clinics play in providing sexual health information and advice to young people. Alison was extremely proactive when it came to partnership working, stating that she would always "encourage access to information, and would encourage young people to attend the [sexual health clinic] so that they can get a full picture". She went on to say that her staff members have been known to facilitate access to NHS practitioners by inviting them into the residential units to provide bespoke sexual health and relationships sessions, in particular recalling how they had got the practice nurse from one of the Glasgow Hospitals to come into the residential unit and talk to the young people about sexually transmitted infections, contraception and pregnancy risk. Sarah (residential carer, trained) highlighted that where residential workers choose to work with outside agencies they can either let them:

"come in and do specific aspects of work or to run a session as a joint thing so you've got somebody from the outside and you've got somebody from the inside and you're able to co-operate... because I think you have to give young people the choice because sometimes they see us in more of a parental role and they might not want to talk to us about things like that, so it's really important to give them healthy access to external people who they might talk more freely with... but sometimes that's not appropriate... it just depends on who the individual seeks out, and that's what's important you know, keeping the individual at the centre of everything".

Working with the NHS was viewed as being extremely important when it comes to monitoring the health of young people in placement who have contracted a blood-borne virus such as "Hepatitis B, Hepatitis C or HIV". For instance, Alison (residential carer, trained) went on to describe how they had worked closely with a sexual health clinic to ensure that one of their young people who was HIV positive went to the clinic "every six months to get blood tests to check that

everything's okay... and to obviously educate him about further relationships, and about using condoms" because they were worried about the fact that he:

“hung about the city center quite a lot and they had to keep saying to him ‘remember you’re HIV positive’... because you cannae say ‘by the way, you’re never tae have sex again’ because that’s... you know that’ll no happen so he needs tae be aware that he’s got an infection that can...well there’s people dying and if you’re transmitting it on that’s really dangerous”.

NHS sexual health services were valued by young people in the care system because of the confidentiality they offered young people. For instance, Eve (16, care leaver) stated that she liked the sexual health clinic she had used because “it’s confidential” and “they listen to you”. This was something that she thought was really important because when you go to a clinic you are discussing “your private life and you’re no wanting everybody else to find oot about it so it’s good to have it confidential”. Stuart (20, care leaver) agreed that services being confidential were a positive thing, stating that he had thought the services were “no bad” because:

“If you wanted to go and talk tae them about something that you were, that was worrying ye you could go up and just talk tae them and they wouldnae pass it on”.

Darren (14, residential care) went on to say that staff at the sexual health clinic he attended made you feel like “you can talk to us” and that “it is safe to talk to us” because they let you know that they’ve “heard it all a million times before so you don’t have to feel uncomfortable” telling them stuff. Knowing that you can tell the staff at the clinics anything without shocking them was something that Darren said “really made a difference” when he had to go and see them. Finally, Ali (16, residential care) emphasised how staff at sexual health clinics tried to help you even if they thought young people weren’t being fully truthful. To demonstrate this she described how she had a really close

friend who lived in a children's unit and who hadn't wanted to go and get a sexual health check because she was worried that the clinic would tell her social worker that she had been there:

"I tellt her there's nothing to hide, and I was like that to her 'it's all confidential' and then she's like that 'no, I don't want my social worker to know'. She doesnae want anybody to know she was at the clinic".

Because her friend was so afraid about the clinic not being confidential but also really wanted to know whether or not she could have a sexually transmitted infection, Ali told me that she had agreed that her friend could give her name and contact details at the clinic:

"she didnae want tae use her name so I telt her 'just use ma name'. I said to her it's ok coz I thought it would be alright but I don't think she's supposed tae do that coz then she's on my record tae. Like they asked her, 'how many you slept wae?' And she turned round and she went 'seven'. And I just looked at her and I was like that, 'right, ok, then. I'll just let her say seven'. And then she's like that, she went, the clinic woman went 'Ali, the last time you were here, you said you had done more than seven. You said you werenae quite sure, you didn't really keep a count of them'. And I just looked at her and I was like that, 'fuck sake'. And then I went 'aye, Ali, what you talking about?' The clinic wumman was looking at me going, like, hinking, 'you're Ali and she's no?'"

She went on to say that she had been worried because she thought they could "get done" for lying to the clinic and that:

"I shouldnae have done that." Coz then, when I go back to clinic, they're gonnae ask me the same questions and I'm gonna be answering something else... but I think they sussed oot that it wasnae me. They sussed out I was me coz I went doon wi' her. They're like that tae me, coz

they phoned me up and passed it on to one of my staff members and it came back to me saying the clinic wants to help our pal if she wants to come back to the clinic but she's too scared to give her name out coz she's never been to a clinic in her life. She's never been checked out. That's what she wanted, to go and get checked out. She just wanted all the tests".

## 5.5 Summary

The aim of this chapter was to examine whether family processes such as connectedness, parental monitoring and supervision mediate communication about sexual health and relationships in the care setting. The evidence presented in this chapter suggests that communication about sexual health and relationships that is underpinned by warm, connected and trusting relationships may afford young people protection against early sexual debut and teenage pregnancy, with both corporate parents and looked after young people emphasising the importance of trust for sensitive and private conversations to be undertaken. In particular, looked after young people indicated that they would be most likely to talk about sexual behaviour with adults that they had: known for a long time; considered to be like family to them; and knew would be non-judgemental and capable of maintaining confidentiality. Similarly, corporate parents emphasised that in order to undertake meaningful sexual health work with young people in the care system they needed to have built a foundation of trust between them and the young person, and that the only way of doing this was to get to know the young person over a period of time. This was particularly emphasised for young people with abuse histories.

Building connectedness within the care system was described by corporate parents in terms of promoting stability for young people. This was done by trying to provide young people with consistency and routine within the care setting, trying to engage young people in education, and by promoting relationships with the birth family when it was deemed safe to do so. This approach, whilst not focussed directly upon sexual health and relationships, was viewed by corporate parents as providing young people with security, fostering trust between the

young person and their carer, and increasing self esteem; all of which the corporate parents felt would in the long term help mediate sexual risk taking and reduce the likelihood of young people becoming involved in exploitative relationships. Corporate parents believe that they could influence sexual health outcomes by not directly communicating about sexual health and relationships was also seen through the use of role modelling, with many of the foster carers and residential carers interviewed emphasising that they tried to model respect, privacy and gender equality within the care setting.

Moving beyond connectedness to look at the effect of monitoring and supervision on sexual health and relationships communication, the empirical evidence presented in chapter two shows that monitoring and supervision that is too permissive or too prohibitive may increase adolescent sexual risk. There was some evidence to support this, with some looked after young people stating that residential and foster carers had no real authority to stop them engaging in risk taking behaviour and that the punishments that they received for doing so were not strong enough to discourage young people from repeating those behaviours. Predominantly, monitoring and supervision used to manage sexual risk within the care setting by; for instance by: arranging the layout of units and family homes so that young people's behaviours can be easily monitored; considering which young people should be permitted to go on outings and holidays together; and carefully monitoring friends and romantic partners visiting the unit. This was identified as a means through which corporate parents could keep individuals working/living in placement safe; something that was highlighted as being particularly necessary for young people who were showing signs of grooming or sexually abusing/exploiting other young people in placement. However, it is also worth noting that the evidence presented in this chapter suggests that monitoring and supervision were also used to try and build connectedness and reduce stigma for young people in the care system by allowing young people to bring friends and romantic partners into the unit so that the staff could get to know these individuals.

Looking at how communication about sexual health and relationships is undertaken within the care system, the evidence presented in this chapter

suggests that corporate parents are predominantly opportunistic communicators who instigate discussions about sexual health either in response to concerns about young people's risk taking behaviours or as a result of being asked direct questions by young people. It is worth noting however that a small minority of corporate parents were proactive and engaged in innovative sexual health work with young people, with conversations focussed upon topics such as puberty, contraception, masturbation, having sex for love and pleasure, contraception, sexually transmitted infections, pregnancy and parenthood. Those corporate parents who were already involved in talking to young people about sexual health and relationships emphasised that the best discussions occurred when corporate parents worked in partnership with other agencies, and when practitioners were open, honest, knowledgeable and young people trusted them and felt that they were not being judged; something that looked after young people also stated that they valued. Furthermore, it was highlighted that within the care system there is a need to ensure that communications about sexual health and relationships are tailored to the biological, emotional and cognitive ages of young people; that discussions are undertaken in language that young people are comfortable with; and at a pace that young people are comfortable with.

## **Chapter 6: Reflections on conducting the research**

### **6.1 Introduction and aims**

The previous two chapters have provided an overview of the qualitative research findings from this study. Before moving on to discuss how these relate to the wider empirical and theoretical literature I would like to reflect upon the research conducted, and how I as the researcher may have impacted upon the data collected. The section begins with my reflections on how the ethical considerations raised prior to the research being conducted were addressed during data collection. In particular I will discuss the role of gatekeepers in recruiting and consenting young people and corporate parents to the study, how I dealt with the disclosure of sensitive information by participants and how such disclosures affected me emotionally. I then move on to look at how my own identity and life experiences may have influenced the data generated within this study. It should be noted that I have decided to omit participants' pseudonyms, age and genders within this chapter due to concerns that including these details would allow for identification of the individuals concerned. It should also be noted that the reflections about members of my own family have been read and commented on by the individuals concerned, and are provided with their approval.

### **6.2 Reflecting on ethical challenges faced within the research**

In this section I reflect upon some of the ethical dilemmas that arose whilst the research was being conducted.

#### **6.2.1 Power differentials in the recruitment process**

Recruiting young people through gate keepers raised the issue of power-dynamics within the research process. Oakley (2007) argues that the process of conducting research with children and young people should not differ from how adults are engaged within the research process. In particular, she states that:

“the consensus that emerges from studies exploring children’s perspectives is that the major issues of the researcher-researched relationship are essentially the same with children as they are with adults... the need to be aware of and respect the imbalanced power relations of the researcher vis-à-vis the researched, the importance of distinguishing ‘private’ from ‘public’ accounts and the need to handle controversial and or personal topics with sensitivity... the issues that are highlighted in thinking about the research in the area of children’s studies are not a particular class of issues: they are questions to which all good researchers will attend”.

This is something that I wholeheartedly agree with, and having conducted research with both adults and children at numerous points within my career I believe that it is important to adhere to the same principles of ethical research practice regardless of the age of my respondents. However, when conducting a study that includes interviewing both adults and children it is impossible not to become aware of power dynamics. Adults are traditionally viewed as holding a more powerful position in society than children, and researchers need to be aware that power differentials between adults and young people can impact upon all stages of the research process. I have already reflected upon how having a legal duty of care to young people can impact upon confidentiality so I will use this space to consider power differentials within recruitment and the interview process.

As I had to rely upon gatekeepers to help me recruit young people to the study it is possible that some young people who might have wanted to participate were excluded from the research as a result of their social workers or carers deciding that the topic of the research was not appropriate for them. Whilst I can’t be certain of the extent to which this existed within the study I was aware that a degree of pre-selection by social workers was occurring in relation to young people in foster care. This became apparent when I was trying to identify ways to improve the participation of young people in foster care and several social workers confided that they didn’t like approaching young people in foster care about participating in research. For example, one of the social workers told me

that she thought I would find it difficult to get social workers to recruit young people in foster care because “we like to treat them as if they are normal children so try not to bother them with things like research studies”.

In addition to young people being excluded by gatekeepers the choice to access residential workers, foster carers and social workers through social work services may have resulted in participants feeling pressurised to participate. Certainly, it was made clear to me by the head of service that there would be an expectation that staff members would take part in the study. This made me feel slightly uncomfortable, and although I let each of the corporate parents know that they could choose not to participate in an interview or terminate the interview at any time, there was at least one occasion where I felt that a worker was participating because they had been told to. This was based upon the fact that the worker seemed quite hostile during the interview, provided answers to questions that were extremely closed and was reluctant to go into any depth or provide much detail in response to questions. Despite this one experience, overall I was reassured that the majority of corporate parents wanted to participate and were eager to share their experiences of providing care to young people.

Similarly, I felt comfortable that the majority of young people referred to the study had not been pressurised into participating by a gatekeeper. This was because as part of the recruitment process I spoke with each of the young people either by telephone or face-to-face about what participating in the study would involve prior to agreeing to meet them at a later date if they expressed an interest in participating. However, there were two occasions where I was told that a young person was “really eager” to help me with my study only to discover that this was not the case. I contacted the first young person by telephone to discuss the possibility of their participating in the study, and was told by them that they didn’t really want to take part because talking about sex was too embarrassing and they didn’t know if they could contribute anything. After talking to the young person it was agreed that he wouldn’t be interviewed as part of the study.

The second occasion occurred when a young person was asked by a residential worker if they wanted to participate in my study whilst I was present. At first they seemed really enthusiastic about being interviewed, but it quickly became apparent that this enthusiasm was faked and based upon the young person not having the confidence to tell myself or the residential worker that they didn't want to take part. After the young person had failed to turn up to four different appointments I asked them whilst phoning to reschedule if they still wanted to participate or whether they would prefer for me not to contact them again. I was assured by the young person that they did want to participate; however after a further two broken appointments they finally confided that they hadn't really wanted to take part and had been worrying about how to tell me this. I reassured the young person that I was not upset that they did not want to talk to me and thanked them for letting me know.

Another power differential that I noticed was how young people were instructed by residential care workers to "be good" and not to do anything that would make the "nice lady" think "negative" thoughts about the unit by their carers when left alone with me. Whilst I would have expected to be treated with respect by the young people I worried that having stipulations placed upon their behaviours would prevent them from being open and honest with me, and encourage them to provide socially acceptable answers in order to meet the expectation that the young people should be presenting the unit in a positive light. To counter this I reassured the young people that I was interested in their views, that they could tell me positive and negative things, and that I wouldn't be offended or tell them off if they wanted to use swear words or words that their carers didn't like. This seemed to put them at ease and I found them opening up about their experiences of being in care.

There were also a couple of occasions where I felt that power issues arose as a result of carers' concerns about young people's ability to cope with the interview. In one case, the carer of one young person in foster care contacted me to state that although her charge had expressed an interest in participating in the study she was worried about whether they had the cognitive capacity to participate. After a long discussion on the phone it was agreed that as the young

person wanted to take part I would come out to the house and we would try some of the questions to see how they coped with being interviewed. The young person told me that they liked being asked questions about their life and asked if they could do the interview for real. At this point she was consented to the study and the interview began. About five minutes into the interview I became aware of the fact that the foster carer, although having indicated that she was going to leave the room, was stood around the corner listening to the interview. This left me with a dilemma as on the one hand I recognised that the carer was merely concerned about her foster child's well-being, but on the other hand I felt uncomfortable that the young person's privacy was potentially being invaded. I decided to pretend that I wasn't aware of the intrusion and continued asking innocuous questions about what the young person liked to do in their spare time, what her friends were like and how she was getting on at school. After no more than 3 minutes of this I spotted the foster carer enter the garden where she remained for the rest of the interview.

