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Title	A review of the Teenage Health Initiative (THI) in the former Western Health Board
Author(s)	Canavan, John; Reddy, John; Kearns, Noreen
Publication Date	2008
Publication Information	Noreen Kearns, Reddy, J., & Canavan, J. (2008). A review of the Teenage Health Initiative (THI) in the former Western Health Board. Galway: Child and Family Research Centre, NUI Galway.
Item record	<a href="http://hdl.handle.net/10379/259">http://hdl.handle.net/10379/259</a>

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# FINAL REPORT

## A Review of the Teenage Health Initiative (THI) in the former Western Health Board

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May 2008



National University of Ireland, Galway  
*Ollscoil na hÉireann, Gaillimh*

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## **Chapter 1 - Introduction**

The Child and Family Research Centre, NUI Galway was requested by senior management with responsibility for Children's Health Services in the HSE West to undertake a review the Teenage Health Initiative (THI) in 2007.

The purpose of the THI review by the CFRC is:

to contribute to the knowledge and information base that the relevant decision makers with responsibility for the THI programme in the HSE require in order to plan its future direction.

The objectives of the THI review by the CFRC are:

1. to document the level of service provision and usage of the programmes in each of the three counties;
2. to describe the type of educational and developmental work conducted under the programme;
3. to examine key stakeholders perceptions of the programme, including its purpose, content, outcomes;
4. to examine key stakeholders opinions and experience of the programme in terms of governance, management and administrative issues.

### **1.0 Methodological Approach**

A mixture of qualitative and quantitative methodologies were utilised in the conduct of this review comprising documentary analysis and face-to-face in-depth interviews.

#### ***1.0.1 Secondary data***

For the latter, secondary data obtained from the former Western Health Board's Regional Office for Child and Family Care, in Merlin Park, Galway, and from HSE managers, and Foróige and Youth Work Ireland managers and project workers. This documentation comprised annual reports, service agreements, progress reports, and relevant correspondence such as letters, memoranda, e-mails, and account information. Other sources included relevant publications and websites pertaining to teenage health and youth services. Additionally, evaluation sheets and feedback forms completed by service users were obtained from THI project workers and analysed, in order to assess the opinions and experiences of teenagers who have participated in the programme.

#### ***1.0.2 Primary data***

Regarding the former, a total of 18 key stakeholders were consulted for this Review, comprising THI former and current project workers, service provider managers from Foróige and Youth Work Ireland, and HSE managers. In total, 13 individual interviews and 2 group interviews were carried out with these key informants. Additionally, 8

referrers identified as frequent users of the THI service were contacted, and 4 telephone interviews were conducted. Details of all contacted and interviewed are outlined in Appendix 1.

In terms of analysis of qualitative data, the tape recordings of all the interviews were transcribed. The text was then categorized into themes according to key words in context and word counts (Ryan and Bernard, 2003 in Denzin and Lincoln [eds]). Codes and subsequent themes arose both inductively, from the interview data, and deductively, based on specific issues outlined in the relevant literature and contained within the interview schedule. On the basis of this analytical framework, the Review is reflective of all stakeholders perceptions, experiences and opinions. The specific quotations attributed to interviewees are assigned ID codes for anonymity purposes.

The layout of this Report is as follows. Chapter 2 presents an overview of the relevant literature pertaining to teenage sexual health. Chapter 3 contextualises the THI programme, using core documentation obtained from key informants. Thematic analyses of qualitative data from interviews with THI project workers, service providers, and service managers are presented in Chapters 4 – 7. The views of teenagers who used the service in the past are documented in Chapter 8, based on feedback from evaluation forms used by project workers at the end of programme sessions. In terms of referrals, the services and professionals which referred teenagers to the THI over the past number of years are listed, while accounts of referrers who have used the service in the past are also presented in Chapter 9. Chapter 10 concludes with a matrix of options for the future development of the THI, based on the core feedback from both the quantitative and qualitative data.

## **Chapter 2 - Literature Review of Teenage Sexual Health, Behaviours & Interventions**

### **2.0 Introduction**

Sexual health is understood as encapsulating not only the absence of sexual infections, disease and other infirmities but also a condition general well-being (physical, emotional, mental and social) in the area of sexuality (Layte et al., 2006). In discussing the THI, there is a need to provide a context for the sexual health<sup>1</sup> and relationship intervention programmes for young people at risk. For many welfare states delivering intervention programmes that more effectively address the needs of significant minorities of ‘at risk’ adolescents remains one of their most demanding challenges (Brady et al., 2003). Consequently, Craig and Stanley (2006: 171) note, that “teenage pregnancy has become a major policy issue, for which young people are often held solely responsible”. The term ‘at risk’ is commonly used to identify adolescents in a variety of settings, including young people involved in substance abuse, early school leavers, youth involved in crime and/or anti-social behaviour and those growing up with complex and difficult personal and family circumstances (Brady et al., 2003).

Teenage pregnancy/parenthood, STIs, their consequences and the restricted life chances they bring, affect disproportionately the weakest and most disadvantaged groups and communities in Irish society. The challenge here is to ascertain how best significant minorities of disadvantaged and isolated adolescents can be adequately equipped with the information and skills required to make appropriate and responsible decisions concerning their sexuality and relationships. Service providers must recognise young people as individuals with sexual health needs and uncertainties arising from their particular circumstances and resist the temptation to treat young people as an all encompassing homogenous entity with common problems requiring solutions (Senanayake and Faulkner, 2003: 120).

### **2.1 Changing Culture & Sexual Behaviour**

Social constructs of masculinity and femininity have a profound impact on social meanings young men and women attach to sex and contraception, thereby negatively influencing sexual attitudes and behaviour (Hyde and Howlett 2004: 9, 10). The authors contend that teenage boys most often perceive sexual intercourse as acceptable irrespective of whether they are ‘involved’ with their sexual partner. Whereas teenage girls are perceived to be gatekeepers directly “responsible for maintaining sexual boundaries”. It follows that young females in Ireland continue to be governed by different expectations and codes of behaviour than those expected of males and whose reputation and social standing is likely to be damaged by the stigma accompanying any hint of teenage sexual activity (Inglis, 1998; Craig and Stanley 2006).

Reflecting wider movement towards an increasingly more liberal social climate in recent decades, especially among young people, Irish sexual culture has converged, according to

Layte (2006: 280) with standards familiar in the UK and across continental Europe. Irish studies mirror international research by repeatedly drawing attention to findings which reveal a steady trend over recent decades toward a lower age of sexual initiation between age cohorts (Layte et al., 2006: 281; Hyde and Howlett, 2004: 19). In fact, current research suggest that it's likely that up one third of 16-year-old Irish school-goers are sexually active, with teenage boys more liable to have had sex before their 17<sup>th</sup> birthday than teenage girls (Mayock et al., 2007: 17; Layte et al., 2006: 281). MacHales and Newell's (1997) survey of students attending post-primary schools across Galway City and County conducted during the mid-1990s found that over one fifth (21%) of 15-18-year-olds had engaged in sexual intercourse (cited in Mayock et al. 2007: 16). These trends are expected to be more pronounced among specific groups of teenagers such as early school leavers (ibid). Moreover, whereas teenage pregnancy rates amongst girls aged between 15-19 years have stabilised at around 2-3% over recent decades (between 1972 and 2001) the number of Irish teenagers seeking abortions in British hospitals has risen steadily over this period, 944 recorded in 2001 alone (Hyde and Howlett, 2004: 89, 90).

## **2.2 Common Risk Factors that Influence Sexual Behaviours**

The recent publication of *The Irish Study of Sexual Health and Relationships* (ISSHR hereafter) (Layte et al., 2006) is a reminder of the significance of sexual health of adolescents as a focus for intervention by the Health Service Executive (HSE) and its responsibilities in this area. Extensive research (Fullerton, 2004: 19; Layte et al., 2006; Kirby, 2001) has concluded that place of residence, experience and level of education, ambitions for the future, family structure and peer networks all influence and shape young people's decisions about sex and parenthood. Consistent higher rates of teenage pregnancy/parenthood, non-use of contraception and sexually transmitted infections (STIs) found in areas of social and economic disadvantage across Ireland (Fullerton, 2004; Layte et al., 2006; O'Keeffe et al., 2006) highlight the need for improving sexual health knowledge. Acknowledged widely as a basic human right of young people as they negotiate their development to sexual maturity, sex education allows adolescents to protect themselves from unintended pregnancies, abuse, exploitation, STIs and HIV/AIDS (Mayock et al., 2007: 16).

It is extremely difficult to achieve good contraceptive and safe practices in the population if there is a sub-group of teenagers and young adults without basic sex education (Rundle et al., 2004). The ISSHR survey (Layte et al., 2006: 282) reports substantial information deficits within the Irish adult population surrounding sex and sexuality, particularly among the lower educated and those from lower socio-economic backgrounds. Within these sections of Irish society, the survey found, young people are both more likely to engage in early sexual behaviour and less likely to use contraception, considerably "less likely to have good knowledge of fertility, emergency contraception, STIs and HIV/AIDS" (Layte et al., 2006: 284). In particular, Irish studies highlight significant deficiencies in knowledge concerning contraception and considerable diversity among



young people regarding the value of information sources (family, school, peers, the media) open to them (Sheerin, 1998; Mayock et al. 2007).

Indeed, the UK's Social Exclusion Unit (SEU, 1999) suggested three dominant factors which link early sexual initiation and teenage pregnancy rates to levels of deprivation:

“low expectations amongst certain young people in relation to employment prospects, particularly where they came from a disadvantaged background; ignorance, particularly of contraception and more general positive sexual health measures; and mixed messages about the significance of sexual activity, with confusion resulting from the conflict between the enormous pressure generated by explicitly sexualised media messages on the one hand and the implicitly embarrassing treatment of contraception on the other” (Craig and Stanley, 2006: 172).

Any confusion or misinformation regarding sex exposes young people to risk behaviour. Reflecting this confusion are data which rank Ireland among the top ten highest (Western) countries for births to mothers aged between 15 and 19 (UNICEF, 2001 cited in Fullerton, 2004: 7) and the significant increase in diagnoses of STIs over the past decades – from 2,228 cases in 1989 to 10,695 cases in 2004 (HPSC, 2005). Fullerton's (2004) in-depth study of recent research surrounding adolescent sexual health suggests that reinforcing apparent higher rates of teenage pregnancy and STIs within disadvantaged and isolated communities and groups are a range of individual factors such as unstable family structures, a family history of teenage pregnancy, poor mental health, involvement in crime, alcohol/drug/substance abuse and having experience of physical or sexual abuse. Excluded and marginalised adolescents, frequently living in poverty, with low educational attainment, possibly in care, excluded from formal education or lacking family support, regularly holding no great sense of hope for the future, often have difficulties forming and sustaining relationships (Aggleton and Campbell, 2000: 289). Sex for such individuals, Aggleton and Campbell (2000: 289) assert, is “sometimes seen as a means of instant gratification, without meaning or value, is often opportunistic, with little forward planning, and the use of contraceptives or condoms is less likely in such circumstances”.

