The perceived sexual health needs of looked after young people: findings from a qualitative study led through a partnership between public health and health psychology

H. Dale1, L. Watson2, P. Adair1, M. Moy3, G. Humphris4

1NHS Fife, Department of Psychology, Stratheden Hospital, Cupar, Fife KY12 0QT, UK
2NHS Fife, Department of Public Health, Cameron Hospital, Leven, Fife KY8 5RG, UK
3Fife Council Social Work Department, Rothesay Place, North Street, Glenrothes KY7 5PN, UK
4Bute Medical School, University of St. Andrews, St. Andrews, Fife KY16 9TS, UK

Address correspondence to Hannah Dale, E-mail: hannahdale@nhs.net

ABSTRACT

Background Looked after young people (LAYP) have poorer sexual health outcomes than their peers. However, research seldom examines the health needs of, or intervenes with, this group. The aim of the current study was to identify LAYP’s perceived sexual health needs and explore sources of sexual health information, knowledge levels, concerns and service preferences.

Methods Looked after young people within Fife, Scotland, were recruited through their workers and carers to participate in qualitative semi-structured interviews. Those aged 12–19 years were targeted for recruitment. National Health Services ethics approval was granted. Thematic analysis was conducted using NVivo.

Results Interviews were conducted with 10 LAYP. Key themes included gaps in knowledge, and gaps between knowledge and behaviour. Being ‘looked after’ may have negative consequences on knowledge, sources of support and safer sex. A flexible, one-to-one service, aimed at several lifestyle issues, not solely sexual health, was preferred by respondents.

Conclusion Looked after young people require support to bridge the gap between knowledge and behaviour and several theories relevant to the findings have been identified. Participants desired more support around a range of health issues, which may come from school, workers and carers, as well as health professionals. Further research examining effective interventions with this group is crucial to improve outcomes.

Keywords public health, sexual behaviour, young people

Introduction

The sexual health of young people in the UK—and Scotland—is persistently found to be worse than most of Western Europe.1–5 Sexual health may be particularly compromised in vulnerable populations. Looked After Young People (LAYP) are a vulnerable group who are under a supervision order with the local authority and may remain at home or be placed away from home.6 LAYP often experience ‘family breakdown, physical abuse, neglect and sexual abuse’,7 which can impact on their wider health and relationships, leading them to commonly have poorer health outcomes than non-looked after individuals.8 LAYP may be more susceptible to sexually unwanted or exploitative activity, more likely to have sex, receive less contraceptive advice and more likely to become young parents than their non-looked after peers.9–14 Although some research indicates that LAYP receive sexual health knowledge from a variety of sources including school, key workers, parents, friends, and health care professionals,15,16 this often relies
on good relationships with workers and carers and consistent attendance at school, which may be lacking. Low self-esteem and limited access to consistent positive adult support may also contribute to poor sexual health.18

The need for targeted interventions around sexual health with LAYP is thus acute and is recognized within current sexual health policy in the UK.9,19–21 To address these highlighted problems, a health psychologist in training was employed by NHS Fife, as part of a national pilot of applying health psychology to key public health challenges within Scotland.22 The aim of this project was to conduct a qualitative study examining the perceived sexual health needs of LAYP. A broad definition of sexual health is adopted throughout to include relationships, emotions and well-being.23 Objectives were to explore where LAYP learn about sex and relationships, their knowledge levels and concerns, in order to assess additional needs, and preferences for further services. The intention was to use the findings to improve services for LAYP in Fife, a semi-rural area in the east of Scotland, with over 700 LAYP of all ages. The high rates of under 16s pregnancy, that characterize this group is a key Scottish health target.24–26

Methods

Participants and recruitment
A purposive sampling method was used to recruit LAYP from residential settings, foster care, kinship care (those looked after by relatives or friends of family) and those living with their own parents. This was achieved through targeting workers and carers from Fife Council Social Work teams, and a range of private and voluntary organizations in Fife, who initially approached LAYP and provided them with details of the study. Inclusion criteria were: the young person had to be aged 12–19, to help ensure representation from those from different cognitive, emotional and social stages of development; ‘looked after’; and competent to consent to participate in the research. Parental/guardian consent was not required since it is not a legal requirement in Scotland.27,28

Interview procedure
Relevant literature was reviewed and discussions with stakeholders examined the most effective ways to explore issues and engage with LAYP and informed the methodology used. Semi-structured interviews were chosen to assess the perceived sexual health needs of LAYP as this was considered a more acceptable and comprehensive method than a fixed format intrusive questionnaire, that may not capture or explore a range of possible answers.29 An interview guide was developed by the authors consulting existing literature. Prior to interviews, all written material developed was opportunistically shown to two females for acceptability and readability, aged 14 and 15, and modifications were made following their comments. Following written informed consent, a tape-recorded interview was conducted with each participant lasting approximately 30 min. Open questions were used such as: ‘Where do you learn about sex and relationships from?’ A protocol indicated actions to be taken should child protection issues arise during interviews.