Another situation during the data collection left me feeling uncomfortable. This situation involved an interview with a young person in residential care who I was told at the start of the interview had asked for a residential worker to sit in on the interview as they didn't feel comfortable talking to people they didn't know. This made me feel slightly uneasy given the topic of the research and when the participant came downstairs I told them what their carer had said and asked if that was what they wanted. Despite saying that it was ok for their carer to stay I got the impression from the uttered "yeah, whatever" and their defensive body language that the carer was not really wanted in the room. This left me in a tricky situation as I wasn't comfortable with what might be discussed, how the carer's presence might influence the young person's ability to talk openly and honestly and I didn't want to burn any bridges with the staff in the children's unit as I was due to interview two other young people in the unit later that week.

I decided to reiterate to the young person what could potentially be discussed during the interview and suggested that her carer might want to stay for the first few questions to see how the young person was doing and then if it seemed like they were doing fine she could maybe just check on us every once in a

while. The carer agreed to this. My suspicions about the young person not being able to talk openly were quickly confirmed as the carer occasionally injected her opinions of events that cast the young person's views in a negative light. This resulted in the young person becoming reluctant to say anything at all. Fortunately, just as I had been about to ask the carer to leave the room, she made the decision to leave. As the door closed the young person sighed, looked at me and said: "*she's such a nosy bitch*" before going on to tell me all of the negative things that they had been reluctant to discuss whilst her carer was in the room.

### **6.2.3 Dealing with sensitive disclosures**

Many of the interviews included references to abuse, neglect, rejection, bullying and suicide, and it sometimes felt like I was walking on a trip wire within the interview setting. During the interviews I found myself constantly monitoring participants' body language and speech patterns to assess whether emotional narratives could be explored or whether I needed to steer the interview towards a safer topic. All decisions about the appropriateness of continuing interviews were based upon a combination of my subjective interpretations of participants' emotional state and their willingness to continue sharing their stories even though they were upset. In addition to paying attention to body language I tried my best to make participants feel at ease. One of the ways I did this was by mirroring the volume and speed of their speech, ensuring that my body language was always open and making sure that where I chose to sit within the interview didn't create too much distance, too much familiarity as a result of me looking down at participants. Additionally, during the consent process I encouraged participants to use their own language to describe their experiences; informing them that I wouldn't take offence or tell them off if they swore within their interviews. I felt that this was important in order to put participants at ease.

At the end of each interview I gave each participant a contact sheet that included links to a range of services including housing charities, free legal services, mental health services, sexual health services, services aimed at sexual abuse victims, smoking cessation services and alcohol and drugs charities. These

sheets contained the hours that services were open, how the services could be accessed (e.g. drop in, appointment, telephone, SMS), how much a telephone call would cost from landline and mobile numbers and whether telephone numbers would be published on phone bills. In addition, I spent between 10 and 20 minutes just talking to participants. During this time I answered questions about the research and myself, and just engaged participants in what they wanted to talk about. This time allowed me to wind down the interviews and ensure that I didn't leave any participants feeling distressed. Despite this, on one occasion I returned to a children's unit the day after interviewing a participant to speak to another young person and whilst there discovered that they had slit their wrists. I felt terrible. I still do. And, whilst logically I knew that this participant had a long history of self harming, that they had just broken up with their partner and that they had had an appointment with mental health services that morning I couldn't help but wonder "did I do that?"

This incident, which happened very early on in the data collection process, reinforced the need for the child protection protocols that had been developed for the study (see chapter 3). For the most part these rules were unnecessary; however, there were two occasions where at the end of interviews I felt that it was necessary to ask young people if I could breach their confidentiality to make sure that they were ok. First, one participant confided that they felt so upset at having to live in a hostel that they had started to think that "the railway line" behind the hostel might be the only way of changing their circumstances. Although the participant went on to state that they didn't really want to kill themselves, I was concerned at how upset they had become and asked if there was anybody they could speak to about how they were feeling. The participant confided that they had told their key worker about the situation and how upset it was making them. At the end of the interview I asked permission to talk to the key worker about what they had told me because I was worried and wanted to make sure that they were getting support. The participant agreed and before they left I had a quiet chat with their key worker; something that reassured me that the young person had somebody that not only cared but was actively trying to make sure they were ok.

On the second occasion, one of the participants became distressed when describing the abuse that they had experienced. During the interview I asked them if they wanted to take breaks or stop the interview, only to be told that they wanted to tell their story. At the end of the interview I was concerned about how upset the participant had become and I asked if I could tell their carer that they had gotten upset within the interview. The participant agreed, and after we had finished talking I quietly told their carer that “they got a bit upset during the interview when talking about their experiences before coming into care”. The carer didn’t press me for details about what we had discussed; instead, confiding that they had expected that to happen because the young person they cared for had a tendency to want to tell people her story.

#### **6.2.4 Emotional impact on the interviewer**

A number of authors have written about the effect that undertaking research on sensitive topics has upon the researcher in addition to the participant. For example, Burman et al (2001) stated that reactions amongst researchers may be triggered by the “emotional intensity of the stories narrated” by those participating in the study. This statement is something that I would agree with as a number of painful disclosures were made in interviews by both young people and the corporate parents. These disclosures included accounts of domestic violence; mental, physical and sexual abuse; bullying; self-harming; attempted suicide; discussions of infertility and marital breakdown; and, sexual exploitation, prostitution and rape. Many of the research conversations were emotionally draining and there were times when interviewing felt like being on an emotional rollercoaster. Even now at the writing up stage it is hard to distance myself from those experiences. Re-listening to the recordings, re-reading the transcripts and thinking about certain respondents and their experiences evokes a visceral emotional reaction within me, and there are some sections of narratives that I cannot listen to without crying.

Before this research began I thought that I might find it hard listening to descriptions of sexual and physical abuse. This was the case, and each time I heard or read phrases such as “she prostituted her children”, “allowed schedule

one offenders to rape her daughter”, “her mother stuck her fingers in her vagina”, “my uncle raped me” and “his father used to throw him against the wall” I would feel a slight gnawing in my stomach that reflected the abhorrence and sadness I felt at the idea that a parent could hurt a child in that manner. Whilst these phrases generated an emotional response, I tended to find that I had a much stronger emotional response to listening to the young people I interviewed describing being bullied, having no friends, not being able to see family members and feeling lonely. These are the examples that I find myself crying over. For example, I remember drafting a section about family relationships whilst commuting by train to a meeting with my supervisors. This section included a young person’s recollection of experiencing Christmas day in a children’s unit. They described how Christmas songs were playing on the stereo whilst staff members and young people sat around the table; the young people quiet and crying because their parents had promised them that they would come and see them on Christmas day and had not. Having experienced several Christmases without my dad - he was a submariner in the Royal Navy - I could empathise with feeling sad at Christmas. However, I never felt alone. I always had my mum and my brother, and I knew that we would get to have a second happier Christmas in January or February when my dad came home and complained vociferously about the fact that the Christmas tree was still up and hadn’t been decorated properly.

Why do these stories make me feel so sad? I can only surmise that having never been bullied, having never not had friends and having always known that separations from family members would be short lived that there is a part of me that is mourning the loss of their childhood. That sounds like an odd thing to say, but having engaged with the data and relived those experiences through listening to transcripts and reading their words, grief is the closest emotion that I can identify. Whilst I know how I have reacted in private I do not know how my reactions were transmitted to or perceived by my participants within interviews. I know from field notes that I was aware of myself gently nodding and using what I can only describe as sad smiles to demonstrate that I was listening, empathising and was interested in their stories. I do know that there was one moment when a participant said something that left me feeling so shocked and

disbelieving that I couldn't hide my physical reaction. They were describing what it was like living in a household where heroin use and domestic violence were present when they told me that their "step-dad got his friends to set the house on fire while we were in it". Within the space of seconds I had taken a deep breath, exhaled it slowly and briefly closed my eyes as the voice in my head uttered "Jesus". After I opened my eyes I looked at my participant who nodded their head, smiled wryly and bit their lip before saying "yeah, I know". I felt guilty for having had such a visceral reaction on the basis that the horror and sadness I felt at hearing their story must have been but a fraction of what they felt; however, on reflection it seemed that briefly showing my shock served to build empathy within the interview.

### **6.3 Reflecting on my own experiences**

Mays and Pope (2001) argue that in order to be reflexive it is important to assess how the research process and the role of the researcher contribute to shape the data that is collected and analysed. In doing so it is important to reflect upon how personal characteristics of both the researcher and participant may influence participation, engagement and the credibility of findings. In addition personal and intellectual biases should be noted and discussed in relation to their effect upon data collection. To some extent I have already begun this reflexive journey by discussing my emotional engagement with participants' narratives. I shall continue it here by looking at how my own personal experiences and the age and gender of participants may have influenced the collection of data.

Conducting research with young people who have been maltreated and abused is so far removed from my own experiences that it was hard not to reflect upon my own childhood as I was conducting the research. My childhood was a happy one that was filled with love, laughter and stability, and even though I grew up in an era where it was still socially acceptable to smack children my parents very rarely raised their hands to me or my brother. Physical force was used so rarely that I can clearly recall those occasions where my mum, pushed to the edge of sanity by two children who wanted to see exactly what they could get away with

whilst dad was at sea, resorted to using "the belt". This was always sufficiently out of character (not to mention sore!) that the rest of the patrol was peaceful.

Being a 'navy brat' significantly shaped my childhood. I became accustomed to the enforced separations from my dad that came with indexes and patrols and although there were often tears shed when he was away my mum was always there to deal with the emotional fall out. When you grow up in a military household there is always the risk that your dad will be posted elsewhere and throughout my childhood my dad was moved from Faslane to Portsmouth, Barrow-On-Furness and Rosyth. My parents decided early on that rather than moving the family to different digs across the country they would create a stable base for their family in Helensburgh and my dad would live in digs when posted away from home. This can't have been easy for my dad or my mum, but what it meant for me was that whilst I had friends who moved away and came back and moved away again, I never had to move house, change schools and make new friends. Listening to the young people I interviewed describe the lack of stability and the number of placement moves that they had experienced was something that I found very foreign.

Having such a different experience of childhood than the young people I interviewed was something that at times served to be an advantage as I was a "naive" outsider who didn't know what it was like to be a child in the care system. This meant that my participants were given the chance to 'educate' me about their lives. Had I had experience of being in the care system the data generated could have been much different, potentially reflecting a degree of shared experiences that could have led to participants sharing more information through feeling that they were talking to a kindred spirit or less information because they felt they didn't need to explain their lives in the same detail. Whilst not having the same childhood experiences is something that has made listening to the young people's narratives difficult I think it has also allowed me to remain honest to their accounts as my role became to convey emotions and experiences that I had never had, and the only way to do that was to rely upon their words.

## 6.4 Summary

In this chapter it has been demonstrated that there were a number of ethical challenges faced when conducting this study, including recruiting young people through gatekeepers, the presence of power imbalances in talking to young people and making decisions about how to handle sensitive disclosures. It was also demonstrated that conducting interviews on a sensitive topic had an emotional impact upon me as an interviewer and led me to reflect upon how my own experiences as a child and adult differed from those of young people and carers within the care system. I now move on to examining how the research findings presented in chapters four and five relate to the wider empirical literature, and what this study adds to the existing literature.

## **Chapter 7: Discussion**

### **7.1 Introduction and aims**

In this chapter, I relate the research findings presented in chapters four and five to the wider empirical literature on sexual health. I begin with an overview of the main research findings before moving on to discuss how these contribute to and extend the empirical literature on sexual health and relationships communication within the care system; and, in doing so discuss the implications of these findings for policy, practice and research. I then move on to outline the strengths and limitations of the study, before outlining the core conclusions that can be made from this study.

### **7.2 Review of study aims and main findings**

To recap, the aim of this study was to address the following research questions::

- What shapes communication about sexual health and relationships within the care setting?
- How is communication about sexual health and relationships within the care system mediated by connectedness, monitoring and supervision?

In order to do this, 54 in-depth qualitative interviews were conducted with looked after young people, care leavers, residential workers, foster carers and social workers in one local authority in Scotland during 2011.

#### **7.2.1 What shapes communication about sexual health and relationships within the care setting?**

The data presented within this section is drawn from chapter four of this thesis, and demonstrates that whilst corporate parents are generally receptive to

talking to young people about sexual health and relationships, a number of factors relating to the characteristics and lived experiences of looked after young people are identified as shaping communications about sexual health and relationships. My findings suggest that:

- Talking about sexual health and relationships within the care setting whilst previously viewed as a taboo subject has become an accepted part of the corporate parent role due to the emergence of a parenting discourse within social work services.
- Talking to young people about sexual health and relationships is identified as being something that a 'good parent' would do, and therefore it is believed that a 'good corporate parent' should be routinely talking to young people about their sexual health and relationships.
- Justification for corporate parents taking on this parenting role is based upon looked after young people being at increased risk of being excluded from school-based sexual health and relationships education, and the belief that looked after young people's birth parents, as a result of their additional health and social care needs, would be unable to undertake home-based discussions about sexual health and relationships.
- It is perceived that lack of stability, exposure to domestic and/or sexual violence and promiscuity in the pre-care histories of looked after young people results in their being at risk of: learning that anger, hostility, arguments and physical violence are normal facets of human relationships; experiencing early sexualisation and being at risk of developing problematic sexual behaviours; developing attachment difficulties, including difficulties trusting other people.
- Whilst it was accepted that corporate parents should be routinely talking to young people about sexual health and relationships, it was identified that corporate parents' age, gender and knowledge of sexual health could

all significantly shape discussions about sexual health and relationships. In particular, it was shown that looked after young people prefer to discuss sexual health and relationships with corporate parents who were of the same gender, were similar in age and who were perceived to be knowledgeable about sexual matters.

- The preference for gendered communication about sexual health and relationships within the care system was identified as being a potential barrier to communication about sexual health and relationships within residential care settings due to the low proportion of male carers. Furthermore, gender-sensitive communications were identified as shaping communications about sexual health by reducing embarrassment and increasing comfort when discussing sexual and reproductive health issues.
- Looked after young people indicated a preference for talking to younger workers. This was attributed to their being more likely to have received sexual health and relationships education and being more “in touch” with young people’s sexual health experience; therefore making them better placed to give advice. In contrast, older workers were often described as lacking knowledge and being out of touch with young people’s needs; a view that was echoed by older workers when they expressed frustration at not knowing what types of contraception could be offered to young people and what the different slang terms for sexual acts meant.
- The young people recruited were living in residential care, foster care, supported accommodation and independent living. Whilst it might have been expected that their experiences of seeking out sexual health and relationships advice might differ according to placement the only difference was that young people who had left the care service were less likely to have received sexual health and relationships advice.
- Training in sexual health and relationships was identified by older corporate parents as improving their sexual health knowledge and confidence talking to young people about sexual health and relationships.

- Whilst sexual health training increased the confidence of corporate parents to talk to young people about their sexual health and relationships there was no discernible difference in corporate parents undertaking sexual health and relationships works, nor was there any difference in corporate parents understanding of the considerations that needed to be made when providing sexual health advice to a vulnerable population. That there was no difference in experience may reflect the fact that the issues underlying sexual health and relationships communication are those that are faced by carers and social workers on a daily basis.
- Tensions appear to exist between the professional and parenting identities of corporate parents. Social workers adopt a more professionally oriented attitude towards communicating about sexual health and relationships, and whilst willing to talk to young people about sexual behaviour if they are approached, believe that their role should be to ensure that young people are referred to the necessary service.
- In contrast, residential and foster carers tended to identify themselves first and foremost as parent. Many of the residential and foster carers stated that they tended to utilise the same parenting techniques that they had used to raise their own children when it came to providing care to looked after young people. In some cases this resulted in carers drawing upon their moral, religious and parenting views to shape the discussions they had with young people.