### **2.3 Sexual Health Knowledge and Education**

Research within socially and economically disadvantaged communities both in Britain and Ireland has identified high levels of ignorance about contraception and sexual health in general as having a direct impact on pregnancy rates (Acton and Hynes, 1998; Hyde and Howlett, 2004; Craig and Stanley, 2006). High-quality sex education is fundamental in preparing young people to understand and manage their sexual development and to facilitate the acquisition of healthy and responsible decision-making capabilities in this area (Mayock et al., 2007: 16). The failure of the Irish State to provide “systematic” and “consistent” sex education to adolescents until the late 1990s has, according to Layte et al. (2006: 283), significantly decreased the likelihood of generations of Irish citizens of ever receiving the necessary “understanding of the biological, interpersonal and emotional dimensions of sexual relationships” which are a precondition to good sexual

health. Unsurprisingly, both the Hyde and Howlett's (2004) study of post primary pupils' perspectives on sexuality and sex education and the ISSHR (Layte et al., 2006: 284) report little discussion between participants and their parents concerning sex (just 11% of male and 21% of female respondents to the ISSHR survey reported doing so).

Where sex education was reported as an aspect of Irish family life it was overwhelmingly directed towards females and protective in its nature, often reinforcing stereotypical conventions of femininity as reproductive and masculinity perceived as a threat (Hyde and Howlett, 2004: 18). Fullerton (2004) traces lower incidents of sexual health knowledge to differing family structures and, specifically, levels education among parent(s). The study established that children brought up within biological two parent families were consistently found less likely to become teenage parents as opposed to the daughters and younger sisters of teen mothers who were more likely to become teenage parents themselves (Fullerton, 2004: 14). Better-educated parents, especially mothers, research has found (Layte et al., 2006: 284-5; Fullerton, 2004: 14), take significantly greater involvement in the sex education of their children which impacts positively on subsequent behaviour, delaying sexual activity, encouraging contraceptive use and promoting better confidence as they navigate their evolution from childhood to sexually active adulthood. Likewise, any reluctance to talk openly about sex or where sex is regarded as an illicit topic in the home, shape individual values and may inculcate a sense of shame and/or embarrassment and therefore ignorance concerning sex and sexuality among affected teenagers (Layte et al., 2006: 59; Inglis, 1998: 122).

Decisions concerning sexual behaviour depends, Fullerton (2004: 19) concluded, "on a range of individual factors such as knowledge, interpersonal communication and skills and as well as access to contraceptive services and advice" (Fullerton, 2004: 19). Since 2003, Relationships and Sexuality Education (RSE) has been mandatory in Irish schools, which includes information on both the negotiation of sexual partnerships and the use of contraception and protection. However, as the ISSHR notes, this programme has not yet been fully implemented (Layte et al., 2006: 281). Moreover, the emphasis on relationships rather than sexuality education and the ability of individual schools to adapt the RSE to their specific religious and cultural ethos blunted, for many, the programmes' effectiveness in delivering quality sex education (Hyde and Howlett, 2004: 16; Inglis, 1998). Sheerin's (1998) study of sex education in the midlands found considerable variations in the quality and level of service across the region. Often, despite extensive research advocating comprehensive sex education, many important topics such as sexual identity, HIV/AIDS, contraception and abortion are excluded from many school programmes (Kirby, 2002: 28). Within formal school settings, Hyde and Howlett (2004: 14-15) maintain, boys are regularly perceived as "irresponsible" and "less open to discussion" and thereby often marginalised from sex education. Ominously, a study of sexual health promotion carried out in Northern Ireland reveals that while schools were found to be inconsistent in their provision of sexual health information it was in the classroom where parents expected their children to acquire information relevant to promotion of sexual health (McLaughlin et al., 2007: 104).

Postponing sexual initiation is generally perceived internationally as the primary means of preventing teenage pregnancy and the spread of STIs among young people (Acton and Hynes, 1998: 6; Frost and Forrest, 1995). Remaining in education and school is recognised as one of the key resources in the effort to delay the onset of early sexual activity and avoidance of unprotected sex. Research from the United States (Kirby, 2002: 28) identifies “involvement in and attachment to school” as decisive in nurturing the aspirations and future goals which are related to “less sexual risk taking and lower pregnancy rates”. Importantly, Mayock et al. (2007: 21) remind, that while schools do have the obvious advantage of having access to great numbers of young people, they may not reach a considerable number of pupils who miss out on schooling because of truancy/suspension, illness or early school-leaving. In addition, Aggleton and Campbell’s (2000: 290) study of sexual health promotion across England and Scotland highlighted that significant numbers of young people receive their first experience of sex education subsequent to becoming sexually active. What is evident across Ireland following the ISSHR survey is that young people whose education ends prematurely for whatever reason have sex-education needs which are not being met (Layte et al., 2006: 287).

Yet while most young people who have been through the Irish educational system since the late 1990s would have received some sex education significant differences remain in the likelihood of receiving sex education among those with high and those with few educational qualifications (Layte et al., 2006: 77). Layte et al. (2006: 77) point out that for those less than 30 years of age the absence sex education in the home is the main reason for the differences across educational groups and call for “urgent attention” be devoted to helping parents in lower socio-economic groups with the sex education of their children, who are more likely to attain lower levels of educational qualification and more likely to leave the education system earlier. Together, social disadvantage, economic marginalisation, low educational attainment and the often inconsistent, previously non-existent, supply of sexual and relationship information from the education system, provide the context in which poor sexual health flourishes. Understanding the underlying cultural constraints which continue to influence Irish reactions to sex and sexuality, limiting knowledge and allowing misconceptions to develop, is essential if equality on sexual health is to be realised.

## **2.4 Sexual Health Intervention Programmes**

Providing sexual health-promotion programmes for youth is critical for increasing their knowledge about contraception and preventing STI. Mainstream thinking surrounding the promotion of sexual and reproductive health has traditionally been dominated by a “commonsense” belief that by dispensing the facts about sex, sexuality and human production, people become sufficiently equipped with the knowledge required to make appropriate decisions around sex (Aggleton and Campbell, 2000: 288). However, despite exposure to a range of sources of information regarding sexual health and reproduction, significant numbers of Irish young people have misconceptions and/or have limited knowledge about preventing pregnancy and STIs (Fullerton, 2004). Moreover, the ISSHR study recommends that because of the steep rise in the number of STIs and an apparent increase in crisis pregnancies in Ireland over the previous decade (1996-2006) a

“concerted effort” should be undertaken to inform people of the “risks of unprotected sex” in general, and more specifically, that “health promotion should balance its message by emphasising the need for protection against both conception and infection” (Layte et al., 2006: 290). These programmes need to be tailored to the needs of individual communities and/or vulnerable populations within communities.

Sex education programmes should cover a wide range of issues surrounding sexual health, combining information concerning the growth and development of the human body, particularly conception and STIs, with the development of healthy and positive sexual attitudes and values (Frost and Forrest, 1995: 190). Similarly, Fullerton (2004) outlines three broad approaches to promoting positive sexual health and preventing pregnancy and sexually transmitted infections (STIs), namely:

1. The provision of sex education
2. The provision of contraceptive services and counseling
3. Good general education/vocational programmes.

International research has encouraged the development of skills-based sex-education programmes designed to develop competence, self-esteem and confidence, allowing the twin objectives of delaying the age of sexual debut and reducing the level of adverse outcomes to be realised, whatever the age of debut (Layte et al., 2006: 281). By combining messages about sexual health with programmes that help young people to develop skills and confidence, focus on education and training, allowing positive mentoring relationships to be formed with adults, employment prospects to be enhanced, encourages responsible decisions about sex (Kirby, 2001: 13). Dealing with issues of confidence, self-esteem, non-sexual ways of showing affection, along with frank and open discussions concerning the pleasurable, emotional and complex aspects of human sexuality during sexual health programmes is essential, Aggleton and Campbell (2000: 289-290) argue, if the effective preparation of young people for sex and relationships is to be achieved.

Given the strength of evidence about the influence of general education and levels of disadvantage on sexual behaviour (i.e. disadvantaged young people being more likely to attain lower levels of educational qualification and more likely to leave school earlier), youth development programmes provide a necessary space in which sexual health information can reach vulnerable youth. Such programmes are important in reaching adolescents likely to engage in risk taking behaviours, for example, young males who maybe outside the education system yet may be responsible for the majority of the child-baring by teenage girls (Frost and Forrest, 1995: 190). Frost and Forrest (1995) identify the ‘life skills’ component in programmes as central in building youth confidence which may allow negotiation within relationships and help adolescents resist peer pressure to have sex. Likewise, the Acton and Hynes (1998: 9) review of youth health programmes draws attention to role playing and interactive discussion segments of programmes and their benefits in limiting the reach of “adverse peer influences” (not only concerning early sexual activity but also substance abuse, involvement in crime, etc.) which affect many young people with low self esteem or who may be deficient in expressing themselves in group situations and/or whose judgement skills may be lacking.

Additionally, confidence building measures may uncover other health issues such as domestic violence, sexual abuse and eating disorders (Acton and Hynes, 1998: 61).

In essence, fundamental in providing for adolescent sexual health is for service providers to determine the reasons for sexual risk-taking by teenagers and aim to match these issues with an appropriate intervention programmes (Kirby, 2002). Taking a 'life skills' approach to education concerning sex and personal relationships reflects the 'new realities' brought by the age of HIV and AIDS and a recognition that the motivation to act wisely and change unsafe sexual behaviour is largely dependent on changing perceived social norms (Aggleton and Campbell, 2000: 288). Indeed, the US ChildTrends organisation found public service interventions which combine sex education with a focus on youth development – “including mentoring, sports, employment, or performing arts” – to have displayed significant impacts on both the frequency of sex, as well as affecting pregnancies and births to teens (Futurist, 2003).