Ethics
NHS Research Ethics Committee approval was granted.

Data analysis
Interview recordings were anonymized by digitally masking names of individuals and places, sent for transcription and transferred into NVivo, a computer software package, which aids the organization of data and enables improvement in the rigor of the analysis.30 The data were then analysed using thematic analysis, a process which interprets and understands qualitative data through coding it into themes.31

Results
Characteristics of the 10 participants are detailed in Table 1. Recruitment of this vulnerable group was complex and met with many barriers. However, the multi-agency approach taken enabled liaison with a range of professionals working in statutory, voluntary and private organizations and facilitated recruitment. The interview data was categorized into many themes and sub-themes.31 Key themes are represented below and focus on the emerging themes from questions about their knowledge and concerns, and preferences for further services.

The impact of being ‘looked after’
The very circumstances of being ‘looked after’, whether it be in a residential establishment, with carers, or with family appears to have impacted upon the extent to which sexual health has been discussed with LAYP interviewed:

I never really got an opportunity [to discuss sex] because half the time I was embarrassed. So I never said anything... I wouldn’t talk to my carers about it... family and everything could have taught me something. I think my dad and that felt embarrassed... [P10]

... see trying get information like that out of my worker, my key worker, it was really really hard. [P8]
For three young people, school was the only place that someone had discussed sex and relationships with them, and a further person had never discussed the topic:

I never got taught about it at all. [P8]

In one case, affection seeking through sexual encounters, along with low self-worth was evident, which may be an indication of attachment issues resulting from previous experiences:

...to be honest, sex is my way out. See if I’m feeling shit about myself and I’m thinking about the past and what I could have had, I still get really down... I’ll sleep with somebody because it makes me feel special for maybe my three minutes... I didn’t get a lot of praise when I was younger or told, oh, this is alright. I didn’t really have what you call a family life, eh, so I wasn’t getting the talks and dad’s being protective and looking after their wee lassies... [P8]

Knowledge around sexual health

The knowledge levels of LAYP were very much focused on the consequences of unprotected sex (pregnancy and sexually transmitted infections (STIs)). The majority expressed a perceived knowledge deficit around STIs:

I know how you can catch them. Just don’t know what they really are and what they can do to you and that. [P10]

The majority of participants considered that school-based teaching in particular lacked depth and did not equip individuals with the necessary knowledge and skills:

I think it has just like focused on like the safe part of it and that... [P6]

Only one person spoke of alternatives to penetrative sex and felt the topic was covered only because they had specifically asked about it, meaning that those less confident to ask questions may be left without the knowledge they require:

We also learn about non-productive methods [non-penetrative sex], although they’re only mentioned because I mention them. [P1]

Several participants showed a distinct lack of knowledge of existing services, particularly the young people’s sexual health services and drop-in’s:

Nobody told us about them... there’s never like a drop-in clinic [for young people]... [P6]

Knowledge-behaviour gap

Interviews revealed that LAYP may lack the skills needed to act on their knowledge, identifying a clear knowledge-behaviour gap. LAYP interviewed were aware of how to practice safer sex, however they felt unable to always apply this knowledge to protect themselves:

I was 14... I think that was a disgusting age to even have to go to the GUM clinic, eh, and I was so scared there... I’m not using anything. I’m on the Pill but that’s it. I still struggle... [to protect myself] [P8]

It can happen. You might start cuddling and you might just want to do it and it’s hard not to. [P4]

Confidence was felt by one person to be an important skill to enable individuals to practice safer sex:

Aye, so you need to actually work on people’s confidence as well as the sex education and that because it’s alright teaching them you about it, but if you’re no’ got the confidence, then it’s not going to really help you is it. [P6]

The barriers to safer sex

LAYP described perceived barriers to positive sexual health, which included impulsive sexual experiences, alcohol and drugs influencing sexual activity, and resistance to condom use:

It can vary. It depends if you’re with somebody or not or if you’re just on a night out, because if you’re on a night out, then you don’t plan it [P9]

It probably often just happens, that’s where you get like messed up and unwanted children, pregnancies and that, like the one night stands, they’re going to get drunk and then go with some guy and end up pregnant. Or they end up being a father... Because when you’re drunk you do not really care. [P6]

I think men feel they don’t enjoy it [sex] as much [when using condoms]; I mean, I’ve heard the expression, it’s like going in the