### **7.2.2 How is communication about sexual health and relationships within the care system mediated by connectedness, monitoring and supervision?**

The data presented within chapter five of this thesis demonstrates that communication about sexual health and relationships within the care system is underscored by the quality of the relationship that exists between corporate parents and looked after young people, and the level of monitoring and

supervision that is observed within the relationship. In particular it was shown that:

- Communication about sexual health and relationships within the care setting appeared to be underpinned by the presence of warm, trusting and connected relationships. For instance, young people in the care system report that they are most likely to talk to individuals that they had known for a long time and who, despite not being related by blood, felt like family to them. These individuals were viewed as being trustworthy, non-judgemental and able to maintain a confidence. Similar views were expressed by corporate parents who felt that it was necessary to have an existing relationship with young people before engaging in discussions about sexual behaviour.
- Due to the increased likelihood that young people will experience attachment difficulties as a result of their pre-care experiences, corporate parents believed that promoting connectedness could potentially mediate the poor sexual health outcomes observed for looked after young people by increasing stability and improving young people's self esteem. In particular, corporate parents advocated improving connectedness to the care setting, educational settings and, where it was safe to do so, birth families.
- Corporate parents also attempted to influence sexual health indirectly through using role modelling to teach young people about positive behaviours, respect, privacy, gender equity and establishing clear interpersonal boundaries within the home setting. An emphasis was also placed upon privacy, including ensuring that young people were respectably covered up when wearing nightclothes and maintaining bathroom and bedroom privacy.
- There was some evidence that permissive parenting promoted sexual risk taking, with some of the young people indicating that corporate parents

had no real authority to stop them engaging in risk taking behaviours and that the punishments didn't serve to dissuade young people from engaging in risk taking. About a third of the young people interviewed stated that their risk taking had got worse since entering the care system; and that in many cases this reflected wanting to be liked by other risky peers.

- Monitoring and supervision were largely used by residential and foster carers to manage risk within the care placement, with the evidence showing that risk behaviours were managed by: arranging the layout of units and family homes so that young people's behaviours could be easily monitored and considering which young people should be permitted to go on outings and holidays together. Managing risk in this way allowed corporate parents to easily monitor behaviour and ensure that all young people in placement were kept safe; especially if there was a young person in placement who was showing problematic sexual behaviours towards others.
- Monitoring and supervision was also present when corporate parents allowed young people to bring their peers and romantic partners into the care setting. Doing this was seen as serving two purposes. First, corporate parents were provided with an opportunity to meet and risk assess peers and romantic partners. Second, inviting these individuals into the care setting could be used to reduce stigma about the care setting and help corporate parents build a connectedness to young people's friends and partners; thus hopefully encouraging them to bring their friends/partners around more frequently.
- Corporate parents were often opportunistic communicators about sexual health and relationships, choosing to use naturally occurring openings or young people's overtures for help as opportunities to engage young people in discussions about sexual health and relationships. Despite this, there were examples of innovative and pro-active sexual health work described by corporate parents, with conversations focussed upon topics such as

puberty, masturbation, having sex for love and pleasure, contraception, sexually transmitted infections, pregnancy and parenthood.

- Verbal discussion about young people's sexual health and relationships was balanced by corporate parents modelling positive, respectful behaviour in the care setting. Corporate parents believed that discussions about sexual health and relationships: should be tailored to the biological, emotional and cognitive ages of young people; should be undertaken in language that young people are comfortable using; and be at a pace that young people are comfortable with. In addition it was emphasised that there was a need for corporate parents to be open, honest and knowledgeable when talking about sexual health and relationships as there were characteristics that were seen by young people as facilitating help seeking.
- Inter-agency and partnership working was advocated for young people demonstrating problematic and risky behaviours; with residential and foster carers identifying that they should focus on relationships work and building self esteem whilst specialist agencies focussed on addressing sexual behaviour. This belief was based on ensuring that practitioners were not working at cross purposes, and to avoid young people receiving mixed messages.

### **7.3 What does this study add to the existing literature?**

In chapter two it was demonstrated that much of what is currently known about sexual health and relationships communication within the care system is focussed upon identifying the barriers to such discussions being undertaken (Constantine et al., 2009, Farmer and Pollock, 1998, Farmer and Pollock, 2003, Lipscombe et al., 2003, Greer, 2010, Stace and Lowe, 2007). Although these studies acknowledged that some corporate parents, mainly residential and foster carers, were routinely engaging young people in discussions about their sexual health, no data was published to show how those conversations were undertaken in practice and what factors shaped those communications. This study, by

examining how sexual health and relationships discussions are undertaken within the care system, and how these discussions are shaped by the lived experiences of corporate parents and looked after young people, provides a unique insight into the provision of sexual health and relationships information within local authority care. Furthermore, by drawing upon the wider empirical literature on parent-child communications about sexual health and relationships, this study serves to provide an insight into how family processes such as connectedness, monitoring and supervision are transferred to and utilised within the care system to support and underpin sexual health and relationships discussions. These issues and how they relate to the wider empirical literature will now be discussed.

### **7.3.1 Understanding how communications about sexual health and relationships are shaped by the characteristics of corporate parents and looked after young people**

In this thesis it has been demonstrated that communications about sexual health and relationships within the care setting are shaped by a number of factors, including: the gender and age of corporate parents; lack of sexual health and relationships training for corporate parents; and the impact that the pre-care and care histories of young people in the care system have upon young people's understandings of relationships and ability to trust others. Each of these issues will now be discussed, along with any recommendations for policy, practice and research.

#### ***7.3.1.1 Gender sensitive communications***

Looking first at the gender of corporate parents it was noted that communications around sexual health and relationships were more likely to be undertaken if both the corporate parent and the young person were of the same gender. This was because looked after young people one, felt less embarrassed when talking about sexual health and relationships with somebody of the same gender and two, were comforted by the notion that the individual they were speaking to would have possibly had the same experiences. These beliefs are not unique to looked after young people and corporate parents, with evidence from the wider empirical literature on parent-child communications about sexual

health and relationships demonstrating that boys often feel more comfortable talking to their fathers about sex, whilst girls feel more comfortable talking to their mothers (Dilorio et al, 1999; Jaccard et al., 2000; Rosenthal and Feldman, 1999; Wight et al., 2006).

Although young people express a preference for gender-specific communications about sexual health, the empirical evidence demonstrates that within the family home, mothers act as the main source of information about sexual health due to societal expectations about gender roles within families (Holland et al., 1996; West, 1999; Wyness, 1992). A similar pattern is observed in the care system, with female corporate parents, in particular those in residential care, acting as the primary communicators of sexual health and relationships advice to young people. One explanation given for this is that positions within social work are predominantly occupied by women; resulting in there being a shortage of male residential carers and social workers and young people being left with little choice about who they should approach for help and advice. That looked after young people had little say in who they could speak to about their sexual health was particularly evident within the narratives of young men in residential care, in which it was highlighted that they often found it embarrassing to initiate conversations about sexual matters with female carers, and wished that there were more male staff members that they could speak to. These concerns were often shared by corporate parents who felt that young men in residential care settings could be being excluded from sexual health education as a result of there being so few male staff members that they could have those discussions with. In contrast, foster carers were conscious that conversations about sexual matters should acknowledge young people's gender. They also believed that, where possible, the gender of carer and young person should be matched for conversations about sexual and reproductive issues; something that appeared from corporate parents narratives to be happening on a regular basis when there were male carers within the household.

The issue of gender in sexual health and relationships communication is often raised within the literature; with Buston and Wight (2006) highlighting that young men are at risk of obtaining poorer sexual health knowledge as they are

less likely to be talked to about sexual health within the home environment. Within this thesis it has been demonstrated that corporate parents, in particular those in residential care settings, are aware of this danger and were attempting to take conscious steps to ensure that young men were not excluded from sexual health and relationships discussions. These steps included: practical things like asking male workers to come into work unshaven so that they could teach young men how to shave and attempting to minimise embarrassment about talking to young people about sexual health; trying to match genders for discussions about sexual health and relationships; and ensuring that all workers received training in sexual health and relationships in order to promote knowledge, increase confidence and reduce embarrassment about discussing sexual health. Whilst this is an important first step towards ensuring that young men are not excluded from sexual health and relationships discussions, the imbalance of male to female workers may still result in young men being excluded from sexual health and relationships discussions.

To counter this, several recommendations can be made. First, an emphasis should be placed on recruiting more men to work within the social carer system. This may prove difficult as employment within the social care system has largely been viewed as a non-traditional area of employment for young men (McLean, 2003); therefore, a greater understanding of men's perceptions of working within social care is needed in order to deconstruct the notion that social care is a female-orientated career. It is therefore recommended that a qualitative study be conducted with male social care professionals to understand their motivations for employment, and their views on how to encourage more men to enter into the profession. The results of this study should then form the basis of a media campaign focussing on encouraging men to work within the social care sector. Second, in the absence of more male staff, regular drop in sessions about sexual health and relationships could be established within residential care. These sessions would be run by both a male and female worker; who would then act as a named contact for young people to phone and discuss any issues that are concerning them. Given the concerns that some of the residential carers raised about operational capacity, it is recommended that the workers for the sexual health drop ins be employed solely to undertake this role.

A small feasibility study should be undertaken to explore the acceptability of establishing sexual health drop-ins within residential care settings, how these should be run and whether these would be of benefit to young people.

### ***7.3.1.2 Corporate parents' age and knowledge***

Little is currently known about the influence of practitioners' ages on communication about sexual health and relationships, and how disparities in age may shape discussions about these issues. However, there is evidence to suggest that discussions about sexual health and relationships may be most beneficial when undertaken by younger workers. For instance, it has been demonstrated that medical practices with at least one young doctor often have significantly lower teenage pregnancy rates than practices with no young doctors. Furthermore, these practices often have the highest rates for smear uptake and cervical cancer vaccinations, and routinely order more investigations into fertility problems experienced by young people (Baker and Klein, 1991, Glatstein et al., 1997, Hippisley-Cox et al., 2000). One reason that has been suggested for the improved outcomes seen for practices with younger doctors is that sexual health issues may be more salient for these individuals as these are issues they themselves may be experiencing (Hippisley-Cox et al., 2000).

There was some evidence within this study to support the view that sexual health issues may be more salient to younger workers, and that as such they were more willing to talk to young people about these issues. For instance, it was demonstrated that looked after young people generally felt that younger corporate parents were knowledgeable about sexual matters and were 'in touch' with the needs of young people. In contrast, older workers were viewed as not understanding what it was like to be a young person, and therefore being 'out of touch' with young people's needs. Furthermore, older workers were often viewed as lacking sexual health knowledge; something that some of the older workers themselves acknowledged when they stated that they didn't always feel knowledgeable enough about the range of sexual health issues that might affect young people and the terminology that young people used when discussing sexual matters. Not being knowledgeable about sexual health affected carers'

confidence to talk to young people about sexual health and acted as a potential barrier to discussions being undertaken.

The evidence presented within this thesis shows that lacking knowledge affects how corporate parents talk to young people about sex. For instance, some of the older corporate parents acknowledged that embarrassment had resulted in their using laughter and humour to try and cover their embarrassment. Although the use of humour and jokes when talking about sexual health can be used to promote intimacy and increase information sharing (Frosh et al., 2002), their use is cautioned against by some authors as joking about sexual health can serve to reinforce the message that talking about sex is embarrassing and that adults do not wish to discuss sex with young people because it makes them feel uncomfortable (van Teijlingen et al., 2007). Thus, it is perhaps not surprising that corporate parents who had used jokes felt that young people hadn't taken their discussions about sexual health seriously. Furthermore, it was shown that where young people had experienced this, they often: reported feeling hurt and rejected by their corporate parents; believed that their carers couldn't be relied upon to provide support; and stated that they would turn to other sources to find out about sex. Where young people have other adults that they can turn to for help and advice, their questions not being taken seriously by carers is likely to have limited impact upon their ability to receive the information that they want. However, where the only individuals young people can turn to are their peers, it is likely that they will be provided with inaccurate sexual health advice (Buston et al., 2002).

Within the literature, concerns about the poor quality of adults' own sexual health education are often cited as acting as a barrier to parents communicating with young people about sexual health and relationships and parents being uncertain as to whether they are providing young people with accurate information (Jaccard et al., 2000, Fullerton and Burtney, 2005). These issues were frequently discussed by the older corporate parents interviewed in this study, with many stating that because they had never received sexual health and relationships education they were often unsure about whether they were answering questions correctly and using the correct words and terms to describe

sexual concepts. Frankham (1992, p27) argues that where parents are concerned about their lack of sexual health knowledge they can feel unprepared to talk to young people about sex and may actively try to avoid doing so.

Promoting knowledge and confidence amongst corporate parents is an important first step in ensuring that sexual health and relationships discussions are undertaken in the care system. Certainly, those corporate parents who had received sexual health training reported that they felt more knowledgeable and confident when talking to young people about sexual health and that because of this knowledge and confidence they were better able to hide their own embarrassment and discuss sexual matters calmly and confidently without having to make jokes. Furthermore, corporate parents highlighted that sexual health training had provided them with the knowledge of where to get access to further information and help signpost young people to additional help. As there is evidence to suggest that providing young people with sexual health and relationships information can be protective against early sexual risk taking, and that providing sexual health and relationships training to corporate parents facilitates discussions about sexual health and relationships within the care setting, it is recommended that in order to promote sexual health knowledge amongst corporate parents, all new residential and foster carers should be provided with sexual health and relationships training as part of their induction process. Given the willingness of social workers to talk to young people about sexual health and relationships, introducing sexual health and relationships training as part of the formal training curricula for newly qualifying social workers is one potential way of ensuring that young people's sexual health and relationships will form part of social workers overall assessment of child welfare.

Moving beyond recommendations for practice, the suggestion from the wider empirical literature that the presence of younger health professionals within clinics affords protective effects for adolescent sexual risk taking and teenage pregnancy raises the issue of whether similar effects may be observed within institutional settings such as residential care. Furthermore, given that it has been demonstrated that the gender and sexual health knowledge of corporate parents influence whether young people approach their corporate parents for

help and advice about sexual health and relationships and the types of discussion that are undertaken, the question of whether other contextual factors relating to corporate parents and carer settings may afford protective effects should be explored. To this end, a fully powered quantitative survey of looked after young people's sexual health experiences should be undertaken within the UK to establish one, the prevalence of sexual risk behaviours of young people and two, factors that mediate sexual risk within the care setting.