## **2.5 Community Participation and Sexual Health Rights**

Adolescence is a critical stage of life when lifestyle choices are established, and sexual behaviour at this stage can influence and shape life paths (McLaughlin et al., 2007: 104). By recognising the socio-economic factors which impede disadvantaged young people in acquiring appropriate sexual health information and values, and working with communities to alleviate the conditions that make people vulnerable, can statutory inspired interventions begin to address this problem. What are required are long-term commitments by institutional actors working alongside communities to reduce and eliminate circumstances that expose certain groups and areas. Jacobson (2000: 30) argues that such engagement must also see civil society i.e. voluntary/community organisations commit proactively in this effort with institutions, while maintaining independence and their ability to advocate on behalf of disadvantaged people. Arguably, placing the real needs of children and young people in a central position, challenging top down approaches to policy and programme development for young people, allowing the opportunities for self advocacy and representation for disadvantaged youth as endorsed by the International Convention on the Rights of the Child (UN, 1991 cited in Senanayake and Faulkner, 2003: 120) empowers young people and the communities in which they live. Applying a rights framework to reproductive and sexual health programmes as Jacobson advises (2000: 30) requires paying as much attention to the process and conditions of delivery as to the outcome.

Interventions which include life skills components and involve teenagers in community work can increase self esteem and confidence of socially isolated young people (Aggleton and Campbell, 2000: 291). Sexual health strategies that combine youth participation in community and social contexts within programmes and services as opposed to constricting sexual health promotion exclusively to specialised or targeted initiatives, can provide the social support – that allow young people to develop “the skills and confidence, focus on education, and take advantage of job opportunities and

mentoring relationships with adults” – thereby helping to provide the skills needed to negotiate safer sex and support the promotion of attitudes which make adoption of certain behaviours worthwhile (Kirby, 2001: 13).

## **2.6 Conclusion**

The multi-faceted explanations for the spread of poor sexual health among some of Irish society’s most vulnerable young people underlines the complexity of this issue and the urgent need to develop a national sexual health strategy, as the ISSHR strongly advises (Layte et al., 2006: 289). Arguably, future strategies conceived in the hope of improving the sexual health of young people must, as Senanayake and Faulkner (2003: 128) argue, work to empower young people to “express their sexuality in safe and in healthy ways and to manage their sexual lives”. Fullerton’s (2004: 28) research points out that a study targeting youths in low income homes confirmed that by increasing available opportunities adolescent birth rates decline. Indeed, the problem of unintended teenage pregnancies, Dryfoos (1985:13) maintains, must be acknowledged as a “symptom of the lack of options available” for at risk youth who are disproportionately members of disadvantaged communities and groups. Any desire to improve the sexual health of disadvantaged adolescents must acknowledge and work to address the societal factors that create social inequalities and foster the unequal power relationships that render certain groups in society more prone to early sexual activity and so more vulnerable to teenage pregnancy and STIs (Aggleton and Campbell, 2000: 289).

Finally, the ‘success’ of sexual health strategies, policies and programmes must be broadened to include the process and conditions of delivery, and other ‘non-quantifiable’ aspects such as self esteem and personal development, as well as the more obvious outcomes such as trends regarding the numbers of teen pregnancies, STIs and births averted.

## Chapter 3 - Contextualising the THI - documentary analysis

### 3.0 Introduction

This Chapter presents an overview of the THI in the Irish health services, from its inception as a teenage pregnancy prevention programme in the late 1990s, to its current status in the former Western Health Board region. It is based on secondary data analysis of relevant publications and websites pertaining to teenage health and youth services, programme content information, and correspondence such as letters, memoranda, e-mails, and account information. The purpose, objectives and content of the programme are outlined. The governance arrangements of the THI in the former Western Health Board, comprising the three counties of Galway, Mayo and Roscommon are set out in terms of management, administrative and financial aspects.

### 3.1 Background to the THI

The Teenage Health Initiative (THI) was devised as a personal development and sex education programme aimed at delaying the onset of early sexual activity among teenagers. It originated in the former Eastern Health Board (EHB) during the period 1997-1998 as a primary preventative pilot programme aimed at targeting teenagers at risk of pregnancy (Acton and Hynes, 1998). A review of the pilot THI was conducted by Acton and Hynes in 1998. The authors concluded that the programme resulted in “significant changes in knowledge, attitude, and behaviour for teenagers on sexuality and sexual health”, and recommended that “such programmes should be continued in all organisations dealing with young people”.

The THI was subsequently expanded regionally, with a total of six projects operating nationally in the following locations.<sup>2</sup>

- NYP Co. Monaghan,
- NYP Ballina, Co. Mayo,
- NYP Castlerea, Co. Roscommon,
- The Gaf youth café, Galway city,
- HIP<sup>3</sup>, Ballinasloe, Co. Galway
- Tallaght Youth Service, Dublin 24

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<sup>2</sup> [http://www.Foróige.ie/index.cfm?fuseaction=Teenage\\_Health\\_Initiatives&content\\_id=24](http://www.Foróige.ie/index.cfm?fuseaction=Teenage_Health_Initiatives&content_id=24)

<sup>3</sup> Teenage Health Pregnancy Prevention Initiative Programme

### 3.2 THI Objectives, Purpose & Content

The programme focuses on teenager's knowledge, skills and attitudes with regards to sexuality/sexual activity. Its purpose is to enable them make appropriate decisions and deal with this complex issue through the development of a personal value system<sup>4</sup>. Three core facets of the programme are knowledge, skills and attitudes:

- *Knowledge* regarding such matters as human reproduction, human biology, contraception, STI's, personal hygiene, sexual attraction, male/female differences, sexual orientation, sexual activities, and the consequences of their sexual activities, and so contributing to dispelling myths;
- *Skills*, such as assertiveness, good communication, decision-making, interpersonal and intrapersonal;
- *Attitudes*, for example personal responsibility, self respect, respect for others, personal standards, attitudes towards friendships and relationships, expectations in relationships and sexual orientation.

The THI programme objectives are as follows:<sup>5</sup>

2. To promote and develop self-esteem by participants.
3. To develop and practice effective communication skills, with a particular focus on assertiveness.
4. To increase self-awareness.
5. To allow young people opportunity to explore the influences on their lives.
6. To enable young people to develop healthy relationships with their peers and with their boyfriend/girlfriend.
7. To enable young people to explore and clarify their attitudes and values regarding in particular human relationships and sexuality.
8. To provide accurate and appropriate information regarding sexuality and sexual health.
9. To provide young people with information on health services available to them.

From a targeting perspective, the following adolescents were highlighted as being at risk of teenage pregnancy:

1. Younger adolescents who have not matured enough to think about the future consequences of sexual behaviour
2. Those engaged in sporadic sexual activity
3. Those who do not have a partner supportive of preventing pregnancy
4. Those who are not achievement oriented
5. Those whose mothers, sisters and friends have had an adolescent pregnancy
6. Those whose fathers are absent from home
7. Adolescents who lack emotional support and stability may look to early sex and motherhood to provide emotional closeness.

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<sup>4</sup> ibid

<sup>5</sup> [http://www.Foróige.ie/index.cfm?fuseaction=Teenage\\_Health\\_Initiatives&content\\_id=24](http://www.Foróige.ie/index.cfm?fuseaction=Teenage_Health_Initiatives&content_id=24)



In terms of the programme content, the documentation indicates a broad range of topics including:

- Self awareness
- Self esteem
- Communications and assertiveness
- Decision making
- Values and attitudes
- Friendship
- Relationships
- Peer pressure
- Teenage pregnancy
- Body image
- Feelings
- Media
- Stereotyping
- Drugs and alcohol

### **3.3 Governance, Management & Administration of the THI in the former Western Health Board (WHB)**

The THI has been operating in the three counties of the former WHB, namely Galway, Mayo and Roscommon since 2001. Initially, it was administered and managed from the WHB Regional Office for Child and Family Care, in Merlin Park, Galway. The programme was developed in partnership with two community based organisations working with youth in the voluntary sector, namely Foróige and the former Galway Youth Federation (GYF), now Youth Work Ireland (YWI), in Galway. In terms of service delivery of the THI in the counties of the former Western Health Board (hereafter WHB), Foróige was contracted to implement the THI programme for the Galway city region, Mayo and Roscommon under a partnership agreement with the former WHB. An agreement was reached with Youth Work Ireland in Galway city to deliver the programme in Galway county, where the programme was named the HIP project. A core strength of these two service deliverers is their expertise in community based educational and developmental youth work. The THI is delivered, in the main in an out-of-school setting, and is participatory by nature, with the teenagers themselves involved in the content and modus operandi of the programme.

The THI was initially funded and administered by the Regional Office for Child and Family Care, in the WHB. The service providers, namely Foróige and YWI employed project workers to operate the programme. Four THI staff were employed, three THI Foróige staff covered Galway city, Mayo and Roscommon, and one YWI employee covered east County Galway. A total of £108,000 (€137, 130) was allocated to Foróige to establish the THI in Galway city, Mayo and Roscommon (inclusive of Monksland) (comprising £36,000/€45,710 for each of the three areas), and £36,000 (€45,710) was

allocated to the former GYF to establish the HIP in the East Galway area<sup>6</sup>. A significant weakness of the programme has been funding related. The funding for the programme remained static at €137,000 per annum and was never index-linked, therefore, funding shortfalls have been experienced throughout the lifespan of the programme and bridging by once-off payments has had to be used.

Following the national health reforms initiated in 2003 and the Health Act, 2004 entailing the abolition of the health board/authority structures (DoHC, 2003), administrative responsibility for THI was left in a precarious situation. This is because regional offices no longer operated under the new HSE organisational structure. Hence, after the health reforms, the governance and management of THI which was previously the under the remit of the Regional Office for Child and Family Care was handled differently in the three counties. In Galway and Roscommon the THI operates on a largely independent county basis, managed by the Local Health Offices (LHO) of Galway and Roscommon, while the THI programme was never formally devolved to the Mayo LHO area.

The current status of the THI programme delivery is as follows. In Galway, the THI is run by Foróige and the HIP is run by YWI, with one staff member assigned to each programme. In Roscommon, the THI programme is run by one staff member from Foróige. In Mayo, the THI was run by a Foróige staff member until Summer 2006, after which it ceased and a decision regarding its future status is dependent upon this independent Review of the programme.

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<sup>6</sup> In conjunction with the Ballinasloe Family Support Service

## Chapter 4 - THI Purpose, History & Service Provision - analysis of primary data

### 4.0 Introduction

Chapters 4 – 7 are based on qualitative data obtained from the key stakeholder interviews while the quantitative data was compiled from relevant documentation such as progress reports, service agreements and annual reports. Chapter 4 begins by describing stakeholders perceptions of the purpose of the THI and its history. The service provision in the three counties, including the numbers of participants over the 2001-2007 period, is set out. A profile of the service users is outlined in order to establish the main socio-demographic characteristics of the teenagers using the THI.