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td>19</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
</tr>
<tr>
<td><strong>Residence type</strong></td>
<td></td>
</tr>
<tr>
<td>Residential schools &amp; homes</td>
<td>7</td>
</tr>
<tr>
<td>Foster care</td>
<td>2</td>
</tr>
<tr>
<td>Kinship care</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
</tr>
</tbody>
</table>
bath with socks on and things like that... if they're like really want to have sex with someone, they'll just be like, okay, fine. It doesn't matter... [P9]

In one case inaccurate information taught in schools represented a further barrier to safer sex:

_Double up the condom and that... It's in case the condom bursts, you have to double it up... it won't break then._ [P6]

**Preferences for health-promoting services**

All LAYP expressed a preference that services should cover a wider range of sexual health topics and should encompass a range of lifestyle issues for reasons including embarrassment and convenience:

_I think like breast examination, genital examinations and things like that._ [P9]

_I think it should be like all aspects of health that you would be too embarrassed to go and see a doctor about._ [P9]

_Aye, mixed as well because the it gives people the security of like, when you go to that place it could be for a number of things, not just one certain thing so they wouldn't feel as embarrassed... So probably widen the range as well._ [P6]

Most participants felt they would benefit from input on a one-to-one basis and from someone who they did not know very well, as well as workers or carers:

_So it doesn’t necessarily have to be a worker or a family member, it could even be a stranger talking to you, eh._ [P8]

Preferences for service design included drop-ins but also appointments. It was also clear that services may need to be adaptable to young people and flexible in the location, contrary to some existing services:

_I would prefer an appointment..._ [P2]

_Somewhere quite close to your GP or hospitals... Probably quite central as well, not like quite out far and out of reach and that._ [P10]

_So I think a phone number or maybe a number to text, because young people do text a lot..._ [P9]

_Being 'looked after' also appeared to leave some individuals feeling stigmatized, which impacted on their preferences for services:_

_It would be better to have it [services] somewhere else, like, like how it would be if you weren't in a residential establishment... you want to feel more like a normal bairn like everybody else._ [P6]

**Discussion**

**Main finding of this study**

Some young people were unable to discuss sexual health with family members, carers or workers, therefore the perceived lack of in-depth teaching in school is particularly significant. In common with young people in general, school was the main source of advice on sexual health for those interviewed, but as LAYP may be at greater risk of missing school, this should not be the only source of information. Parents and family structure influence attitudes to sexual conduct, and emotional availability of parents is linked to more positive sexual behaviour, highlighting that the relationships LAYP have with those around them as a key factor in improving sexual health. For young people in general, friends, parents and siblings in that order are the people with whom it is easiest to discuss personal and sexual matters. Previous experience and status as LAYP, including changes in placement, means that obtaining such input may be particularly problematic for this group. In some cases issues of affection-seeking suggest that LAYP may require more support because of their previous experiences. These social and environmental factors have a strong influence on behaviour according to several theories: The Health Belief Model (HBM); Protection Motivation Theory (PMT); the Theory of Planned Behaviour (TPB) and Social Cognitive Theory (SCogT). Consequently if these external factors can be influenced, improved health behaviours among LAYP may result. These factors may also influence wider sexual health well-being around healthy relationships and delaying sex until ready. Therefore, reluctance of key individuals, such as workers, to discuss sexual health may impact significantly on the behaviours of LAYP, particularly if they miss schooling. This highlights the need for carers and workers to strive to maximize the health of LAYP and build strong relationships with them to encourage discussions around sexual health.

Young people interviewed retained general knowledge of the consequences of unprotected sex; however, they lacked details around other areas of sexual health. Knowledge of non-penetrative sex was highlighted as important by one individual and may assist in minimizing unprotected sex through highlighting alternative options, especially in unplanned, impulsive or alcohol/drug-influenced sexual encounters. Knowledge gaps around STIs may lead to low motivation to avoid them, along with an inability to accurately assess the severity of and their susceptibility to STIs. Perceived severity and susceptibility, along with the similar constructs of outcome expectancies, attitude, and risk perception are important in influencing behaviour within the
following theories: HBM, PMT, TPB, SCgT and the Health Action Process Approach: HAPA. Therefore their perceptions of STIs may not be negative to the extent that it would result in health protective behaviour around condom use. Similarly, they may not be able to sufficiently perceive the negative psychosocial consequences of risky behaviours and relationships.