### ***7.3.1.3 Abuse histories and problematic sexual behaviours***

Providing care to these young people was identified as being something that corporate parents, in particular residential and foster carers, found to be particularly challenging as young people's understandings of relationships had often been adversely affected by their abuse histories. Returning to the notion of internalised scripts, exposure to sexual violence and/or sexual abuse in childhood can negatively impact young people's sexual development by altering their views of what is and is not appropriate within the context of sexual relationships. Finkelhor and Brown (1985) characterised the development of sexual scripts amongst victims of sexual abuse as being motivated by traumatic sexualisation and a pervasive sense of powerlessness, stigmatisation and betrayal. Traumatic sexualisation occurs when young people's sexual identity, including their feelings and attitudes, becomes shaped by their experiences of childhood sexual abuse. Often, traumatic sexualisation occurs when young people are repeatedly rewarded by offenders for the behaviours that they are being asked to undertake; these rewards can come in the form of "*affection, attention, privileges and gifts for sexual behaviour*" and may result in the adoption of developmentally inappropriate sexual behaviours. These learned sexual behaviours may then be re-enacted as attachment behaviours designed to promote closeness to others (Alexander, 1992); something that several of the corporate parents interviewed had witnessed and experienced when caring for young people. There was some evidence within this thesis that both young men and women being cared for had been groomed by older men.

Young people who had experienced traumatic sexualisation were viewed by their corporate parents as either being sexually 'switched off' as a result of their

abuse experiences or engaging in risky and age-inappropriate sexual behaviours. The effect upon young people's sexuality underpinned how corporate parents talked to these young people about sexual health and relationships, with many of the corporate parents indicating that they focussed upon building relationships, taking a "no blame" approach, trying to bolster self esteem and focussing on the potential for positive relationships in the future rather than in the past. In addition as it was believed that young people who had experienced significant levels of maltreatment often also experienced cognitive delays, the corporate parents stated that they often tailored discussions about sexual health and relationships to the age- and stage- of the child; something that echoes current Governmental advice about the delivery of sexual health and relationships education within schools.

Talking to young people who had experienced sexual abuse or were displaying problematic sexual behaviours was something that corporate parents identified as being particularly challenging, as not only was it emotionally draining, but they were often unsure how much of the information that they were sharing with young people was being understood and assimilated by that young person. As a result, many of the corporate parents stated that they tempered any communications about sexual health and relationships with young people they perceived to be at risk of being sexually exploited, or sexually exploiting others with strict monitoring and surveillance; something that I shall return to discuss in section 7.3.2.2. One reason why corporate parents found it so difficult to talk to young people who were displaying problematic sexual behaviours is that few of those interviewed had received specialised training in how to talk to these young people about their behaviours. As such, it is recommended that individuals who are directly involved in the care of young people who are exhibiting problematic sexual behaviour should receive specialist training focussed upon working with young people demonstrating problematic sexual behaviours before being asked to undertake communications about sexual health and relationships with this group.

In this study it was demonstrated that the provision of sexual health training to corporate parents improved their sexual health knowledge, and confidence

talking to young people about sexual health. However, despite these findings there was some evidence to suggest that corporate parents continued to experience difficulties when talking to young people about their sexual health, particularly where young people were demonstrating problematic, sexualised behaviours. Given that young people who exhibit these behaviours are those who have been exposed to sexualised material at a young age, including exposure to pornography and sexual abuse, it is likely that corporate parents may require some additional support and advice when being asked to talk to this population about sex (Minnis and Del Priore, 2001).

Certainly, there is some limited evidence to suggest that foster carers find it difficult to cope with caring for young people who are displaying sensitive behaviours including self-harm and highly sexualised behaviours, including problematic and abusive behaviours. For example, Stace and Lowe (2007) reported that corporate parents found managing these behaviours to be distressing and found it difficult to understand why young people would engage in these behaviours. And, there was certainly evidence within this study that corporate parents not only found it difficult to monitor the behaviours of young people who were showing problematic sexual behaviours, but also were emotionally challenged by working with these young people. As such, it is recommended that training for residential care workers, foster carers and social workers include advice and guidance about monitoring and supervising looked after young people's sexual health and relationships, with specific emphasis placed upon: monitoring risky behaviour within the community; providing monitoring to young people at risk of sexual exploitation; and how to monitor and supervise young people with problematic sexual behaviours.

#### ***7.3.1.4 Corporate parents' views about the acceptability of talking to young people about sexual health and relationships***

At the beginning of this thesis it was demonstrated that the Scottish Government, in response to concerns about the elevated levels of sexual risk taking observed amongst looked after young people, has recommended that residential carers, foster carers and social workers play an instrument role in

providing sexual health and relationships information and advice to young people within the care system. The data presented in this thesis demonstrates that the adoption of this recommendation by local authorities has resulted in a shift in values away from sexual health and relationships discussions being viewed not as a taboo subject that should not be discussed with looked after young people, but rather as an important and necessary part of the corporate parenting role. Whilst this shift in values may be reflective of wider societal acceptance of sexual health and relationships education, it is likely that the acceptance of talking to young people about sexual health and relationships can be attributed to the emergence of a wider discourse on parenting within social work practice.

This discourse, which was first introduced by Utting (1997), is based upon the notion that associating parenting and professional identity through the creation of a “corporate parenting” responsibility serves to encourage state agencies to take their responsibility towards children looked after by local authorities seriously. In Scotland, the concept of corporate parent responsibility has been spearheaded by the Scottish Government (2008c), who have advocated that all individuals involved in the care of looked after young people should “seek the same educational and health outcomes for those young people as any good parent would want for their own children”. That professional and parental responsibility towards young people have become synonymous in social work practice can be seen within the fact that all of the corporate parents interviewed stated that the reason why they should provide young people with sexual health and relationships information is that talking about sexual health and relationships within young people is the duty of a “good parent”. Despite this, the evidence presented in this thesis suggests that corporate parents tend to be opportunistic communicators who tend to only undertake discussions about sexual health and relationships when young people are displaying risk behaviours or instigate discussions by asking for help and advice.

One potential reason for the apparent lack of pro-active and preventative sexual health work being undertaken by corporate parents is that being asked to talk to young people about sexual health and relationships can cause tensions to emerge between corporate parents’ professional and parenting identities. In section 3.7

I highlighted that role theory might be useful in explaining these tensions. Role theory was used by Stryker and colleagues to demonstrate that within society individuals can occupy different social positions; each of which have clear roles and expectations attached to them that help shape the attitudes and behaviours of the individual. Often, these social positions are arranged hierarchically according to how salient the role is to that person's identity and the social position that they occupy (Stryker and Serpe, 1994, Stryker, 1980). In essence, role identity can be thought of as the meanings that people attribute to themselves whilst operating within a certain role and for each role a person assumes there will be a corresponding identity that underscores how that individual behaves and interacts with the world. For instance, it has been well documented within the literature that individuals working within a profession develop specific beliefs and attitudes about that profession in order to establish the boundaries of their professional role and the ways in which they interact with other individuals. This set of beliefs, attitudes and understandings about the individuals' role, within the context of work, is generally referred to as professional identity (Adams et al., 2006, Lingard et al., 2003).

The results presented in chapter four provide a novel insight into how corporate parenting identity is constructed in relation to sexual health and relationships education. For instance, the narratives of the social workers interviewed suggest that they had adopted a professional identity that was characterised in terms of managing the care and protection of young people under their supervision. In this role, the social worker is charged with overseeing and liaising with all of the individuals that have contact with looked after young people in order to ensure that their needs are met. That social workers identified their role in terms of these concepts can be seen within their views on talking to young people about sexual health and relationships, with many of the social workers interviewed identifying that talking to young people about sexual health was part of a parenting role and should be undertaken by residential and foster carers, whilst their role should be more about managing, co-ordinating and working with both carers and other professionals to ensure that the sexual health and relationships needs of young people are met through the provision of specific interventions.

For social workers, being expected to talk to looked after young people about their sexual health and relationships appears to be synonymous with asking them to step outside of their professional role identity and adopt a parenting identity, and it was apparent from social workers' narratives that operating outside of their usual role resulted in feelings of discomfort and uncertainty. Where this occurred, it appeared that social workers attempted to hypothetically reframe and reconceptualise talking to young people about sexual health and relationships as part of their professional identity by placing discussions about sexual health within the remit of Getting It Right For Every Child and their legal duty to consider all of the child's needs. However, it should be emphasised that talking to young people about sexual health and relationships could only be undertaken if social workers were provided with sufficient training to allow them to do so in a professional manner, and that such conversations would be constrained by other demands upon the social workers' time.

Residential and foster carers also appeared to struggle with issues relating to identity. These individuals tended to describe their main role identity as being a parent to looked after children. All of the residential and foster carers identified that talking about sexual health and relationships should be part of their role; however, they also highlighted that although relationships were openly discussed within the care setting, communications about sexual behaviours tended to only occur when young people entered into romantic relationships, carers became aware of adolescent sexual risk taking, or when young people raised sexual health issues with them. This meant that whilst conversations about relationships formed part of the usual care task, conversations about sex, sexuality and sexual health were often reactionary and opportunistic. These findings reflect those observed in the literature on parent-child communication about sexual behaviours (Dilorio et al., 1999, Fullerton and Burtney, 2009, Rosenthal and Shirley Feldman, 1999).

The reactionary nature of 'sex talk' within the care system may reflect the fact that the majority of the carers interviewed stated that they felt more comfortable talking to young people about relationships, and believed that talking to young people about sex was a role that should be largely undertaken

by trained health professionals. In addition, some of the carers reported being concerned about the appropriateness of talking to young people about sexual behaviours as in their experiences of parenting their own children talking about sex was a role that was carried out by outside agencies such as schools. The lack of comfort that carers felt towards adopting a sexual health role may reflect the fact that carers are not sexual health specialists, and as such may worry about being able to provide young people with all of the information and advice that they might need (Haydon, 2003). Certainly, the narratives of some of the individuals suggests that this may be the case, with carers being concerned about the contraceptive knowledge, and their ability to accurately discuss the female reproductive system. These concerns resulted in carers being receptive to partnering with other professionals to deliver sexual health and relationships, and to ensure that looked after young people had access to the full range of advice, support and treatment opportunities. This is something that I shall return to discuss in section 7.3.4.

For carers, believing that they should be routinely talking to young people in the care system about sexual health and relationships was often at odds with the practices they had adopted when parenting their own children around sexual health and relationships. This tension was often underscored by religious views on talking about sexual behaviour. For instance, it was shown that some of the corporate parents who had a strong religious identity struggled with being asked to deliver sexual health and relationships education as the provision of this ran contrary to their beliefs about the provision of contraception and talking to children about sex. Where corporate parents exhibited strong religious identities they often described tensions between their desire to be 'good corporate parents' who provided young people with sexual health and relationships advice, and their desire to be true to their own thoughts, feelings and beliefs about talking to young people about sex. This resulted in their struggling within themselves and having to make conscious choices about what they would and would not be willing to talk to young people about, with some corporate parents stating that they would be unwilling to discuss sensitive issues such as abortion; a finding that is echoed within the wider literature looking at healthcare

practitioners' attitudes towards prescribing contraception and carrying out medical terminations of pregnancy (Gardner et al., 2007, Austin et al., 2005).

Within this study, the difficulties that corporate parents could experience reconciling their religious beliefs about sexual health and relationships was best exemplified by the experiences of one residential carer (Sarah) who discussed how being asked to talk to the young people she looked after about sex had angered her as she believed that children and young people did not need to be spoken to about sexual health because of the provision of sexual health and relationships education within schools. To Sarah, being asked to discuss sexual health placed her in a position where she had to reconcile her views on her religion, her own parenting style and the professional parenting role that she was being asked to adopt in order to be able to talk to young people about sexual behaviours; something that she did by reframing her views on communicating about sexual health in terms of risk and the vulnerability of young people in the care system; something that for Sarah also meant reconciling her view that the innocence of childhood should be protected with the fact that many looked after young people have already had that innocence eroded and therefore need to be protected in another manner.

Reconceptualising and reframing views about childhood innocence and how it affected parenting skills was also something that foster carers had had to deal with. For instance, several of the carers emphasised the parenting difficulties that they had experienced in relation to caring for looked after young people demonstrating problematic sexual behaviours. These tensions often emerged from wanting to provide children with a normal home environment, and the shock that was experienced when foster carers discovered that some of the young people that they cared for had, in addition to being abused or exploited, gone on to demonstrate abusive and exploitative behaviours towards others. In these situations, carers often stated that their parenting practices tended to switch away from communication about sexual health and relationships, and instead focussed upon managing risk within the care setting and trying to ensure that young people received referrals to specialist services (e.g. Farmer and Pollock, 2003; Lipscombe et al., 2003). From the narratives that were

constructed by individuals caring for young people with problematic sexual behaviours, it appeared that having to adopt a risk averse, surveillance approach to parenting often took an emotional toll on foster carers. In some cases this led to their becoming isolated from their own friends and family as one, the need to monitor behaviour meant that they could not leave the young people they cared for unattended and the behaviours of the young people they cared for were seen as disturbing and often not easily accepted by other adults. This was further exacerbated by the fact that many of the foster carers interviewed stated that they had been underprepared for taking on this role and hadn't received sufficient training in how to care for young people with problematic sexual behaviour.

Acknowledging corporate parents' professional, parenting and personal identities and accepting that tensions may exist between these identities is an important first step to understanding why corporate parents may be hesitant to communicate about sex with looked after young people. For instance, the narratives of both the corporate parents and looked after young people highlighted that carers often have their own beliefs and attitudes about sensitive topics such as pre-marital sex, abortion and homosexuality. Whilst it is important that these beliefs are respected, it is also important that they do not impinge upon carers' ability to provide care and support to young people. The interview data presented in this study suggests that young people need a safe environment in which they can discuss sexual health and relationships. The presence of sexist, judgemental and homophobic attitudes can serve to undermine the creation of this safe environment, and may dissuade young people from approaching corporate parents for help and advice. It is therefore recommended that training courses focussed on sexual health and relationships communication within the care system should include a module that asks corporate parents to reflect upon how their own values and role identities may impact upon their practice and affect how they talk to young people about sexual health and relationships. Carers' reflecting upon their own attitudes and values is particularly important as young people can be empowered to seek out additional sexual health and relationships support when their carers provide

them with honest, non-judgemental advice, explain all of the available options and spend time helping young people make informed decisions (Haydon, 2003).

### **7.3.2 Understanding how communications about sexual health and relationships are mediated by connectedness, monitoring and supervision**

Having discussed how sexual health and relationships were shaped by the characteristics of looked after young people and corporate parents, I now move on to discuss how communications about sexual health and relationships were perceived to be mediated by connectedness, monitoring and supervision. In doing so, I discuss how these findings relate to the wider empirical literature and make recommendations for policy, practice and research.

#### ***7.3.2.1 Secure, connected and trusted relationships***

The results of this study demonstrate that corporate parents believe that pre-care factors such as lack of stability, child maltreatment, parental psychiatric distress, parental drug and alcohol misuse and exposure to domestic and sexual violence can have an adverse effect upon young people's understandings of relationships and their ability to form trusting, secure and connected relationships with other people. For instance, many of the corporate parents used the example of young people witnessing domestic violence to explain how repeated exposure to violence can result in young people believing that anger, hostility, arguments and physical violence are normal facets of relationships. Furthermore, it was believed that exposure to age-inappropriate and sexually violent behaviours, including child sexual abuse was particularly damaging for young people; resulting in young people being at increased risk of early sexualisation and developing problematic sexual behaviours.