### 4.1 Purpose

The purpose of the THI programme was explored with the interviewees. It was explained that the programme was based on a broad view of health, based on personal and social development, rather than a narrower medical model, and focusing specifically, although not exclusively, on sexuality and sexual health. Interviewees described how the education and information role of the THI provides teenagers with the necessary knowledge and decision-making skills to make informed choices regarding their sexual activity.

*“ there are issues here for you in terms of decision making or self-esteem or low confidence and if we can build that up when you’re in a situation where you’re being put under pressure to do something you don’t want to, you’re going to be more confident in terms of saying no”. INTV14*

*“It provides an environment where young people comfortable and safe to be able to explore sexuality and relationships, all of that type of thing”. INTV11*

More broadly the THI focuses on self-development and relationship-building, as the following quotations indicate.

*“The purpose of it for me was to give young people an avenue and a safe space in order to, I suppose, learn in the area of sexual health, but also and very importantly, there was huge focus on relationships, self awareness, self esteem”. INTV7*

*“And as I see it, built more around the development of healthy relationships or positive peer groups and all that kind of stuff as opposed to the quite negative peer pressure that some maybe exposed to, the more vulnerable ones”. INTV1*

*“There is education and life skills around sexual health and practical knowledge and equipping young people with the information and with the skills to be able to make an informed decisions about their own sexual activity.....”. INTV11*

*“I suppose it’s around equipping the young people with the knowledge and the skills, exploring their attitudes around their sexual behaviour to enable them to make choices that are positive for themselves in their life”. INTV2*

*“.....It’s also teenage health, it’s not just around sexual activity, it’s also around the whole area of personal development, self-esteem, all of that area”.INTV5*

A key aspect of the programme was the provision of “accurate, factual, practical” information and dispelling myths, and thereby reducing potentially dangerous/risky sexual behaviour.

*“There are so many myths going around. And you get that particularly because of the nature of adolescence and you know that you’re going to get myths about all these type of things”. INTV11*

*“..... there are a lot of myths out there with that group and we need to look at their peer group”. INTV3*

*“Like I wanted the young people taking part in it to be able to make safe decisions around their health. And I wanted them to go away from this group in the ten weeks feeling more knowledgeable, feeling not afraid to ask questions and definitely better about themselves”. INTV7*

The THI was an important resource for young people with sexual identity issues, with the topic of homosexuality arising in some instances, particularly amongst the boys.

*“There’s obviously a whole issue around homosexuality with young boys..... When I was an NYP worker, one of the key things that kept coming up with young lads was actually about being homosexual ..... those young lads were then moved into the whole area of teenage health initiative programme” INTV5*

*“And also there’s issues in relation to having a service and someone who perhaps could talk to a young person who is gay, you know, doing that sort of work with them to keep them informed ..... Just having a service available, that there’s some young lad who presents and he’s gay, and he needs some advice, you know, to have someone there he can discuss issues with and support him”. INTV13*

In addition to the informational and educational aspects of the programme pertaining to sexual health, its holistic nature and varied service delivery methodology was emphasised by several of the project workers. They noted that the THI has a much broader remit than sexual health *per se*, as outlined by the quotations below:

*“I think the good thing about the THI though is that it just doesn’t focus on information giving, do you know?. It’s not just about right ok, these are the rudiments of whatever, now, make your own choice. It very much looks at*

*sexuality and relationships in a really holistic way, so I think that's what is really good about it as a programme because, you know, the conversations can really focus on what are the child's attitudes to their own sexuality or their fears or their expectations or their ideas. It's not just, right, because it's not just good enough just to equip young people with information and then go off and see you later, do you know that kind of a way? So I suppose that is what I would think is, it has a definite advantage over other programmes in say schools.....?. It looks at your choices, it looks at you the individual, it looks at you within a peer group. I suppose, one of the things, it tries to do everything...." INTV2*

*"It is a holistic approach yeah. And we'd have done beauty, hair, make-up I mean everything, yoga, stress so it was very, I think you need that though if you've a group of young people, you can't just say come on in we're going to do a sexual health programme. If you are saying to young people this is a really good programme for girls and it covers sex but we'll do a bit around you self-care. I mean if you've a young person that doesn't take care and pride in themselves, chances are yeah, they're going to be more promiscuous, definitely. And if you build up that [respect for themselves], yeah, it transfers over to so many other areas in their lives". INTV14*

Moreover, project workers described a broad variety of issues and problems encompassing areas of mental health, alcohol and drug misuse, smoking, eating habits, which were interlinked with decisions concerning sex, and hence highlighted the need for and value of a such an approach:

*"..... depending on what the actual need was but drugs and alcohol would have always come into it. By their [teenagers] own admission that it's always as a consequence of drinking too much and they might make sexual choices that they may regret, you know?" INTV15*

*"So it would be broader than sitting down with individual work, it's a more holistic approach to a young person and their development which I think is crucial. You can give somebody an education, you can say that's all you need to know on sexually transmitted diseases but that's not enough. There are underlying issues there, problems". INTV14*

*"Substance and alcohol abuse was another major factor, very few of them ever had sex sober". INTV2*

## **4.2 THI Background**

The historical background to the THI was explored. Interviewees' knowledge of this varied considerably, based on when they became involved with the project and their respective roles in relation to it. It was explained that the THI was not based on any national model, but came into being as a result of being championed and funding being

sourced through the Regional Office for Child and Family Care in the former WHB. Interviewees explained that the need for the THI service was identified through in the context of working with vulnerable young people in various youth projects over a number of years.

*“But there was a sense from working with neighbourhood youth projects around the three counties that there were kids who were particularly vulnerable and that the Teenage Health Initiative would go some way towards addressing that. And there was a combination of motivators around it I think. There was concern around teenage pregnancy, concerns around sexually transmitted diseases as well as the general stuff, like you know, poor and low self-esteem, poor bonding with the parents, a lot of issues that would have emanated from the youth projects”.*  
INTV1

The situation in each of the three counties varied in terms of service management and provision. Prior to the dissolution of the Health Boards, it was explained that the Regional Office for Child and Family Care in the former WHB played a pivotal role in coordinating and managing the service. However, this situation no longer applied once the HSE was established, and the THI in the three counties now runs on a county-by-county as opposed to a regional basis.

*“It’s a local responsibility now, and we have a local service agreement..... that really happened about the middle of 2005.”* INTV12

While Service Agreements<sup>7</sup> are drawn up between those in the HSE with responsibility for children and Foróige and YWI service provider organisations, an ad hoc situation was found to characterise the THI programme, which has not tended to be governed by such agreements. This circumstance has reinforced the confusion and uncertainty which pervades the management of the programme generally.

#### **4.3 THI Service Provision – Urban Rural Mix & Numbers of Teenage Participants**

The urban/rural mix of THI service provision and service users was discussed with interviewees. In Galway, one project worker is based in Galway city (working from a city centre premises at the Gaf youth café), and one worker is based in Ballinasloe. The THI programme is delivered in a predominantly outreach manner, with some work also conducted in the Tuam area.<sup>8</sup> Both the project work and manager in Galway county commented on a trend of increasing numbers of teenagers participating in the THI that are from rural backgrounds.

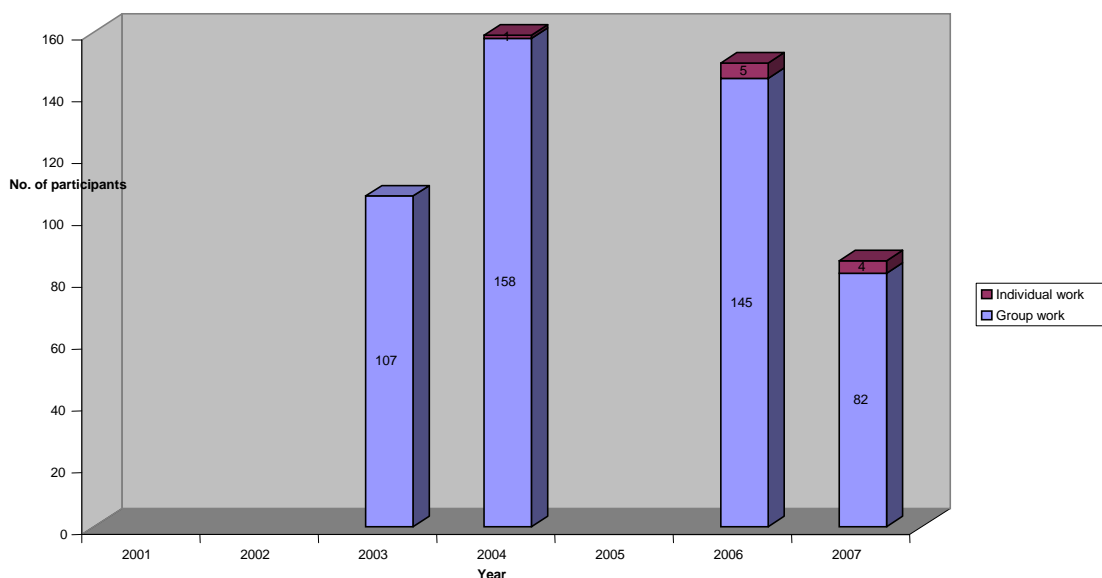
Figures 1 and 2 below outlines the number of teenagers who participated in the THI in Galway city and county over the seven year period.

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<sup>7</sup> These are medium term in nature, usually between 3-5 years in duration (as opposed to Service Plans which are annual documents)

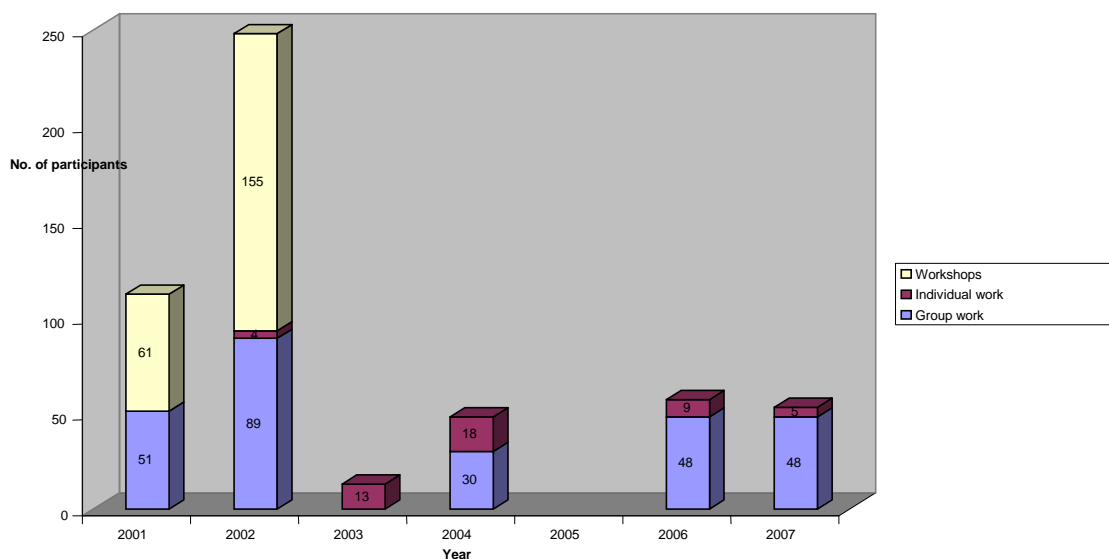
<sup>8</sup> Both Ballinasloe and Tuam are RAPID designated areas in terms of social disadvantage.