Further constructs that appear in several theories may have influenced the significant knowledge-behaviour gap in relation to condom use, since some people experienced difficulties to act on their knowledge. Behavioural skills, self-efficacy, perceived behavioural control and motivation of LAYP, including planning to keep safe, require extra development to promote health protective behaviours. These factors may assist in reducing any knowledge-behaviour gap and feature in several theories: PMT, TPB, SCgT HAPA and the information-motivation-behavioural skills model. Significant barriers to safer sex, including the unplanned nature of sex and the influence of alcohol/drugs on behaviour, suggest that enhanced skills to counteract the barriers and facilitate safer sex are needed. One theory, the HAPA, indicates the importance of action and coping planning, to help foresee any barriers and deal effectively with them.

LAYP interviewed desired flexible health-promoting services, aimed at all health issues including sexual health. This has implications for generic health services and any specific health service input for LAYP. Knowledge about drop-in services and perceived accessibility of existing specialist services was low in this sample; therefore, information may need better targeted to vulnerable groups.

As discussed above, these findings resonate with several theories of behaviour; however, no single theory appears to fully explain the findings, rather components from a range of theories appear to be important. Collectively these identify many factors that are important for health protective behaviours that appear to be lacking from the repertoire of LAYP. In particular, these include sufficient knowledge, perceived severity of, susceptibility to, and risk perception around STIs, and, more generally, realistic outcome expectations around pregnancies and STIs positive attitudes towards safer sex, more accurate norms about behaviours, motivation to engage in safer sex, high self-efficacy around choices and decisions, action and coping planning to better manage the barriers to safer sex and more generally a higher level of behavioural skill. Whilst the underlying social and environmental factors that may make LAYP more susceptible to poorer sexual health may not be able to be changed, the more internal factors identified here may be crucial in changing negative behaviours in LAYP and may all need to be targeted to result in significant positive behaviour change. Thus, the need for interventions to assist LAYP in improving their healthy lifestyles is crucial and application of health psychology expertise may then directly assist in addressing health behaviours in this group.

Limitations of this study
Recruitment was a major challenge, despite senior social work support for the project, with some workers/carers appearing unwilling to approach or discuss the study with LAYP. LAYP from residential settings were over-represented—a symptom of the recruitment barriers—but this group has been identified as having particularly high rates of unprotected intercourse. Selection relied upon the willingness of both worker/carer and young person; it is possible that participants were more confident and motivated than LAYP in general. LAYP are a heterogeneous group and while they are generally at higher risk of teenage pregnancy, individual circumstances may vary. Despite these limitations, most themes reached saturation, indicating that interview numbers were sufficient to draw conclusions from the sample.

What is already known on this topic
LAYP fair worse than their peers around sexual health, and desire more input around sexual health. School is the most common, and sometimes only, source that LAYP receive sexual health information from. One identified key factor to successfully reducing teenage pregnancy has been targeting those at greatest risk including LAYP.

What this study adds
This study supports the need for further input around sexual health for LAYP, but not in isolation from other lifestyle issues. Workers or carers have an important role in building relationships with and discussing sexual health with LAYP, as part of their ‘parental’ role, but some may be reluctant to so. Engagement with social work staff and relevant carers at both senior and operational level may be needed to address this, and specific sexual health training may be required. There were issues about the quality and comprehensiveness of the sex and relationships education received by some LAYP, and ensuring that staff delivering SRE are sufficiently trained is also important. Addressing the knowledge-behaviour gap through interventions is essential and may be achieved through drawing on behavioural theories, and particular constructs identified in this study as important in influencing the behaviour of LAYP.
Health-promoting services and interventions, specifically those addressing sexual health, may best be targeted with other health issues, to better engage young people in more sensitive topics. As a result a pilot intervention has been developed in Fife and supports LAYP to change their behaviours around a range of health issues, drawing on a range of techniques used in health psychology.4,5

Conclusions

This study has identified both a desire and a need for interventions for LAYP and has highlighted key theories and constructs that are relevant to our understanding and development of means to help reduce negative behaviours. Gaps in the knowledge and skill of LAYP to practice safer sex were evident, but there are opportunities to better address these deficiencies through workers, carers and school. In addition, a desire for support around a range of health issues accessed within a single service was evident. Building strong relationships between health and social work, and applying health psychology expertise to a challenging public health issue has been fruitful in providing evidence to influence core services and to develop a new service model to meet the needs of these young people.

Funding

This work was supported by NHS Fife and NHS Education for Scotland.

Acknowledgements

The time and honest opinions offered by interview participants is gratefully acknowledged. Thanks to all individuals, teams and organizations who assisted in the recruitment of young people and the provision of suitable interview venues.

References


27 Children (Scotland) Act. 1995


39 Dale H, Watson L. Exploring the barriers and facilitators to health research with children and young people who are looked after. Scottish J Residential Childcare 2010;9, in press.