The adoption of behaviours modelled within the family home has been widely discussed within the literature. For instance, Kirby (2003) argues that parents often indirectly communicate their values about relationships and sexuality through the behaviours they display within the household. These observable, often unspoken actions serve to model how individuals should behave within the

context of relationships and implicitly transmit parental values to children. In particular, Kirby argues that whether parents “appear nude or partially nude in front of their children, whether they engage in sexual relationships outside of marriage and how they respond to children’s siblings or friends who gave birth as teenagers undoubtedly affects the values of their children”. Based upon this assertion it can be argued that the young person who repeatedly views domestic violence may develop an internal relationships script that states that violence within relationships is normal; that sexual behaviour should be controlling and forced, rather than loving; and that other people cannot be trusted or depended upon.

Certainly, there is some evidence within the empirical literature to suggest that this may be the case, with young people who have witnessed violence during childhood being shown as being fearful and inhibited, developing low self esteem and demonstrating lower social competence, with the authors noting that aggression and antisocial behaviours are commonly observed amongst young people who have witnessed domestic abuse (Fantuzzo and Mohr, 1999, Wolfe et al., 2003, Sternberg et al., 2006, Evans et al., 2008). Furthermore, it has been demonstrated within the empirical literature that young people who have grown up in households characterised by lack of stability, child maltreatment, parental psychiatric distress, parental drug and alcohol misuse and exposure to domestic and sexual violence often have very poor understandings of relationships which serve to promote social isolation, adversely affect young people’s self esteem and, in some cases, result in young people entering into unhealthy and exploitative romantic and sexual relationships through a desire to feel wanted and loved (Markham et al., 2010, Jaccard et al., 1996).

Internal scripts about relationships may also be underscored by the quality of the bond that develops between young people and their parents/carers, with it being argued within the literature that the presence of adversity within the home can result in young people failing to develop the secure, trusting relationships that are needed for positive psychosocial development. For instance, attachment theory argues that the quality of care that young people receive within the context of the parent-child relationship is associated with the

security of the bond that develops between parent and child, and that individuals who develop secure attachments also develop enduring emotional bonds with their caregivers that result in their actively seeking out the support of that individual during times of vulnerability and distress (Bowlby, 1998). This was something that was widely believed by the corporate parents interviewed, with their narratives illustrating that young people who are exposed to adverse circumstances within the home setting may be at increased risk of forming insecure attachments; resulting in their experiencing an emotional disconnectedness from their corporate parents that may act as a barrier to help seeking and promote engagement in risk taking behaviour. For instance, in this study, corporate parents often emphasised their belief that lack of connectedness could result in young people being at increased risk of sexual exploitation due to their seeking out relationships with other people in order to fill the emotional gap experienced through disconnectedness. In some cases this may result in young people being susceptible to being groomed by older, exploitative males.

Attachment theory may be useful in interpreting the findings of this study. In addition, within the sexual health literature, attachment theory is synonymous with the concept of parent-child connectedness. Connected relationships are defined within the literature as being warm, loving and trusting, and there is a wealth of evidence that demonstrates that such relationships not only serve to promote discussions about sexual health and relationships but also afford young people with protection against early risk taking and pregnancy (Dilorio et al., 2003, Fullerton, 2004, Lezin et al., 2004, Miller et al., 2001, World Health Organisation, 2007). Of the factors identified as promoting connected relationships, trust was identified as being the main barrier and facilitator of discussions about sexual health and relationships occurring within the care setting. Young people who find it difficult to trust other people may find it difficult to identify an individual within the care system that can provide them with help, support and advice about their sexual health. This in turn may result in that young person not asking for help or relying upon their peers for help and advice; something that it has been noted within the empirical literature increases the risk of young people obtaining incorrect and inaccurate

information (Buston and Wight, 2006). Within this study there was evidence of this occurring; with many of the looked after young people interviewed stating that they would only talk to people they trusted about topics to do with sexual health and relationships, even if they were unsure as to whether that person could provide them with accurate information.

That trust was identified as a potential barrier to young people seeking help was also identified by the corporate parents, who went on to state that they felt that the development of a secure trusting relationship between young people in care and the adults that cared for them was essential for sexual health and relationships discussions to be meaningful. Certainly, the evidence presented within this thesis suggests that promoting trust within the care system would be a crucial first step in ensuring that looked after young people feel comfortable seeking out the help of their corporate parents about sexual health and relationships. As a result, the introduction of an attachment-based approach to sexual health and relationships communications within the care setting should be explored. One potential method that could be used is Schofield and Beek's (2006) secure base model, which is currently used in foster care and emphasises the need for attachment and resilience focussed parenting with looked after young people.

The secure base model draws upon the four dimensions of care giving – namely availability, sensitivity, acceptability and co-operation – that were identified by Ainsworth et al (1971) as being likely to promote secure attachments. The secure base model actively encourages corporate parents to be mindful of children's needs and behaviours when making decisions about how to respond to young people's help seeking behaviours. In essence, Schofield and Beek (2005) argue that being mindful of young people's individual needs, in conjunction with the provision of "sensitive, available, reliable caregivers, who provide practical and emotional help and support, and reduce anxiety" can affect the development of young people by freeing them "to become more competent and confident in tackling new challenges in learning, in work and in relationships", whilst, at the same time providing a "secure base" that young people can return to if things go wrong. Looking specifically at sexual health, there was some

evidence presented within this thesis to suggest that lack of sensitivity and availability of corporate parents acted as a barrier to young people seeking out their help and support about sexual health and relationships. As such, reframing sexual health and relationships training for corporate parents to draw upon the secure base model may offer corporate parents the opportunity to reflect upon how their practice impacts upon young people's behaviours.

For instance, it was evident from the narratives presented by the young people that the young person that wants to approach their caregiver because they are considering having sex for the first time may be nervous about how that individual will react to finding out that they are thinking of becoming sexually active. In this situation, the corporate parent who reacts by saying 'let's sit down and talk about that' and acts to proactively explore young people's thoughts and feelings in order to help them determine a plan of action will help to engender a sense of trust, and will likely leave that young person with the impression that they can be relied upon in the future for help and advice. In contrast, the corporate parent who reacts with shock or who tells the young person to go away because they do not have the time to deal with their problem may be seen as rejecting the child's overtures for help; thus fostering a sense of insecurity, and creating a barrier to future help seeking interactions. Thus, teaching corporate parents how to handle these introductory approaches for help in a sensitive, non-judgemental and attachment promoting manner is extremely important as those initial reactions will act either as a barrier or facilitator for future help-seeking, and should form the basis of training for corporate parents in sexual health and relationships.

Moving beyond the use of attachment in sexual health and relationships training, interventions that are known to promote attachment for young people within the care system should also be evaluated to assess whether they afford any protective effects for adolescent sexual risk. This is because, it has been widely reported that the provision of sexual health and relationships education within the school setting, whilst having the potential to modify behaviour, often results in increased sexual health knowledge without a concomitant increase in contraceptive usage and reduction in teenage pregnancy (Henderson et al.,

2007; Elliott et al., 2013). Instead, best current knowledge suggests that the antecedents of sexual risk taking during adolescence may be mediated by either improving the quality of connectedness within families or providing young people with a secure support system. For instance, evidence from the evaluation of the Family Nurse Partnership – an intensive antenatal health visiting programme that focussed on improving mother-infant attachment whilst providing access to health, social and welfare services for vulnerable mothers – concluded that improving the quality of the attachment bond between afforded long-term protective effects for adolescent sexual risk taking, with those young people whose mothers had received the intervention reporting fewer lifetime sexual partners at age 15 (Olds et al., 1998).

In a recently published paper, it was argued that the provision of sexual health and relationships education should not be viewed as a panacea as it is likely that providing additional sexual health and relationships education will not result in further improvements to adolescent sexual health (Elliott et al., 2013). Instead, it was argued that a greater emphasis needs to be placed upon tackling the underlying causes of poor sexual health, including redressing deleterious relationships, tackling inadequate parenting and reducing social exclusion. Looking first at redressing deleterious relationships, the evidence presented in this thesis suggests that working to promote permanence and resilience for looked after young people is an important first step in building the secure, trusting relationships that are necessary for communications about sexual health and relationships to occur. From my reading of the literature, there are two promising interventions that may, as a result of attempting to improve permanency and build attachment, offer protective effects for sexual risk taking. These are Multi-Treatment Foster Care, the New Orleans Intervention for Mental Health.

Multi-treatment foster care is aimed specifically at adolescents with severe behavioural difficulties and chronic engagement in anti-social and delinquent behaviour. The intervention is designed to support young people within the care system by providing support and opportunities for young people whilst simultaneously providing interventions for parents/guardians to ensure that they

maintain the gains they made whilst in MTFC once they returned home (Chamberlain et al., 2007). Multi-treatment foster care usually consists of a 6-9 month foster care placement with individual therapy, family therapy, skills training and academic supports put into place, may improve sexual health outcomes for young people by increasing the amount of structure, routine, monitoring and supervision that young people are exposed to. Certainly, evidence from randomised controlled trials of MTFC in the USA have shown significant increases in school attendance, increased foster care placement stability and reduced teenage pregnancy rates (Kerr et al., 2009, Leve et al., 2013). Recently, Glasgow became the first Scottish city to implement a multi-dimensional treatment foster care programme for young people in residential and foster care who are exhibiting complex behavioural and/or emotional difficulties (Connelly and Welch, 2013). It is recommended that the provision of MTFC to young people in Glasgow be fully evaluated to assess whether there are short- and long-term protective effects for adolescent sexual risk taking. This work should be supplemented with qualitative work exploring the effect of receiving MTFC upon young people's ability to trust other people and their health seeking behaviours.

Turning to the second intervention, the New Orleans Intervention for Mental Health at improving mental and physical health outcomes for young people aged 0-5 years within Glasgow (Pritchett et al., 2013). The intervention, developed by Zeanah et al (2001) aims to promote permanence by working with families using an attachment based intervention that is designed to maximise the chances of the child being returned to live with their parent. At the same time foster carers are jointly registered as adoptive parents so that if the intervention fails and it is recommended that the child remain within foster care they are freed for adoption at that point. Outcome evaluation shows that the New Orleans approach has freed more children for adoption and that where young people are allowed to return home there are fewer subsequent episodes of maltreatment (Zeanah et al., 2001). Given that earlier placement and more stable placements have been shown to reduce the risk of experiencing poor educational and mental health outcomes (Meltzer et al., 2003, 2004a, 2004b) the results of the BEST trial may have profound implications for the sexual health outcomes of looked

after children by promoting trust and security, and hence parent-child communication about sex from a younger age. In order to explore this issue in more depth, it is recommended that trials such as the BEST study build in permissions to link to young people's routinely held medical records so that the effect of permanence and other contextual factors can be examined in relation to STI diagnoses, conception and termination rates.

Moving on to tackling inadequate parenting and reducing social exclusion, it is important to consider that the outcomes for children who are looked after by local authorities have not really changed since the inception of the poor laws in the early 19<sup>th</sup> century. This is partly because much of the intervention work that is undertaken with vulnerable and socially excluded young people is undertaken in isolation from wider societal and economic contexts, in particular failing to take into account the structural inequalities that continue to exist within society and perpetuate inter-generational cycles of inequality. James Heckman (quoted in: Greeley, 2014) argues that *“focussed, personal attention paid to the young children of poor families isn't some warm fuzzy notion... it's a hard-nosed investment that pays off in lower social welfare costs, decreased crime rates and increased tax revenue”*. In essence, what Heckman is arguing is that early investment in the lives of vulnerable children can increase their chances of becoming socially included. Thus, whilst it is important to consider which interventions may be used with young people already in the care system, looking at which interventions can be provided to vulnerable young mothers in order to attempt to break intergenerational cycles and reduce the antecedents of adolescent health risk behaviours and social exclusion for the next generation should be explored.

Given the increased likelihood of young people in the care system experiencing early parenthood, it is recommended that looked after young people and care leavers who experience pregnancy be prioritised to receive interventions during pregnancy that are designed to promote attachment whilst encouraging access to health and social welfare services. This recommendation is based upon evidence from programmes such as the Family Nurse Partnership (FNP), which incorporated intensive nurse home visitation during pregnancy and the first two

years of life, and was shown to have positive benefits for adolescent sexual risk taking, with the authors noting that young people aged 15 whose mothers had received FNP reported 58% fewer sexual partners, smoked 28% fewer cigarettes and spent 51% fewer days consuming alcohol (Olds et al., 2010, Olds et al., 1997) FNP is currently being evaluated in the UK, and early results suggest positive benefits for mother and infant (Barnes et al., 2011).

Currently there are a number of longitudinal evaluations of antenatal parenting interventions being undertaken in the UK (e.g. Henderson et al., 2013, Barnes et al., 2013). One of these, the Trial of Healthy Relationship Initiatives for the Very Early-years (THRIVE), is being conducted within Glasgow, and aims to assess whether the provision of antenatal parenting support to women with additional health and social care needs can improve maternal mental health, promote secure mother-infant attachment and improve child socio-emotional functioning and language development by age 30 months (Henderson et al., 2013). In the longer-term, the research team seek to utilise routinely collected health, education and social care records to explore whether the provision of antenatally delivered parenting supports results in long-term benefits to children's health, including the adoption of risk taking behaviours during adolescence. Unfortunately, the potential impact of THRIVE upon adolescent health will not be known for many years; however, it will be interesting to see whether antenatal parenting intervention serves to improve mother-child attachment, reduce child maltreatment and improve child socio-emotional functioning as these are all known antecedents of adolescent sexual risk taking.

### ***7.3.2.2 Parental monitoring and supervision***

Monitoring and supervision of adolescent activities is an important aspect of parenting, with the research evidence demonstrating that young people are less likely to give in to peer pressure and engage in risky behaviours and activities when their parents monitor and supervise their behaviours. The evidence presented within this thesis shows that monitoring and supervision were predominantly used by corporate parents to mediate risk within the care setting, and that these were most stringent for young people demonstrating problematic

sexual behaviours or who had been identified as being at risk of being sexually exploited. In particular, it was demonstrated that residential and foster carers frequently undertook risk assessments within the care setting; carefully considered the location of children's bedrooms and which children were in close proximity to each other; and, established firm rules about personal boundaries, privacy and nudity within the care setting.

Despite this, there was some evidence presented within this thesis that suggests that corporate parents were less likely to monitor and supervise the behaviours of young people within the community, and that this served to increase adolescent risk taking. First, social workers felt that residential and foster carers lacked the authority to control young people's behaviours, and that risk taking was only recognised once young people were displaying behaviours that allowed that risk to be easily identifiable e.g. returning home drunk or covered in mud. This was something that was recognised by the young people interviewed who stressed that corporate parents' lack of awareness of their behaviours resulted in their only being spoken to about sexual health once they had already engaged in risk taking behaviours. Second, social workers felt that corporate parents also lacked the authority to properly enforce rules within the care setting as they had no real means of disciplining young people for their actions; thereby negating the effects of any monitoring designed to identify risk taking. This was also recognised by the young people, who agreed that the lack of punishments available resulted in them flouting rules about curfews because they knew that their corporate parents couldn't punish them, and that if they did receive any punishments they would be inconsequential (e.g. the removal of pocket money). Knowing that corporate parents wouldn't physically punish them led many young people to say that they engaged in risk taking behaviour more frequently than they had at home.