FIGURE 1 THI Service Provision in Galway City



Note: No data available for 2001, 2002, 2005

FIGURE 2 THI Service Provision in Galway County

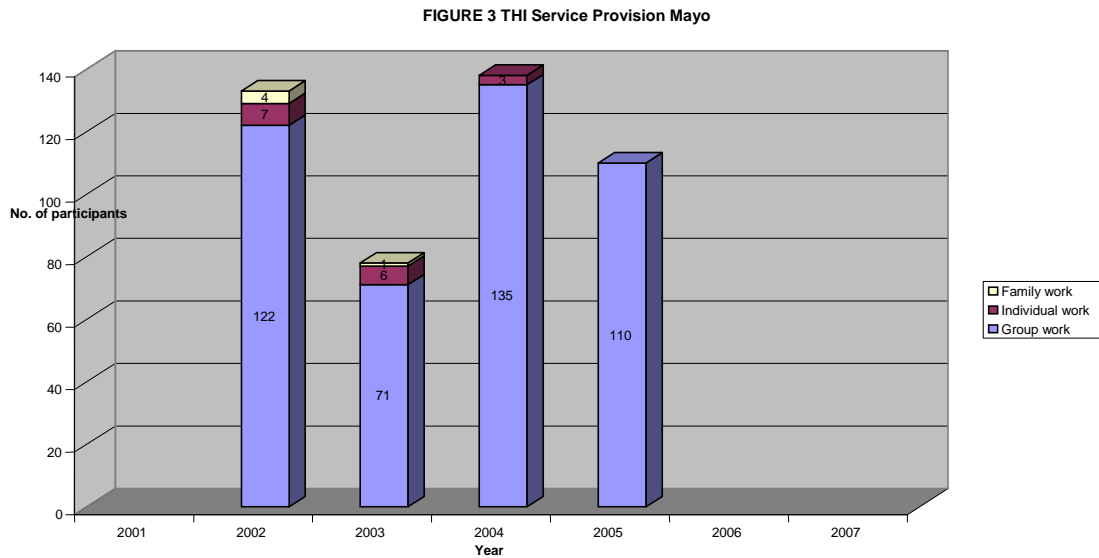


Note: THI project worker on leave in 2005 and from Jan-Aug 2006

In addition to the THI, a week long holistic health Summer Programme in June-July 2004 was planned and implemented by the THI project worker in Galway city, in conjunction with six other Galway youth services. Groups from Ballinfoyle, Westside, Ballybane, Knocknacarra, the Gaf, and Athenry were involved, with a total of 58 participants. Another Summer Programme in 2006 consisted of 57 participants from SPARK, Westside NYP, the Gaf, Knocknacarra 1&2, Ballybane NYP.

In Mayo, the population was described as predominantly rural and isolated. Data for the period 2002 to 2005 is presented in Figure 3. The THI base was located in Ballina. It was explained that for practical purposes the THI service mainly provided services in the urban centres of Ballina, Castlebar and Westport, while work was also carried out in smaller towns of Claremorris, Kiltimagh, and Belmullet, based on specific referrals. One interviewee highlighted the large size of the county as significant challenge to the service.

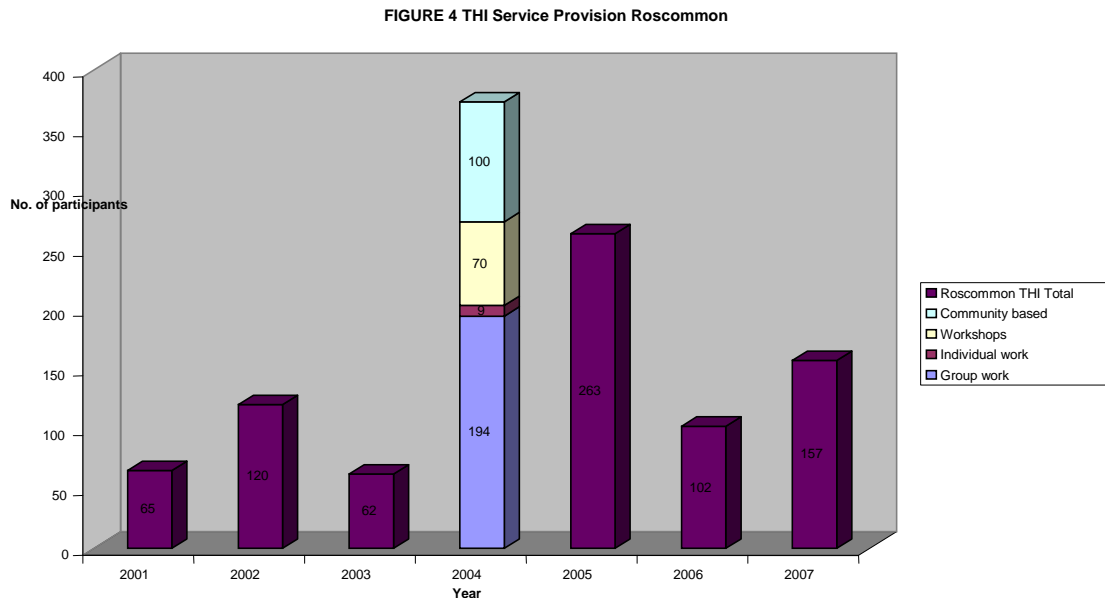
*“Well that was the difficulty with the job, was the enormity of the county”.*  
INTV14



Note: No data available for 2001, 2002, 2006, and 2007



Roscommon county is also made up of a mainly rural population, with Athlone, Monksland and Roscommon named as the main urban areas targeted under the THI initiative. Data for the period 2001-2007 is presented in Figure 4. The THI base is located in Castlerea.



The challenge of dealing with complex problems and the lack of social networks and problem of isolation in Roscommon county was highlighted.

*“You know, you might have a house that’s ten or twenty miles from anywhere else and I don’t know if you know Roscommon, it’s much more isolated”. INTV5*

*“And in a place like Roscommon, it might be only four or five families per parish, or maybe two or three per parish, or town, whereas that wouldn’t be seen as significant in Dublin or Limerick or whatever. Here the intensity of problems is the same it’s just they’re in smaller numbers. But I mean, any of the stuff that we are dealing with at the moment, you know, you’d have the same as inner city Dublin or, you know.....In Dublin they have that community, have the neighbour that will take in the children while, whatever. People all know it’s there and in their own little way are helping. These [rural based] families are out in the middle of nowhere sometimes, isolation is huge, huge”. INTV1*

The issue of rural resettlement over the last five years approximately and the consequential social and family problems associated with such population groupings was also discussed with regards to Roscommon. For instance this issue was pointed out by two managers:

*“Well the whole re-settlement area where you have an awful lot of social issues which are re-housed down into areas of Roscommon..... And families are just there and there’s no real connection with the community, no support in the community. I suppose there are two issues there, one is THI but the other is actually..... getting those families linked into the community”. INTV5*

*“.....given the complexity of the problems that are coming, particularly to places like Monksland now and, well every town in the place, but with so many people coming to live here that have no family supports really”. INTV1*

It was noted that for those living in urban environments – i.e. the city - there was a much greater access to other services and supports in contrast to those living in rural areas, hence making the job for THI workers in Mayo, Roscommon and Galway county particularly difficult.

*“And I think in Mayo particularly we’ve suffered in the rural context in terms of say, yeah the projects are doing so much but the other outlying areas, they have suffered hugely”. INTV14*

*“I would suspect that in the other counties, in Mayo and Roscommon they need THI more than we do [in Galway] because they don’t have Neighbourhood Youth [Projects], or as many of the resources as we have. They wouldn’t have a nurse in the Gaf or stuff like that, you know?” INTV4*

*“ The city is concentrated, much more services out there, I mean they’re different issues really. We’ve [Galway city] Spark, we’ve the Gaf, we’ve the Foróige project, there’s a great network of support and the workers on the ground in Galway really, in my estimation, most of them actually interlink, including HSE, the Gardaí project”. INTV5*

*“It’s much more difficult for the rural based service than the city based to be honest but it’s a pressure that’s not needed when there is enough pressure in working, dealing with the clients as it is in some ways”. INTV8*

#### **4.4 Profile of THI service users**

From a service development point of view the importance of knowing and understanding the core characteristics of service users led to discussion on the profile of teenagers referred to and participating in the THI. An analysis of the data reveals a particular set of common characteristics of those referred to the service as described by several of the interviewees. In particular, those attending THI programme were described as “vulnerable”, “at risk” young people, often coming from what were described as “disadvantaged” “marginalized” backgrounds. Early school leavers, those with school attendance problems, young people in care, in the child protection system, and siblings of young mothers were specifically referred to as actual or potential service users by

interviewees. Moreover, it was explained that teenagers involved in the THI tended to come from lower socio-economic backgrounds, with unemployment and poverty in the family a possible issue.

For many teenagers involved in the THI, relationships with both family and peers were described as problematic by several interviewees. Regarding the former, “*dysfunctional*” family situations involving multiple problems such as family breakdown, complex histories, and poor parenting were described as “*a common thread*”.

*“They [the teenagers] don’t have anyone to listen to or talk to at home, those kinds of things that are important.....A lot of those [young people] maybe coming from families where there is no father, or where the relationship with the father is very poor so that the need for a positive relationship there would be really important”. INTV11*

*“.....I’m just thinking parents with mental health issues, domestic violence..... Very little, very little parental supervision with any of the kids that you were working intensively with. There were no boundaries from home”. INTV2*

An interesting point was made by one of the project workers who referred to the issue of trauma in the young person’s life as a “*trigger*” for inappropriate sexual behaviour.

*“Often there is a trauma in their life though, whether it be separation, parental loss, death of a parent being a huge one, or alcohol abuse or not knowing a parent, maybe a single parent. There’s often a trauma, in fact I’d say in a hundred per cent of cases”. INTV9*

Rape within a family was mentioned by one interviewee (Intv5).

A number of inter-connected issues arose from discussion with the interviewees with regards to commonalities of young people using the service, comprising family/parental problems, poor self-image, peer pressure and the lack of knowledge of sexual matters. The lack of “*self-esteem*” and “*confidence*”, and “*poor self-image*” amongst young people involved in the THI was frequently mentioned. Another key factor highlighted was “*peer pressure*” to engage in sexual activity. One HSE manager aptly explained the situation:

*“There is a huge expectation of young people to be sexually active at an earlier stage, out of a relationship. In some of the disadvantaged areas both in the city and in the county there is quite an amount of, I suppose, sexual activity and in some way abuse within adolescents themselves, do you know what I mean? [i.e. under-age sexual activity]. It’s quite a difficult situation and it’s, there is intimidation and bullying.....They are still teenagers and they are still minors and they are still underage but there is that pressure on both males and females in relation to sexual activity that’s quite concerning in some ways”. INTV8*

A link between family relationship problems and poor peer influences was referred to as another common factor amongst the teenagers using the THI:

*“There’s usually a breakdown in communication with their parents or parent or guardians, and that they are relying a lot more on a peer group to support them. And that peer group tends to have a negative impact on their decision making and choices and them taking responsibility for their actions”. INTV1*

Closely interlinked with poor self-esteem and peer pressure is the lack of knowledge amongst young people regarding sexual matters. One THI project worker described the situation as follows:

*“I would say a typical young person that would use the THI would not have an awful lot of knowledge around sexual health, would be one of the main things and that maybe lacking in confidence which is something that you’d have to look at, or peer pressure..... But to be referred into the THI it would be around lack of sexual boundaries, lack of sexual knowledge, between boys and girls and maybe lack of awareness around sexual health and the pitfalls, the damage it can do if they don’t understand what they are getting themselves into, they can’t understand the consequences afterwards. It’s too late or you’re already in a situation where you can’t help”. INTV6*

Similarly, a HSE manager stressed the serious consequences of young people engaging in sexual behaviour without having the required understanding and knowledge of their actions:

*“Because I think, there is a very poor understanding, or lack of understanding, of the severity of a lot of the actions and there is very little consequence in relation to it as well, you know? I think that leads to early sexual behaviour without that understanding or comprehension or consequence in some ways. Again, I suppose there is poor knowledge as well, young people with very little knowledge of what sexual behaviour entails..... Even though young people portray themselves as being quite knowledgeable and articulate and they know what they’re talking about and they have all this language that sounds great, but half the time they haven’t a clue”. INTV8*

Another characteristic of some teenagers involved in THI was their lack of engagement in sports and social activities in their communities.

*“Very disengaged. They didn’t tend, they weren’t in the soccer clubs, my groups anyway, they weren’t in the football clubs, they weren’t in the, do you know? ..... No, clubs, they wouldn’t be pro-active about their leisure time, they would be hanging around and that kind of thing like”. INTV2*

Despite these characteristics which many of the teenagers involved in the THI were described as portraying, nonetheless, it was simultaneously pointed out that the profile of THI service users is not homogeneous.

*“[It] just totally varies. That was one of the things that surprised me....”INTV9*

*“See, to my memory, there wasn’t necessarily a typical, because you had everything from, you know, a young person who wouldn’t have good social skills and low self-esteem, then you had the complete opposite, a child who was very out-going. So there wasn’t necessarily, and it all depended too on the referring agency and their interpretation of the programme. Because it was a programme that fitted everything, it ticks a lot of boxes for services”. INTV15*

Some workers described working with teenage groups from local authority estates while others worked with:

*“kids who were coming from lovely houses in the countryside..... from single parent houses to fairly well off families”. INTV2*

*“.....but then I’ve also got the other end of the spectrum which would be maybe very much professionals, you know”. INTV9*

In terms of gender, a predominance of females both participating in the THI service and providing the service was found. Regarding the former, there was unanimous agreement that females made up the vast majority of both referrals and participants on the THI in all three counties. Figures 5 and 6 for both Mayo and Roscommon below clearly indicate this trend (NOTE: do not have data for Galway to conduct a similar gender analysis).

FIGURE 5 Gender THI Mayo

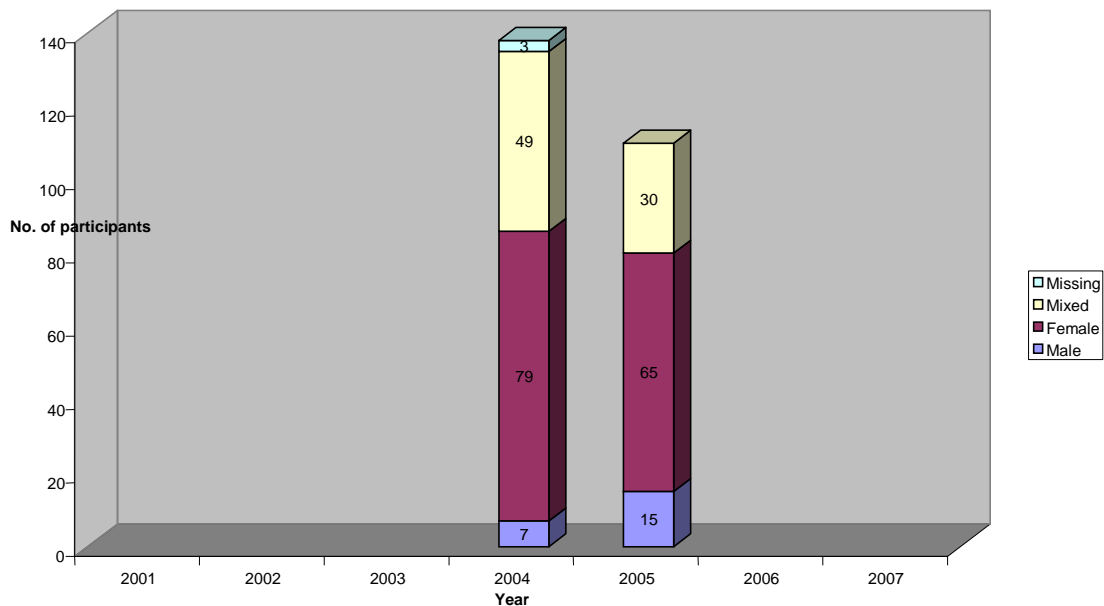
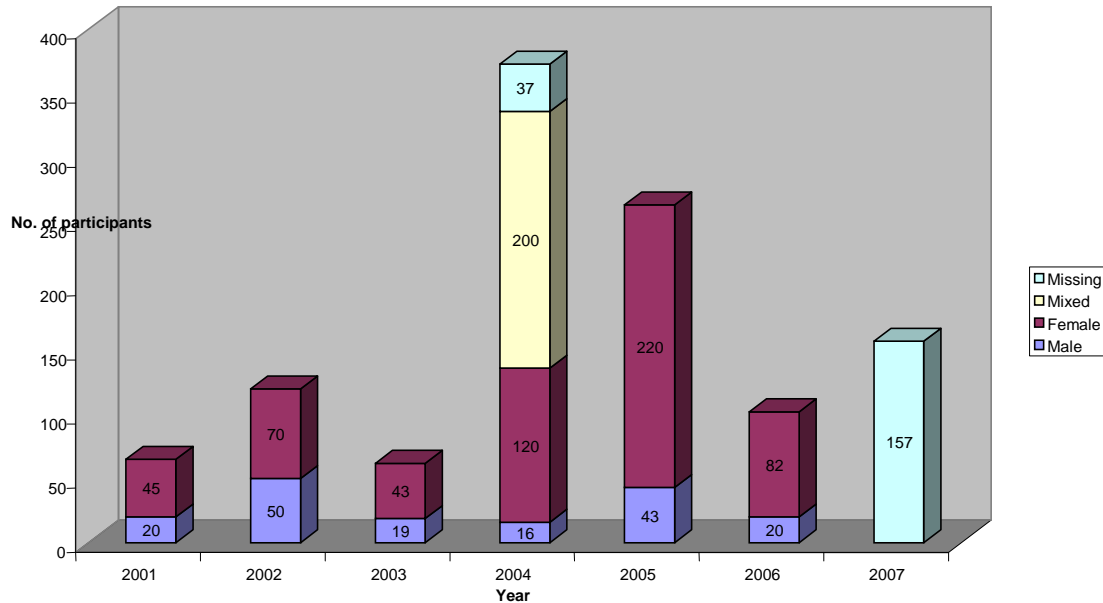


FIGURE 6 Gender THI Roscommon



It was explained that because female sexual behaviour is associated with the risk of pregnancy, females are targeted, referred and come to the attention of the service much more often than males. Some noted that more girls tend to access the Neighbourhood Youth Projects (NYPs) and other community projects, and are therefore more readily identifiable if in need or at risk. Hence, a very evident gap in the service has been the lack of males receiving the THI programme. Some of the THI staff explained ways in which they tried to address this issue.

*“The only reason I had males was because, say [I] actively targeted males myself with two agencies that I knew dealt with males”. INTV15*

*“..... I would have done, I provided this drop-in facility. I would have put up posters all around the different projects again in the community for a drop-in facility for boys or girls if they had any questions in relation to sexual health. I used to work in the Gaf ..... I was nearly always there on a Friday between two and four or something, or after school time. So I was there for young people, so posters were put up in schools out in the various projects”. INTV7*

*“What way you overcome it? I think lads will benefit more from one to one.....The group work isn’t working for males, its not” INTV11*

*“Yeah, I mean it’s a difficult subject as it is and I think the group work aspect of it, I think, adolescent boys can cope with that because it’s a group and because it’s more kind of the information sharing, people’s stereotypes and no one individual...” INTV8*

It was pointed out that the Irish culture in comparison to other European cultures, is not conducive to young males talking about issues such as sexuality and mental health. As one manager put it:

*“.....I think in primary schools in other countries they deal with it much earlier. They develop a language, an emotional language whereby people can talk to each other and it’s ok to talk. You see it even in the Italians or any of that, Spanish, they’re much more comfortable with each other, and certainly males with each other than we are over here.....That it’s not part of the male psyche to be able to say you’re pissed off and this is why you are pissed off. It’s just not done.....It’s a macho thing”. INTV11*

Additionally, all the THI project workers interviewed for this Review, with the exception of one (now a manager) were female. The need for more males to provide such as service is clearly evident, especially given the very sensitive and intimate nature of the topics being discussed, and the perceived difficulty for young men to address these with female staff. As some interviewees reflected:

*“There has been some work with young males, I think you definitely need a male facilitator within that, you need to have..... I think it’s a difficulty the lack of males within the services and the need for a male role model for young males”. INTV11*

*“Well even for a young boy to talk to an adult, to turn around to a woman and say, look I have feelings towards boys, you know.....and if you asked any boy, I think he’d find it easier to say I’d find that easier to say to a man because he’d say, Jesus, I used to feel like that. You [females] can’t relate”. INTV14*

*“Yeah and sexuality for boys is such a big thing. Having a woman telling you, they have no interest in this ..... I suppose it would just ring alarm bells in your head - their behaviour, seven, eight, nine year olds displaying quite worrying behaviour publicly to adults and you try and address that and they have no interest in hearing it from a woman”. INTV8*

It was pointed out by some managers that this situation regarding the lack of males is not unique however to THI, rather in any type of youth work and social care work, the lack of males is a problem. The interviewees stated that men don’t tend to apply for such jobs.