The evidence from the wider empirical literature suggests that it is not the instigation of rules and boundaries that helps to mediate sexual risk taking but how those rules are applied, with parenting that is viewed as being too strict or very lax serving to increase adolescent risk rather than diminish it (Rutter, 1998). From the results of this study it can be argued that the perceived

permissiveness that arises from corporate parents not being able to fully monitor and regulate young people's behaviours may serve to increase risk taking. This is something that has been discussed elsewhere within the literature; with Bundle et al (2002) identifying that young people in the care setting reported adopting risk behaviours such as smoking and alcohol use whilst in care setting because they believed that their carers did not disapprove of these behaviours. Given that young people's behaviours within the care system are often closely monitored, the perceived lack of monitoring and supervision that occurs around young people's behaviours within the community raises an interesting question as to whether the lack of consistency between permissiveness and restrictiveness acts as a barrier to young people in the care system obtaining positive sexual health outcomes. Certainly, it has been demonstrated that the most optimal form of parenting for adolescent health is an authoritative approach which balances monitoring and supervision, with connectedness and allows the young person to become autonomous (Baumrind, 1991, p62, Maccoby and Martin, 1983, Spera, 2005, Chan and Koo, 2011, Lamborn et al., 1991, Shucksmith et al., 1997, Cohen and Rice, 1997, Garcia and Gracia, 2009, Rothrauff et al., 2009, Radziszewska et al., 1996, Montgomery et al., 2008). To that end, research is needed to ascertain whether difference in parenting styles, in particular how parents monitor and supervise their children, impact upon young people's health and wellbeing. And, more importantly, which parenting style affords the most benefit to young people within the care system.

Establishing which parenting styles provide benefits to young people in the care system is extremely relevant with regards to trying to prevent sexual exploitation and grooming as the research evidence suggests that corporate parents struggle to monitor and supervise the behaviours of looked after young people in the community (Farmer and Pollock, 2003; Lipscome et al., 2005). Young people's susceptibility to grooming was something that was particularly concerning to corporate parents who highlighted how older men used transactional sex to encourage young people to engage in risk taking behaviour. The recent scandal involving Rotherham City Council and their failures to protect young people in the care system from grooming has emphasised that looked after young people are often actively targeted by sexual offenders. Individuals

who target young women and men will often use engagement, entrapment and control to persuade them into sexually exploitative situations, whilst playing upon their social isolation, low self-esteem, low-self worth and poor attachment to persuade the young people that they have chosen these relationships (Montgomery-Devlin, 2008). These relationships are often framed by abusers as being normal boyfriend/girlfriend relationships; however, the use of transactional behaviours to control the young person often means that there is an unequal distribution of power in favour of the abuser that serves to help them manipulate and control the young person. These behaviours can include the provision of gifts such as sweets, cigarettes, clothes, drugs and alcohol that are used to make the young person feel that they are cared for. This was something that several of the caregivers who were interviewed in this study had experienced. Of these, the provision of drugs and alcohol is perhaps the most insidious as young people often utilise these as a coping mechanism to block out their painful pasts, and there is some evidence that abusers are aware of this, and will provide these to young people in exchange for services 'in kind' (Montgomery-Devlin, 2008). This was something that one of the young women I interviewed discussed.

### **7.3.3 Supportive, collaborative working**

In sections 7.3.2 I touched upon the need for there to be additional training, pastoral support and collaborative working in order to ensure that looked after young people receive sexual health and relationships education, and corporate parents are supported in the process of discussing and managing young people's sexual health and relationships. I now move on to discuss the role of supportive, collaborative working. In doing so, I reflect upon how social work and specialist sexual health professionals co-operate and support each other in providing sexual health and relationships education to looked after young people. I begin by looking at the experience of collaboration and support within social work, before moving on to discuss multi-agency partnership working.

Looking first at collaboration and support within social work services, the main issues that arose as a result of this thesis were the need for sexual health and

relationships training, pastoral support and clear guidelines and protocols on the storage and transfer of confidential information. In section 7.3.1 I discussed how many of the residential and foster carers who were looking after young people did not feel confident about their ability to deliver sexual health and relationships information. Lack of confidence was affected by a range of factors, including: not having received sexual health training, having doubts about the appropriateness of discussing sex and relationships, not feeling comfortable adopting a new professional role, and worrying about providing young people with incorrect information. As a result of this I recommended that training in sexual health and relationships should become a mandatory part of residential and foster carers training. I also argued that, given the number of carers who felt that their own sexual, religious and parenting values influenced their opinion about whether it was appropriate or not to talk to young people about sexual health, that any sexual health training that was undertaken should include a module that asked carers to reflect upon these values, how they might affect their practice, and what could be done to support them providing young people with sexual health and relationships advice that might be contrary to their own beliefs.

Senior management teams within social work departments can provide support for this process by facilitating access to sexual health and relationships training, and offering pastoral support to individuals who are providing sexual health and relationships advice to young people (Hoyden, 2003). In particular, it is recommended that managers regularly review and evaluate carers' and social workers' experiences of talking to young people about sex and relationships. These reviews, which would be built into the regular supervision sessions for foster carers, residential carers and social workers, would be used to monitor workers' perceptions of their ability to talk to young people about sex and relationships, and seek to identify any barriers that have been encountered during practice (NHS Greater Glasgow and Clyde and Glasgow City Council, 2009). Given the recognition that carers' and social workers' own sexual, religious and parenting values can influence how they think and communicate about, sex and sexuality, it is important that supervision sessions identify areas in which carers might require additional training and support. Carers and social

workers should also attempt to reflect on their practice in order to identify gaps within their knowledge, and to identify where they may require help from specialist services in order to meet the sexual health needs of young people in placement (Benzie, 2006, Hoyden, 2003). Once issues have been identified, carers and social workers should be encouraged to raise these issues with managers, link workers or supervising social workers, who in turn should be encouraged to facilitate access to the training and support needed.

Where carers and social workers experience anxiety or distress in relation to discussing certain topics, and attempts to empower them through training and support have been unsuccessful, the findings of this study suggest that it might be better for that individual not to be involved in sexual health work with the young person. For instance, where a worker has strong anti-abortion beliefs they may find it difficult and distressing to be involved in providing advice and care to a young woman who has chosen to terminate a pregnancy. Given the emphasis that young people placed on the importance of open, honest, trusting and non-judgemental relationships in persuading them to engage in services, it would seem prudent not to involve an individual whose values may be perceived as judgemental and disempowering to the young person involved directly in her sexual health care. Where carers cannot be empowered to discuss sexual health and relationships with looked after young people, partnership working should be considered.

Partnership working is defined as being “about developing inclusive, mutually beneficial relationships that improve the quality and experience of care” (DHSSPSNI, (no year)). Collaboration and partnership between social work services and the NHS was advocated by NHS Health Scotland as a way of attempting to facilitate looked after young people receiving sexual health and relationships education (Healthcare Policy and Strategy Directorate: Child and Maternal Health Division, 2009). Carers and social workers have a wide range of partners that they can choose to work with to ensure that young people receive sexual health and relationships information. These include, but are not limited to, general practitioners, doctors and nurses working in sexual health clinics, LAC nurses, school nurses, child and adolescent psychologists or psychiatrists,

specialist agencies focussed on addressing the effects of child trauma. The narratives created by looked after young people and corporate parents highlighted that there was a significant amount of partnership working already being undertaken, with young people describing how their carers or social workers had arranged for them to see professionals such as the LAC nurse, the school nurse and their GP. Descriptions of these experiences were largely positive, and reflected young people's beliefs that these individuals were medically qualified, and could be trusted not to break their confidentiality.

Reviews of research evidence demonstrate that the most effective approaches to supporting looked after children use an integrated and co-ordinated approach (McNeish et al., 2002). This means that whilst it is important to ensure that young people are provided with the best possible access to advice, support and treatment opportunities, it is perhaps more important to ensure that this takes place within the context of an agreed care plan that outlines what the role of each professional will be. Where this occurs it is important that carers and social workers clearly understand the roles and responsibilities of other professionals and agencies involved in providing sexual health and relationships (Haydon, 2003). Within this study, the importance of this was demonstrated through carers' reflections of working collaboratively with specialist agencies to ensure that carers' did not duplicate or potentially derail therapeutic pieces of work that were being undertaken with young people. In addition, it is important to ensure that individuals are clear about what is expected of them in relation to young people's care plans, as there is some evidence to suggest that where there is lack of clarity about the appropriateness of providing sexual health and relationships advice, young people in the care system are often excluded from gaining this information (Constantine et al., 2009).

Partnership working affords carers and social workers with a potential way of redressing the fact that looked after young people have often been excluded from school-based sexual health and relationships education. Billings et al (2002) argue that where young people are excluded from school-based sexual health and relationships education, and they are also unlikely to receive information about sexual health within the home and care setting, that it is essential that

alternative sources of information and support are made widely available to young people in care. In this study, the narratives of residential carers, foster carers and young people highlighted the willingness of carers to accompany young people to sexual health clinics, GP practices and pharmacies to gain access to contraception, STI testing and pregnancy tests. Carers should be encouraged to offer this support to young people, but be respectful of young people's right to confidentiality. There was also some evidence that carers were actively encouraging young people to use locally available sexual health services. In addition to using sexual health clinics, young people should be encouraged to participate in local sexual health initiatives such as C-cards (e.g. <http://www.freecondomsglasgowandclyde.org/>), which allows young people to obtain free condoms from pharmacies without having to ask for them. Encouraging the use of NHS services in this way ensure that carers know that they are referring the young person on to a practitioner who is fully trained in sexual health, but will also be knowledgeable about the effects of being in care on young people's health and wellbeing.

To facilitate young people accessing NHS services, carers and social workers need to have up to date knowledge of the services that are available within their local area. However, a study recently conducted in Scotland found that this was not the case, with service providers and carers being unable to the full range of services that were available to young people in the care system (Dale, 2009). As such it is essential that information about local services that offer support, advice and treatment relating to pregnancy testing, contraception, emergency contraception, sexually transmitted infections, abortion and relationships should be readily available to all residential carers, foster carers and social workers so that they can share this information with young people. This information can be shared with young people on a one-to-one basis; alternatively, given the reticence that some young people in this study had about approaching their carers for help and advice, information about sexual health and relationships could be made available through posters and leaflets that young people could pick up or read as they want.

Sharing information naturally raises the issue of confidentiality. This issue, in particular breaches of confidentiality, was raised by most of the looked after young people interviewed. In particular young people in residential care reported seeing private information about their sexual health written in open handover diaries, and overhearing staff members discussing the sexual behaviours of young people in placement. Where this happened young people were upset and angry, and described feeling unable to trust their carers. Ensuring that the boundaries of confidentiality are clearly understood and maintained is a process that should be supported by a policy framework that encourages carers to maintain confidentiality. In essence, this would mean that information regarding sex, sexuality and personal relationships should not be shared with other carers or professionals unless there is reason to suspect that the young person is engaging in highly risky and potentially exploitative sexual behaviour. In this situation, it would be preferable that workers explain to the young person both the intention to break their confidentiality, and the reasons for doing so (National Children's Bureau, no year). Maintaining confidentiality in this way would mean that information about sexual health and relationships was only shared on a 'need to know' basis. To help facilitate this, carers should be aware of local authority guidance on how to record, store and disclose information about young people's sexual health and relationships.

One area where the sharing of information is vital is in regards to the health records of young people who are new in placement. In order to facilitate discussions about sexual health and relationships within the care setting, residential and foster carers should be provided with information about any previous sexual health and relationships education that has been received by the young person that they are caring for. They should also be provided with information about the sexual experiences of young people that they are caring for in order to allow them to respond sensitively to the sexual health needs of the child (Haydon, 2003). This information should include information about any problematic sexual behaviours that are being displayed as foster carers and residential workers need to be aware of these issues in order to make plans for safe care (Farmer and Pollock, 2003). The findings of this study suggest that in order to ensure that safe care practices are adopted within the care setting,

individuals living and working within the setting need to work collaboratively in order to ensure that other children and adults in placement remain safe, and that there is minimal room for allegations being made.

Carers who are looking after young people who have problematic sexual behaviours, or who are at risk of being groomed, require high levels of support both from social work services and specialist agencies. Within this study there was a number of carers and social workers highlighted the emotional burden associated with providing sexual health and relationships education to looked after young people. As such, it is essential that these individuals receive pastoral support from managers and link workers, and be given the opportunity to reflect upon how they are coping. Several of the carers who had looked after young people who were showing highly sexualised and abusive sexual behaviours stated that they had never received training in how to manage problematic behaviours, and that their understanding had come from experiential learning and discussing issues with their social worker. Given that caring for young people with problematic sexual behaviours is both emotionally and labour intensive (due to the increased need for monitoring and supervision) these training deficits should be recognised and addressed.

Young people with problematic sexual behaviours should be encouraged to develop healthier sexual attitudes and practices. To facilitate this, young people with problematic sexual behaviours should be provided with the same sexual health and relationships education as other young people in the care system (Haydon, 2003). These discussions should allow young people to reflect upon their past experiences, learn about age-appropriate sexual behaviours, and learn to differentiate between healthy and unhealthy relationships. Providing sexual health and relationships advice to looked after young people who have problematic sexual behaviours is a potentially long and drawn out process, that requires patience and a high level of emotional capacity to deal with. Carers and social workers can be supported to undertake this role; however it may be that this work would be best undertaken by a specialist agency. Within this study several examples of working collaboratively to shape young people's understandings of relationships when they have been sexually abused or

exploited. These instances combined specialist workers who were trained in trauma-based sexual health approaches to address the problematic sexual behaviours, with carers monitoring young people's behaviours and working with the young person in placement to model behaviours and increase young people's self-esteem.

#### **7.4 Strengths and limitations of the study**

This study has many strengths. It is an original piece of work that explores how looked after young people and corporate parents feel about talking to each other about sexual health and relationships and what factors promote and restrict communications about sexual health and relationships being undertaken within care settings. Not only do the findings contribute to the growing literature on the lived experiences of young people within the care system but they can also be used to help inform the literature on parenting around sexual health. In addition, whereas other research conducted into the experiences of looked after young people and care leavers has been criticised for not relating the research findings to theoretical debates, this study seeks to alleviate those concerns by relating the findings to attachment theory and proposing mechanisms through which interventions focussed on improving the sexual health of looked after young people may be designed to reflect. Another strength of the study is that I successfully recruited large numbers of looked after young people and care leavers (n=36); something that other PhD students working in this area have experienced difficulty with (Dale et al., 2010; Roesch-Marsh et al., 2010). This was partly due to having the opportunity to build networks with academics and policy makers working in this area prior to the research being undertaken was something that I found extremely beneficial as it allowed for me to identify the key individuals that I needed to contact within social services prior to the research being undertaken. This, in conjunction with the "buy in" that I received from senior management and the appointment of an internal liaison to help manage the study and negotiate with social work staff proved invaluable to the recruitment process.

Although senior management “buy in” can be viewed as a strength it can also be argued that one of the main weaknesses in this study was that working within the constraints of the social work department meant that the achieved sample was accessed via gatekeepers. Whilst both I and the strategic sexual health lead kept accurate notes of those individuals we contacted as part of the study, the switch to a snowball design half way through the recruitment phase means that it is not possible to know how many looked after young people and care leavers were aware of the study. In addition, even where corporate parents were contacted and asked to provide young people with information about the study it may be that they chose not to do so. This means that some young people who might have been willing to participate were excluded. For example, those in foster care who I was uncertain about whether they were being told about the study or not. The corollary of this is that some young people may have felt pressurised to participate in the study by their social workers or carers.