*“I suppose I’ve worked in family support for years and getting men involved in it is hard work. You give up eventually”. INTV8*

Regarding the age-group of THI participants, the interviewees explained that the programme was for the 13 to 18 year old age group, however, the most common age bracket of teenagers using the service was stated to be between 14 to 16 years.

## 4.5 Summary

The purpose of the programme was understood and described in a lot of depth. It is evident from this research that the breadth of issues potentially arising in such a programme is significant. In other words, notwithstanding the need for a specialised programme covering sexual health, the issue cannot be boxed or treated in a silo manner. This is because many of the factors associated with poor sexual knowledge and risky sexual behaviour are interlinked with other inappropriate attitudes, behaviours and problems associated with self-esteem, substance misuse, parental/family environment, school drop-out and so on. The recognition and ability of the THI project workers to deal with this is evidence of a holistic approach to teenage health. Furthermore, while a core aspect of THI is the provision of information and knowledge, it is delivered in a two-way manner, with a lot of participation on the part of teenagers using the service.

The rather complex historical background of the THI, comprising a regionally managed and funded service which was subsequently governed on a county-by-county basis has resulted in confusion. Basically, the THI programme got lost in the health reform process, and the original intention to evaluate it sooner and possibly mainstream it did not occur as a result. A level of uncertainty regarding service agreements between the funders i.e. the HSE and service providers i.e. Foróige and Youth Work Ireland (Galway) with regards to the THI was found.

In terms of spatial distribution of service provision issues which arose were

- (a) the sparse, rural nature of the populations in both Mayo and Roscommon counties
- (b) the discrepancy between service availability in city versus the county locations
- (c) pressures on the service resulting from rural resettlement in county Roscommon

The service user profile is highly complex, characterised by a disparate range of personal, family, social problems encountered by many of the teenagers involved in the THI. It reinforces the importance of providing a needs-led, holistic service.

There is a notable gender discrepancy in terms of service provision, with females comprising the vast majority of participants. The narrow, original basis for the programme in terms of pregnancy prevention is a possible reason for this. Nonetheless, a clear service gap exists with regards to males, who equally require a teenage health service. Management and staff need to urgently address the challenge of how to bring this service to teenage boys. An element of creativity and innovation is required in order to increase the level of both referrals and participation of boys in the programme.

The lack of males delivering the programme is also problematic, and should be highlighted as a future recruitment consideration.

Finally, most of those using the service were in their mid-teens.



## Chapter 5 - THI Educational and Developmental Content & Service Delivery Approach - analysis of primary data

In this Chapter a description of the programme content and approach includes the types of issues covered, how the programme is delivered. The types of prevention targeted by the THI are discussed. The importance of the family context is explored in terms of parental involvement. The educational context is also examined, in terms of the role of schools and teachers in covering the issue of teenage sexual health.

### 5.0 Programme Content & Approach

A particularly noteworthy aspect of the THI programme content and approach was its description as flexible, needs-led, and participatory. It was explained that a broad template, based on a similar programme in the former EHB, in the form of a THI programme manual exists covering a range of core issues. However, in practice, interviewees pointed out that the content and methods of delivery were adapted and built on by individual project workers as they deemed appropriate, depending largely on the group and/or individual circumstances and needs.

*“[The programme is] totally dependent on where they’re [teenagers] at....”*  
INTV9

*“I would have been very much more focused on the needs of the group and if we needed to spend more time looking at self awareness I did so if there was a need. So very needs led. From time to time then I added to the programme where I saw a need or adapted it, or if I saw stuff that I thought was relevant I would have included it in it. .What I had was a makeshift folder..... Whenever we saw something on self-esteem we’d look it up, oh, we might include that. We saw it on decision-making from another programme we grabbed it from there and put it in the folder. That’s the way it worked”. INTV7*

*“You have your topics and you look at your group and you see what do they need.....I suppose that’s what is good about it though, that its not a curriculum. And sometimes your approach, I remember doing it with a group of girls in Carrick on Shannon, they weren’t into the kind of activity based, they wanted just to talk”. INTV2*

*“They [the project workers] really have a programme and they’re going to go through [it], but they let the young people kind of dictate what and when.....you can only work at their [young people’s] pace.....I think the partnership is good”*  
INTV8

Some project workers explained how the adaptation of the programme content was based on other useful programme content from projects such as:

- ‘Boys Don’t Cry’,

- ‘Too Hot to Handle’,
- ‘Sense and Sexuality’
- ‘Nuts’,
- ‘Copping On’
- ‘Crimewatch awareness’

and materials from the Crisis Pregnancy Agency and Aids West.

It was pointed out that this rather loose nature of the programme required an element of innovation on the part of projects workers. As one group of project workers explained:

*“You are thinking about an activity group or soccer group or anger management programme or self-esteem. You’re thinking about lots of different things. In doing the THI so many different things come up.....You have to be constantly creative. It’s a more mentally demanding position...in comparison to the NYP worker”* INTV2

## 5.1 Medical Aspect of the Programme

Some discussion arose during the interviews in terms of the medical aspect of the programme and the provision of such information by clinical staff such as nurses or doctors. This research found that over the course of the programme, the position of one of the service providers, namely Foróige, has shifted on this issue. Initially, a situation was described whereby THI project workers were required to have a medical person with them for certain specific sexual aspects of the programme, in order to answer the technical and clinical type of questions. Some were critical of this approach.

*“I felt that by having just the THI worker doing the personal development side and then bringing in an outside specialist just to do the sexual health side of it, in other words that the THI worker couldn’t talk about sex or anything to do with sex, that it was undermining the worker. And I felt that it was undermining the project and undermining the programme, and also it was undermining the worker in relation to if a young person comes to them with an issue that they want to talk about, they want an answer there and then, do you know, we cant wait until next week”. INTV11*

Additionally, a practical difficulty arose as a result, with project workers in some locations (especially rural) finding it very difficult to coordinate the programme based on the availability of medical personnel. One project worker discussed the potential availability and suitability of health professional in the following terms:

*“In an ideal world, it should be somebody contracted or they should be somebody for the county that you knew had a good relationship and understood and wouldn’t take offence to some of the language that the teenagers might use”. INTV15*

More recently, the situation regarding health professionals involvement in the programme has changed and become much more flexible, and is more context specific. For instance, the THI programme which is run in Galway city has its base in a youth café (the Gaf). Because of this, the THI project workers in the city had access to and worked closely with a nurse who was based in the café, and employed by the Galway Youth Federation.<sup>9</sup> In other locations, projects workers were afforded more scope to:

*“.....discuss whatever they want as long as they feel confident and they’re not giving out misinformation...” INTV5*

*“But if there was something that came up that required more expert advice then the THI worker was free to go and avail of that or get it wherever she felt she needed to get it from. Whether or not there was a structure or an identified nurse, I’m not sure about that”. INTV13*

*“..... oh we wouldn’t leave a child there not answering them. You’d say I’ll remember that question and we’ll come back to you. Often the group could start talking one day and they’d start going into more of the stuff around sexual health when the nurse is not there, you don’t leave them hanging dry, you talk to them about it, you know what I mean like”. INTV7*

In other words, THI staff answered all questions which the teenage participants asked where possible, and in cases where they did not know the precise answer, they would either arrange to bring in someone with a clinical background to a group session, or source the answer from them, and bring it back to the group or individual at the next session. In terms of boundaries, it was explained that THI workers do not provide specific medical and/or clinical advice, that is the role of the nurse or doctor.

The synergy of using both sets of skills of project workers and clinical staff was recognised by one manager who commented:

*“We [project workers] can do certain aspects of it, but if you want a better, more rounded programme, I would feel you bring in the nurse. By the same token, if you want a programme around personal development, self-esteem, decision making, don’t just bring in a doctor or a nurse. That’s not your skill base”. INTV5*

It was also pointed out by some project workers that another advantage of having a nurse or doctor involved in the programme was knowing there is someone else in the community they could go to if the need arose.

*“Now if there was medical stuff that they needed answered then I guess I would ask the local nurse but it would be more so that the young people would have a link in the community if I happened not to be around that they’d know this nurse and they’d know I can trust her if I need to go and get the morning after*

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<sup>9</sup> As a result of recent HSE cut-backs, a nurse is no longer currently employed in the Gaf.

*pill.....[it] was more about having as you said a link into the community”*  
INTV2

*“And in fact we would try and create links with the service [THI] and the GP for when, just say, our intervention is finished, so there is something left there for people. Or there is a familiar face basically that they can go to”. INTV3*

## **5.2 Primary, Secondary and Tertiary Prevention**

The evolution of the THI programme over the past seven or so years is evident in terms of its approach to prevention. Initially, the THI was designed to be a primary prevention programme, aimed at delaying the onset of sexual activity amongst teenagers. This work is done through personal development, and in addition to sexual health, it also deals with broader aspects of teenage health. To quote THI project workers:

*“First of all, it’s a prevention programme. So it’s targeting the, you know, the prevention of the onset of too early sexual activity, inappropriate [behaviour] I suppose, in terms of age and maturity and development, that’s the first element of it”.INTV5*

*“It implements programmes with young people around primary prevention, that’s delaying the onset of sexual activity amongst young people, it’s mainly personal development with a focus on sexual health .....” INTV9*

*“Certainly parts of our work would still involve primary prevention work and the THI staff would go into NYP’s and run programmes with young people who were just maybe thirteen, fourteen, at that age where they just might be, kind of, at that, ‘will we, won’t we?’ kind of decision making thing and give them the information and maybe build their self-esteem so that if they do make the decision to go ahead, they’re going to make it based on the right reason, do you know what I mean? Rather than being pushed into it or whatever”. INTV3*

A HSE manager commented:

*“It [the THI] has a focus on prevention in terms of teenage pregnancies, STI’s. Just I suppose keep them [teenagers] safe, safe behaviour, safe relationships.”*  
INTV4

One project worker (Intv15) pointed out that when she first started working on the programme it was called “*Pregnancy Prevention*”.