Another weakness of this study is that young people had to show some degree of engagement with social work services, care leaving services or other charitable organisations working with looked after young people and care leavers. It is also worth remembering that the results presented in this study are based upon small, potentially non-representative samples of young people looked after in local authority care, social workers, residential care workers and foster carers. As such, the results presented may not be fully generalisable to the experiences of all corporate parents and looked after young people. This limitation may be further heightened by the fact that although this study does shed some light on the lived experiences of young people in the care system, the voices of corporate parents are more strongly represented within this thesis. This was not the original intention of this thesis; however, it became apparent early on in the research process that young people found it difficult to talk about many of the issues that corporate parents identified as potentially shaping communication about sexual health and relationships within the care system, including child sexual abuse, problematic sexual behaviours and the effects of domestic violence on young people’s understandings of relationships.

Despite these limitations it should be noted that the findings presented in this thesis significantly extend our knowledge of how communications about sexual health and relationships are shaped by the characteristics of corporate parents and the young people that they look after, and the role that connectedness, parental monitoring and supervision play in mediating sexual health communications.

## **7.5 Conclusion**

This thesis has presented findings from qualitative interviews conducted with looked after young people and their corporate parents, and demonstrates that whilst communication about sexual health and relationships within the care setting has become more accepted, the everyday undertaking of these discussions is fraught with difficulties associated with corporate parents' role identity, and the impact of young people's pre-care and care histories upon their ability to form secure and trusting relationships with their corporate parents. Whilst the results show that providing corporate parents with training in sexual health and relationships improves confidence and ensures that sexual health and relationships work is undertaken within practice, the findings suggest that the salience of these messages may be lost when there is not a secure and trusting relationship between carer and looked after child underpinning these discussions. As such, the findings suggest that in order for corporate parents to communicate with young people about sexual health and relationships within the care setting there needs to be an emphasis placed upon improving young people's ability to trust other people, and that attachment based practices may result in the promotion of positive outcomes for looked after young people. Future policies and training relating to the provision of sexual health and relationships education within the care system should reflect this fact.

## Appendix 1: Secondary analysis of HR2 and AES data

Data from two studies measuring the sexual health experiences of adolescents in Scotland were compared in order to establish whether the sexual health of young people looked after in residential or foster care at the time of data collection differed from the sexual health of young people not looked after at the time of data collection. Ethical approval was granted by Edinburgh Napier University's Ethics Committee and permission to access pupils was sought from local directors of education and senior management in each educational setting.

Study 1 used cross-sectional, self-reported data collected from secondary four pupils (mean age 15.5 years) attending 12 mainstream high schools in Scotland during the academic years 2006/7, 2007/8 and 2008/9 in order to evaluate the national sexual health demonstration project, Healthy Respect 2. Data were collected under examination conditions, with pupils offered additional help and support from trained researchers when they encountered difficulties. A total of 80% (N=4204) of the 5283 pupils eligible to participate completed the Healthy Respect 2 questionnaire, with the missing 20% being comprised of spoiled questionnaires (5%) and those absent from school because they were attending college and vocational courses, sick, temporarily excluded, permanently excluded or attending alternative education provision (Elliott et al., 2013).

In contrast, study 2 used cross-sectional, self-reported data were collected from pupils aged 14-17 years (mean age 15.5 years) attending AES using a shortened, simplified version of the questionnaire used in the evaluation of Healthy Respect 2 (Henderson et al., 2011a). To allow comparison with the Healthy Respect 2 data, the AES chosen were located in the same geographical areas. The Table below shows the range of AES placements sampled. Data were collected either under examination conditions or as a one-to-one semi-structured interview delivered by trained researchers. A total of 94% (N=219) of the 233 pupils eligible to participate in the survey completed a questionnaire, with the remaining 6% consisting of young people who did not want to participate and those identified by AES staff as likely to really struggle with content and comprehension (Henderson et al., 2011).

Descriptive statistics and binary logistic regressions were created using IBM SPSS v19. Due to the small numbers of young people reporting that they were looked after (<1% of the sample) analyses are not conducted separately for gender. Instead, the co-varying effects of age and gender are statistically controlled for. The results are presented in the table below. From this it can be seen that looked after young people had significantly elevated odds of being sexually active prior to age 16; to have used drugs or alcohol at sexual debut; to have been less than 13 years of age at sexual debut; and to report that they had used emergency contraception at sexual debut. Whilst there was no difference in reported rates of condom use or overall contraceptive use at sexual debut, young people in residential and foster care were significantly less likely to report that they had used condoms at most instances of anal or vaginal sex.

	Looked after child % (n)	Non-looked after child <sup>^</sup> % (n)	OR (95% CI)
<b>Sexually active</b>			
has had vaginal or anal intercourse	62.9 (22/35)	39.9 (1441/3614)	2.51 (1.26, 5.03) <sup>§</sup>
used drugs or alcohol at debut	65.0 (7/20)	31.0 (932/1350)	4.03 (1.59, 10.19) <sup>§</sup>
was under 13 years of age at debut	58.8 (10/17)	21.3 (268/1261)	5.13 (1.92, 13.70) <sup>***</sup>
partner was 3+ years older at debut	5.9 (1/17)	7.6 (93/1228)	0.84 (0.11, 6.50)
<b>Contraceptive use at sexual initiation</b>			
none	31.8 (7/22)	18.2 (260/1427)	2.05 (0.83, 5.10)
condoms	47.4 (9/19)	64.6 (925/1432)	0.50 (0.20, 1.24)
oral contraception	15.8 (3/19)	14.4 (205/1423)	1.11 (0.32, 3.86)
EC72 ('morning after pill')	21.1 (4/19)	5.4 (77/1420)	4.65 (1.51, 14.30) <sup>***</sup>
used any form of contraception (excl. EC72)	57.9 (11/19)	68.7 (984/1432)	0.63 (0.25, 1.58)
used any form of contraception (incl. EC72)	68.4 (13/19)	71.2 (1019/1432)	0.88 (0.33, 2.34)
<b>Protected against pregnancy at all instances of sex</b>			
always	31.6 (6/19)	50.1 (639/1276)	0.46 (0.17, 1.21)
most of the time	42.1 (8/19)	69.7 (890/1277)	0.32 (0.13, 0.80) <sup>**</sup>
<sup>^</sup> reference category for binary logistic regression			
<sup>1</sup> adjusted for age and gender			
* p<0.1, **p<0.05, ***p<0.01, § p<0.001			

## Appendix 2: Ethical approval letter



Faculty Ethics Committee

Email: [Office@lbss.gla.ac.uk](mailto:Office@lbss.gla.ac.uk)

3<sup>rd</sup> February 2011

Dear Ms Nixon

SS/10/0027 - "Young People, Sexual Health, and Growing Up in Care"

Thank you for your application seeking ethical approval for the above project. The committee has considered your application and require the following issues to be addressed and amendments made before ethical approval is granted.

### Essential items that must addressed prior to ethical approval being granted

1. In the response to Q. 3 of the Application Form (about half way down the reply) the researcher points out that in the event of a respondent disclosing something of a sexual nature which could be deemed illegal (the person in some sort of danger for example) then the researcher 'may' have to report this. There is also the associated problem that some respondents might be unaware of what is or is not legal anyway. I think that given the nature of the subject matter here and the likely backgrounds of the respondents (as acknowledged in the Application Form) there is the likelihood that someone may indeed report underage sexual behaviour with an older person for example. In this case, I wonder how the researcher will react. Is it not a legal requirement to report such a thing to the police even if it happened in the past? I think the researcher should consider how she would deal with this issue. She may have to tell the respondent that she 'will' report it, rather than that she 'may' report it which seems to imply the exercise of discretion which may be legally problematic. This is a very tricky issue since it potentially involves a 'qualified' confidentiality undertaking that may inhibit the divulging of exactly the type of information that the proposed study seeks to uncover.
2. As a corollary to the above would a respondent necessarily be aware of the distinction between what is and is not legal?
3. The information sheet attached to Attachment 8 could perhaps be simplified a little using the Plain English Campaign's free online dictionary given that many of the respondents will likely have learning difficulties.
4. Appendix 9 states that not filling in and returning the form will be regarded as implying consent to participation. While more convenient there may nevertheless be a case for requiring an **opt in**.
5. In appendices involving consent e.g.11 and 12 I would suggest that it should be made explicit that not answering a question and or withdrawing from the interview does not require the provision of an explanation.

Before the research can properly begin, your response in respect of these items must be reviewed and approved by:

- a. your supervisor, (who when satisfied with your responses can give you final ethical approval to proceed with your project), or
- b. your local subject group ethics committee representative (if designated by your supervisor), or, and only if a. or b. is not possible,
- c. the Research Ethics Committee.

If following c. above, your resubmitted application should be sent electronically to [Office@lbss.gla.ac.uk](mailto:Office@lbss.gla.ac.uk) and accompanied by a cover sheet showing how you have approached each item listed above.



1<sup>st</sup> March 2011

Dear Ethics Secretary,

Please find our response to ethics below. We were grateful for your insightful comments on ethics application **SS/10/0027**. As a result of your comments Catherine has re-engaged with the relevant legal statutes and guidance to inform the policy about the disclosure of underage sexual activity. This policy has now been presented in our response to you and I am satisfied that this strategy on how to respond to disclosures is transparent and follows the legal requirements and guidelines for reporting underage sex. I am also satisfied that after every interview Catherine will advise the young people of the services that are available to them.

With regards to the issue of parental consent, Catherine will go beyond the legal requirements to ensure that the natural parents of all young people who participate are informed of the study. Whilst legally, social work services and other organisations providing access to the young people will provide consent for the young people to be approached to take part in the study, the young people will have the final say about whether or not they take part.

As the lead supervisor for this piece of research, I am confident that all of the ethical points that you raised have been thoroughly addressed and I am happy for data collection to proceed.

Yours sincerely,

A handwritten signature in black ink that reads 'Marion M. Henderson'. The signature is written in a cursive style with a large initial 'M'.

Dr. Marion Henderson.

## Appendix 3: Recruitment letter sent to all young people



Dear <insert name>

My name is Catherine Nixon and I am a researcher at the Medical Research Council in Glasgow. I am studying how being "in care" affects young people's sexual health and relationships. I would like to talk to you about:

- what you know about sexual health
- where you have learned about sexual health and relationships
- your experiences of romantic and sexual relationships
- what shapes your views on sexual health and relationships
- your views on sexual health education
- your views on sexual health services

What does the study involve? You would be asked to take part in an interview at a time and place of your choice. The interview will last about 1 hour and I will ask questions about your experiences, views and opinions about sexual health. What you tell me in the interview will be confidential - that means that I will not tell anyone what you tell me. As a thank you for taking part in the study you will receive a £20 gift voucher.

The information sheet attached provides more detail about the study. Please take the time to read this and if you want to discuss it with your social worker/case worker/link worker.

If after reading the information you are interested in helping me then could you please ask your social worker/case worker/residential care worker to please pass your details on to me. I will then contact you to arrange a time that we can meet.

Please note that taking part in the study will **not** affect the care and support that you receive from your social worker.

Thank you,  
Catherine Nixon

## Appendix 4: Young person's information sheet and consent form

### **Young People, Sexual Health and Growing Up in Care Study**

#### ***Invitation***

You are being invited to take part in a research study looking at the effect of being in care on young people's sexual health. It is important that you understand why the research is being done and what it will involve before you decide whether you want to take part. Please read the information on this sheet carefully, and discuss it with your carers, family or friends if you want to. If there is something that you do not understand, or you would like more information about, please contact Catherine Nixon on 0141 357 3949.

#### ***What is this study about?***

I want to collect information on how being in care affects the sexual health of young people in Scotland. Very few studies have asked young people to talk about this. The information that we gather will be used to help people who make decisions about sexual health services and education understand the effect that being in care has on the relationships that young people in care have with their boyfriends/girlfriends, if being in care affects your attitudes towards sex, how you behave in romantic and sexual relationships, and how you learn about sexual health and relationships. I hope that finding out this information will help to improve the way that sex education and services are delivered to young people in care in the future.

#### ***What will taking part involve?***

You will be asked to take part in one interview which should last no longer than 1 hour. This will involve me (Catherine) asking you some questions which you will be free to answer in as much detail as they wish. We would like to digitally record your answers. You can choose where the interview will take place. As a thank you for giving up your time to take part in the research, you will receive a £20 gift voucher.

#### ***Why take part?***

This study will give you an opportunity to discuss your unique knowledge, beliefs, feelings and experiences about being in care. By taking part I hope that the answers you and other young people provide will result in improvements being made to the sexual health education and services available to children in care.

#### ***Will my taking part in the study be confidential?***

Yes, all the information collected will be kept strictly confidential with one exception. If you tell me something that makes me think you or someone else is at risk of being hurt then I will have to tell someone. Otherwise, your name and any details by which you could be identified will not be used. All names mentioned will be changed.

***What will happen to the results of the research study?***

The interviews from all those who take part will be examined to identify common issues affecting young people in care. Some of what you say may be quoted in reports and articles, but your name will **not** be used.

***Who is organising and funding the study?***

The research is being conducted by Catherine Nixon, and is supported by the MRC/CSO Social and Public Health Sciences Unit and Edinburgh Napier University. The study is funded by the Chief Scientists Office for Scotland. The study has been approved by the University of Glasgow, College of Social Sciences Ethics Committee.

***Will taking part in the study affect my child's care?***

Taking part in the study will **not** affect the care that you receive and will **not** affect the support that you receive from your social worker.

***What if I don't want to take part?***

You do not have to take part in the study if you do not want to, and even if you say yes to taking part, you can choose to stop taking part at any time. If you do not want to take part, please let Catherine know. Not taking part in the study will **not** affect the care that you receive and will **not** affect the support that you receive from your social worker.

***What else do I need to do now?***

If you would like to take part in the study, please complete the form enclosed with this letter and post it back to me using the stamped addressed envelope. I will be in touch with you shortly after I receive your form to explain the study in more detail and arrange a time to see you.

If you would like more information on the study before agreeing to take part, please contact me by:

Writing to: Catherine Nixon, MRC/CSO Social and Public Health Sciences Unit, 4 Lilybank Garden, Glasgow, G12 8RZ

Telephoning: 0141 357 3949

Emailing: [Catherine-n@sphsu.mrc.ac.uk](mailto:Catherine-n@sphsu.mrc.ac.uk)

Should you have any concerns about the research, please contact Marion Henderson (Senior Investigator Scientist) or Catherine Ferrell (Survey Manager) on the details below:

Write to: Dr. Marion Henderson OR Catherine Ferrell, MRC/CSO Social and Public Health Sciences Unit, 4 Lilybank Garden, Glasgow, G12 8RZ

Telephone: 0141 357 3949

Email: [Marion@sphsu.mrc.ac.uk](mailto:Marion@sphsu.mrc.ac.uk)

[Catherine@sphsu.mrc.ac.uk](mailto:Catherine@sphsu.mrc.ac.uk)

# Young People, Sexual Health and Growing Up in Care

## CONSENT FORM FOR YOUNG PEOPLE

To be completed by young people who wish to take part in the Young People, Health and Growing Up in Care project.

I have read and understood the information sheet.

I understand that I do not need to answer any questions that I don't want to and that I can withdraw from the study at any time.

If I choose not to answer questions or withdraw from the study I understand that I do not have to tell you why

I understand that the things I say may be used in reports, articles and talks by the researcher but that my name will be changed so that no comments can be traced back to me.

I agree to be interviewed for the Young People, Sexual Health and Growing Up in Care project

I am happy for my interview to be recorded

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Male/Female (Please circle)      Age: \_\_\_\_\_      Date: \_\_\_\_\_

## Appendix 5: Corporate parent's information sheet and consent form

### **Young People, Sexual Health and Growing Up in Care Study**

#### ***Invitation***

You are being invited to take part in a research study looking at the effect of being in care on young people's sexual health. It is important that you understand why the research is being done and what it will involve before you decide whether you want to take part. Please read the information on this sheet carefully, and discuss it with your colleagues if you want. If there is something that you do not understand, or you would like more information about, please contact Catherine Nixon on 0141 357 3949.

#### ***What is this study about?***

The Medical Research Council, Edinburgh Napier University and the Chief Scientist Office are conducting a piece of research looking at the sexual health experiences of looked after young people. In particular, the study aims to understand the effect that being in care has on the relationships that young people have with their boyfriends/girlfriends, if being in care affects their attitudes towards sex, how young people behave in romantic and sexual relationships, and how young people learn about sexual health and relationships. The research will be conducted between June 2011 and December 2011, and will involve looked after young people, care leavers, foster parents, residential care managers and social workers within Greater Glasgow and Ayrshire.

#### ***Why take part?***

Over the last few years, the Young People's Sexual Health Steering Group, which is a collaborative venture between Glasgow City Council and NHS Greater Glasgow and Clyde, has been undertaking a piece of work aimed at improving the sexual health of looked after and accommodated young people and to promote positive communication about sexual health and relationships between social work staff, carers and young people. Taking part in this study will provide the steering group, which is also one of the Children and Families planning groups; with an opportunity to gain feedback upon how effective this piece of work has been and what relevance it has to young people and their corporate parents.

#### ***What will taking part involve?***

You will be contacted by Catherine Nixon from the MRC who will explain the study and ask if you are willing to participate in a forty minute interview. Interviews can be conducted either face-to-face or via a telephone call at a location of your choice. The interviews will focus upon your experiences of working with looked after young people, your views on the sexual health of looked after young people and your experiences of providing support around sexual health and relationships.

***Will my taking part in the study be confidential?***

Yes, all the information collected will be kept strictly confidential with one exception. If you tell me something that makes me think that you or someone else is at risk of being harmed then I will have to tell someone. Otherwise, your name and any details by which you could be identified will not be used. All names mentioned will be changed.

***What will happen to the results of the research study?***

The interviews from all those who take part will be examined to identify common issues affecting young people in care. Some of what you say may be quoted in reports and articles, but your name will **not** be used.

***Who is organising and funding the study?***

The research is being conducted by Catherine Nixon, and is supported by the MRC/CSO Social and Public Health Sciences Unit and Edinburgh Napier University. The study is funded by the Chief Scientists Office for Scotland. The study has been approved by the University of Glasgow, College of Social Sciences Ethics Committee.

***What if I don't want to take part?***

You do not have to take part in the study if you do not want to, and you may choose to withdraw from the study at any time.

***What else do I need to do now?***

In the next few weeks you will be contacted by Catherine Nixon from the MRC who will explain the study and ask if you are willing to participate in a forty minute interview. In the meantime, if you would like more information on the study please contact me by:

Writing to: Catherine Nixon, MRC/CSO Social and Public Health Sciences Unit, 4 Lilybank Garden, Glasgow, G12 8RZ  
 Telephoning: 0141 357 3949  
 Emailing: [Catherine-n@sphsu.mrc.ac.uk](mailto:Catherine-n@sphsu.mrc.ac.uk)

Should you have any concerns about the research, please contact Marion Henderson (Senior Investigator Scientist) or Catherine Ferrell (Survey Manager) on the details below:

Write to: Dr. Marion Henderson OR Catherine Ferrell, MRC/CSO Social and Public Health Sciences Unit, 4 Lilybank Garden, Glasgow, G12 8RZ  
 Telephone: 0141 357 3949  
 Email: [Marion@sphsu.mrc.ac.uk](mailto:Marion@sphsu.mrc.ac.uk)  
[Catherine@sphsu.mrc.ac.uk](mailto:Catherine@sphsu.mrc.ac.uk)

# Young People, Sexual Health and Growing Up in Care

## CONSENT FORM FOR SOCIAL WORKERS/FOSTER CARERS AND RESIDENTIAL WORKERS

To be completed by social workers foster carers and residential care workers who wish to take part in the Young People, Health and Growing Up in Care project.

I have read and understood the information sheet.

I understand that I do not need to answer any questions that I don't want to and that I can withdraw from the study at any time.

If I choose not to answer questions or withdraw from the study I understand that I do not have to tell you why

I understand that the things I say may be used in reports, articles and talks by the researcher but that my name will be changed so that no comments can be traced back to me.

I agree to be interviewed for the Young People, Sexual Health and Growing Up in Care project

I am happy for my interview to be recorded

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Job Title: \_\_\_\_\_

Male/Female (Please circle)

Date: \_\_\_\_\_

## Appendix 6: Care History Questionnaire

**How old were you when you first came into care?**

(Please circle age)

0    1    2    3    4    5    6    7    8    9    10    11    12    13

**Which of these describe the reason(s) that you came into care?**

(Tick all that apply)

- |                                  |                          |                            |                          |
|----------------------------------|--------------------------|----------------------------|--------------------------|
| In trouble with police           | <input type="checkbox"/> | Parent/guardian illness    | <input type="checkbox"/> |
| Persistent truanting from school | <input type="checkbox"/> | Emotional abuse            | <input type="checkbox"/> |
| Beyond parental control          | <input type="checkbox"/> | Sexual abuse               | <input type="checkbox"/> |
| Parent/guardian needed help      | <input type="checkbox"/> | Physical abuse             | <input type="checkbox"/> |
| Parent/guardian alcohol use      | <input type="checkbox"/> | Neglect                    | <input type="checkbox"/> |
| Parent/guardian drug use         | <input type="checkbox"/> | Other (please state below) | <input type="checkbox"/> |
- 
- 

**How many times have you come into care?**

(Please circle)

0    1    2    3    4    5    6    7    8    9    10+

**How many care placements have you had in total?**

(Please circle)

0    1    2    3    4    5    6    7    8    9    10+

## Appendix 7: Young person's interview topic guide

### Care experiences

- **Can you tell me a little bit about how you came to be in the care system?**

Prompts:

- First placement type and reason for entry into care
- Number and length of placement
- What is current placement like

### View of sexual health issues affecting young people in care?

- **Thinking about sexual health, can you tell me what you think are the most important issues affecting young people in care?**

Explore issues:

- Pubertal changes, gender differences and menarche
- Emotions and self esteem
- Boyfriends/girlfriends
- Choosing when to have sex and delaying sex
- Contraception
- STIs
- Teenage pregnancy/parenthood
- Circumstances surrounding sex
  - Risky
  - Drugs/alcohol
  - Force
- Regret
- Sexual health education
- Service use

- **What/who do you think influences the sexual health of young people in care?**

Prompt: do any of these influence it?

- Type of care placement
- Stability of placement
- Security
- Influence of peers/partners/parents/carers/corporate family
- Media
- Other

### Sexual health education

- **Where have you learnt about sexual health and relationships?**

- School
- Family
- Friends/peers
- Media
- Social workers
- Carers
- Health professional e.g. LAC nurse

- **What did you learn about sexual health and relationships?**  
Explore:
  - What do you know?
  - What don't you know?
  - Where have you learned that information from?
  - What do you think about the quality of the information you received?
  - Have you spoken to your carer sexual health and relationships?
    - Why/why not?
    - What have you spoken to them about?
  
- **How did you feel about learning/being spoken to about sexual health by <insert options from previous questions>?**
  
- **Do you think there are barriers to young people in care accessing sexual health and relationships education?**  
Prompts:
  - What are those barriers?
  - What could be done to overcome the barriers?
  - Whose responsibility should that be?
  
- **Do you think it is important to learn about sex and relationships?**
  - Why/Why not?
  
- **What do you think are the most important things for you to learn about?**
  - Why?
  
- **What would you change about the way young people in care learn about sexual health and relationships?**
  - Why do you think that?

### Help, support & guidance around sexual health and relationships

- **What support should young people in care get in relation to their sexual health and relationships?**  
Explore:
  - Pubertal changes and menstruation
  - Boyfriends/girlfriends
  - Relationships
  - Choosing to have sex and sexual delay
  - Getting and using contraception
  - Using sexual health services
  - Pregnancy
  - Abortion
  - Other topics/advice/kind of support not mentioned
  
- **Has anybody in the care system ever spoken to you about sexual health and relationships? What about? How did it make you feel?**

- **If you or a friend were in trouble and needed advice relating to a private matter, who would you go to for help?**

**Prompts:**

- Why would you go to that person?
- Would you go to different people for different things?

### **Sexual health service use**

- **Are there any barriers to young people in care accessing sexual health services?**
  - Have you used a sexual health service before?
  - What was it like?
  - What did you go for?
  - How did using the service make you feel?
  
- **If a young person came to you asking where they should go to access a sexual health service could you give them that information?**
  - Where would you direct them to?
  - Why?
  - Would you accompany them there if they wanted you to?
  
- **What do you think a sexual health service for LAC should be like?**
  - Staff
  - Accessibility
  - Opening hours/appointments
  - Location/entrance
  - Confidentiality
  - Other?

## Appendix 8: Corporate parent's interview topic guide

### Caring experiences

- **Can you tell me a little bit about your experience working with/caring for looked after young people?**

Prompts:

- Type of contact with young people
- Length of time working with them
- Current role
- Reasons for working with group

### View of sexual health issues affecting young people in care?

- **Thinking about sexual health, can you tell me what you think are the most important issues affecting young people in care?**

Explore issues:

- Pubertal changes, gender differences and menarche
- Emotions and self esteem
- Boyfriends/girlfriends
- Choosing when to have sex and delaying sex
- Contraception
- STIs
- Teenage pregnancy/parenthood
- Circumstances surrounding sex
  - Risky
  - Drugs/alcohol
  - Force
- Regret
- Sexual health education
- Service use

- **What/who do you think influences the sexual health of young people in care?**

Prompt: which of these would you say it is?

- Type of care placement
- Stability of placement
- Security
- Influence of peers/partners/parents/carers/corporate family
- Media
- Other

## Sexual health education

- **Where do you think that looked after young people learn about sexual health and relationships?**
  - School
  - Family
  - Friends/peers
  - Media
  - Social workers
  - Carers
  - Other
  
- **Thinking about the looked after young people and care leavers you know or look after, do you know what they know about sexual health and relationships?**  
**Explore:**
  - What do they know?
  - What don't they know?
  - Where have they learned that information from?
  - What do you think about the quality of the information they received?
  - Have you spoken to them about sexual health and relationships?
    - Why/why not?
    - What have you spoken to them about?
  
- **Do you think there are barriers to young people in care accessing sexual health and relationships education?**  
**Prompts:**
  - What are those barriers?
  - What could be done to overcome the barriers?
  - Whose responsibility should that be?
  
- **Do you think it is important for LAC to learn about sex and relationships?**
  - Why/Why not?
  
- **What do you think are the most important things for them to learn about?**
  - Why?
  
- **What would you change about the way young people in care learn about sexual health and relationships?**
  - Why do you think that?

## Help, support & guidance around sexual health and relationships

- **What support should young people in care in relation to their sexual health and relationships?**  
Explore:
  - Pubertal changes and menstruation
  - Boyfriends/girlfriends
  - Relationships
  - Choosing to have sex and sexual delay
  - Getting and using contraception
  - Using sexual health services
  - Pregnancy
  - Abortion
  - Other topics/advice/kind of support not mentioned
  
- **Have you ever delivered support to a young person in care/care leaver in relation to their sexual health?**
  - Can you tell me about that in more detail?
  
- **How did delivering that support make you feel?**  
Prompt: ask respondent to choose 4 emotions from cards
  
- **Did you feel that you had received sufficient training to be able to talk to a young person about their sexual health?**  
Prompts:
  - What training/support had you received?
  - What training/support would you have needed?
  - Who should have given you that support?
  - What effect do you think the training had/would have had upon your ability to support the young person you were speaking to?
  
- **What effect do you think your advice had upon the young person's...**  
Prompts:
  - self confidence and self esteem?
  - knowledge?
  - relationship with boyfriend/girlfriend?
  - sexual relationships?
  - their relationship with you?

## Sexual health service use

- **What do you think are the barriers to young people in care accessing sexual health services?**
  
- **If a young person came to you asking for information about sexual health services, could you give them that information?**
  - Where would you direct them to?
  - Why?
  - Would you accompany them there if they wanted you to?
  
- **What do you think a sexual health service for LAC should be like?**
  - Staff
  - Accessibility
  - Opening hours/appointments
  - Location/entrance
  - Confidentiality
  - Other?

## Improving outcomes

- **What could be done to promote positive sexual health outcomes for LAC?**
  - Why do you think that?

## Appendix 9: Young people's placement histories

Participant name	Number of placements	Ever in care living arrangements					Care leavers living arrangements			
		<i>Living at home</i>	<i>Kinship care</i>	<i>Foster care</i>	<i>Children's unit</i>	<i>Residential school</i>	<i>Living at home</i>	<i>Supported care</i>	<i>Own tenancy</i>	<i>Refuge or hostel</i>
Anna	2	Y		Y						
Katie	2				Y					
Rebecca	3	Y		Y	Y					
Kacie	4		Y		Y					
Chris	2				Y					
Jamie	1				Y					
Darren	2		Y		Y					
Kristina	7		Y	Y	Y					
Gavin	6			Y	Y					
Sarah	1				Y					
Mary	2				Y					
Niamh	1			Y						
Sophie	5				Y					
Stephanie	6	Y	Y	Y						
Tom	1			Y						
Ali	9	Y		Y	Y					
Tony	8				Y			Y		
Amy	2		Y		Y			Y		
Eve	8	Y		Y			Y	Y		
Nadia	4		Y	Y	Y			Y	Y	Y
Mike	6		Y		Y				Y	Y
Alan	5	Y	Y	Y	Y	Y			Y	
Catriona	2				Y			Y		
Kim	3			Y	Y				Y	
Karen	3				Y					Y
Caitlyn	5								Y	
Andrea	90+	Y	Y	Y	Y	Y			Y	
Eddie	5				Y			Y		
Stuart	7		Y	Y		Y				Y
Matt	3			Y				Y		Y
Freddie	3		Y			Y		Y		
Jack	12				Y	Y			Y	Y
Tim	1				Y			Y		Y

\*Current placement type is shown in red, where two placement types are shown the young person was in the process of transitioning from one placement to another and spending equal amount of time in both placements.

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