It was noted that this preventative-type work is particularly suited to group work (see discussion later individual versus group-work).

It was explained that over the years, it became increasingly obvious that the programme had to become involved in secondary prevention measures, since some of the teenagers

being referred to the THI programme were already sexually active. Hence, the THI adapted to meet the needs of such teenagers, as the following interviewees explained.

*“The most part, it was meant to be primary. Now it’s evolved that it’s nearly all, it’s secondary because that’s where the demand has been coming in because there are so many referrals coming in now for young people who are sexually active and making bad decisions or young people who are confused about their sexuality. I mean that would be a huge part of it now”* INTV3

*“..... secondary prevention which is giving young people who are already sexually active the information they need to keep themselves healthy”. INTV9*

*“I’d say the majority of young people that take part in the programme aren’t necessarily sexually active but there is certainly a good percentage that are, I’ve no doubt about that. Or if not at the moment will be in the near future”. INTV11*

*“In terms of the content there, how it has evolved, I think what’s happened is originally the THI was set out as preventing the onset of various sexual activity, that was the aims and the objectives and that was around which the original programmes were targeted. I think in the process all of these other issues emerged of young people were sexually active and then the content obviously moved on and evolved from there”. INTV5*

Hence, the variety of possible work which THI project workers are involved in at any one time can vary significantly, depending on where particular groups or individuals are with regards to sexuality issues. Flexibility is crucial in this regard, with THI staff describing how they need to tailor their programmes to meet such diversity.

*“It’s not a definite programme so you can be working with, you could be doing very much prevention work with a group who are beginning to address their own kind of puberty issues and then you could be doing the same programme but completely different with a group who are engaged in risky behaviour. So the programme can transfer to meet the different needs. And I suppose that’s part of a being a facilitator.....”* INTV2

### **5.3 Service Delivery - Group Work & Individual Work**

A lot of discussion took place with regards to ways in which the THI was delivered. Basically, two principal approaches were discussed, group work and individual work. The tabular data presented in Chapter 4 show the divergence of approaches used in the three counties over the years, with the vast majority of teenagers participating in the THI via a group format as opposed to a one-to-one basis. The advantages of both approaches were outlined, and it was generally agreed that ideally the THI should be engaged in a mixture of both group and individual work, as opposed to one or the other.

The interviewees described how initially the THI project workers were predominantly involved in “*broad based*” group work with teenagers, and individual work was not generally promoted. The main reason for this is because as referred to earlier, THI was viewed as a preventative programme, and both the funders i.e. the HSE and service providers i.e. Foróige and GYF would have endorsed this.

*“Yeah, like again, we would have been very much coming from the preventative side of things, you know what I mean. Like I wanted the young people taking part in it to be able to make safe decisions around their health. And I wanted them to go away from this group in the ten weeks feeling more knowledgeable, feeling not afraid to ask questions and definitely better about themselves”. INTV7*

A broad range of advantages of the group approach were specified.

*“The argument that group work is also very effective in terms of picking up social networks, in terms of picking up support structures, even self-esteem with young people” INTV5*

*“Group work is good, because it’s economic, because there’s safety in numbers, for all good reasons, obvious reasons”. INTV9*

One interviewee felt that group work was particularly suitable for younger teenage boys:

*“I think, adolescent boys can cope with that because it’s a group and because it’s more kind of the information sharing, people’s stereotypes and no one individual, I suppose, your own opinion isn’t exactly, you’re not going, that’s wrong, that’s ridiculous”. INTV8*

The nature of individual based work, on the other hand, is very different to group work and depending on their skills and experience, some projects workers feel more comfortable with the latter.

*“The issues that come up in individual, it’s very different to group work. Group work is very much like, you go in, you implement the programme, issues can come up but they’re usually not very personal. They’re very general questions, the difference between a question you’re asked when you’re in doing individual work and questions you’re asked in group work, they’re miles apart.....[regarding individual work] it’s adolescent support, often around sexual health relationships but often, sometimes around other issues like anything really you know that’s bothering them”. INTV9*

Some explained that where individual work did occur as part of the THI, it was generally conducted with a view to preparing individuals for entering a group work setting.

*“Yeah, I think, for me to primarily, the primary focus is to prepare the young people, to get them to a level that they can participate in the group activity”.*  
INTV15

*“I think individual work has a role to play but a lot of people would argue that the individual work’s role is more around preparing the young person to enter the programme. In other words that the THI work generally speaking would be done in a group. The individual work would be preparing these young people for the group”.* INTV5

*“And a lot of them will say no, I’m not ready for a group. So a lot of the time when they’re in the group they’re much better at expressing themselves; they’re happier within a group whereas when you meet an individual first and they’re not able for a group at all so you have to spend time with them getting them ready for a group”.* INTV6

As the THI developed over the years and the learning around the service needs expanded, interviewees described a recent shift in emphasis towards more “*targeted*” individual based work. The main routes by which teenagers were engaged in individual work were described, comprising referrals from other youth projects, social workers and so on, as well as a smaller number of self-referrals. It was noted that this change involving individual work has been “*needs led*” in the sense that the particular needs, concerns and choice of the adolescent determines their participation in the THI on a one-to-one basis. It was noted that often, individuals who are referred individually to the THI are engaged in high risk behaviour.

*“And it was very much needs led and then the longer the project was in place, the more referrals for intensive individual work came in and because these were particularly at risk, or they were higher risk than the groups ..... And then it was acknowledged at agency level that the individual work was very valuable”*  
INTV9

*“.....usually when they come individually, its kind of a crisis issue”* INTV14

*“Once they come to me they’re at the top of the risk ladder you know, so prevention definitely”* INTV9.

It was pointed out that in some instances, teenagers would have originally been part of a THI group and taken out of the group for various reasons including not being prepared to work in a group setting, or needing one-to-one intensive support because of specific sexual health concerns.

This shift within the THI to incorporate more individual based work was viewed positively by interviewees and it was felt that the more specific targeting of the programme to high-risk teenagers was beneficial.

*“I think it [the THI] may be should be targeted at the higher end of the spectrum in some ways. I think individual work would probably be more valuable”. INTV8*

*“I think it was far too restrictive from the beginning. Now we are doing one- to-one work which is important because the nature of a drop in service..... Group work is fantastic and if it works it is really, really good and it is really empowering, but its not for everybody..... There has always been this debate around group work or individual work. If you even look at that and say, ok, we’ve said it there, the group work isn’t working for males, it’s not. How are we going to engage with young males? The individual work, yes, it works well” INTV11*

*“The boys are engaging a little bit better individually .....” INTV3*

*“Well I prefer more targeted work so, more individual work. I think that group work is alright to a point, if you’re trying to bring somebody into a group and sort of engineer a situation where you’re covering a certain, or you know that a certain group are, one or two are active and you put them in a group so they’re not sort of stigmatised or standing out, that’s fine. But I would be more in favour of the targeted stuff, the individual stuff. That would be my view”. INTV13*

In sum, it seems that both group work and individual work have evident advantages, and the THI can benefit from both types of work. Furthermore, it was noted by one manager that the THI should not just be about individual work and group work, rather a more innovative approach, involving thinking outside the box is required.

*“It should be looking at the whole information provision that we’re giving to young people. It should be nearly like co-ordinating the information that we give to young people, either through leaflets, but it should also be looking at things like the drama for example. Things like building in a capacity to be able to work in schools where there has been a real need identified within the school.....I think there are ways we could learn from the likes of the project in Waterford. There could be an emphasis on peer education.....Access to information via the Internet, there is potential there to do things”. INTV11*

## **5.4 Parental Involvement**

The issue of parent involvement in the THI was explored with interviewees. The importance of engagement with parents in terms of supporting them on how to discuss sex with their teenagers and how to listen was reiterated by a number of interviewees. The need to develop and provide more parenting programmes arose as an aspiration of some interviewees.

*“I mean if I was to do it again I think my concern was that you’re equipping teenagers with knowledge but which the parents might not necessarily have so*



*you're assuming that the parents know all about sexual health and you're assuming that they know all about STI's and all about types of contraceptives and you're telling all the teenagers this and who is telling the parents?. .....You need parents to re-enforce the message" INTV15*

*"With time I definitely would have been doing more work with parents again because there is such a need for that and like if at all possible like the young person would get the proper healthy message at home, that is the ideal situation, but it's not happening in a lot of cases". INTV7*

It was explained that as part of the THI, visits are made by the project workers to the parents of the teenager prior to their participation on the programme. During such visits the nature, purpose and content of the programme is discussed and consent is obtained for participation of their child. It was noted that parents are generally very pleased to receive this support:

*"All parents as you can imagine were absolutely delighted that someone was going to be doing this [the THI] with them [their teenager son or daughter]" INTV7*

*"I think that parents are generally delighted that something like this is happening" INTV11*

It was pointed out earlier, that in many cases, teenagers involved in the THI may be coming from families where there are parenting problems. The research therefore, sought to find out whether parents were also supported if necessary under the THI, for instance through some sort of parenting programme. Roscommon was the only county which has established a specific programme for parents, with a manual for parents recently developed by the current project worker, in conjunction with Youthreach.

*"Well we do parenting work at the moment but like, a structured manual, a paper manual so that we'll have a written programme for empowering basically parents so that they can do this work themselves, a lot of this work themselves so that, because really they're the ones who should be doing it". INTV3*

Some interviewees working in Roscommon explained that the local NYPs do a lot of work with parents, and also run parenting programmes, covering various topics, with approximately 3 to 4 weeks given to each topic area. They explained that the THI in conjunction with the NYPs intend to invite parents to attend a parenting programme in the area of sexual health.

More ad hoc group sessions, workshops and once-off talks have been given to parents by some of the project workers in both Galway and Mayo.

At the more informal level, the research found that the THI staff engage with parents, particularly when the latter initiate it. Such engagement with parents was mainly in terms of support and information sharing.

*“.....just I suppose as a listening ear, to try and support them in their parenting role.....” INTV7*

*“I would leave the door open to parents to contact me at any time.....I have loads of information that I can give. [The] crisis pregnancy DVD, I send them out to parents all the time for any, if I get any enquiries.....and little animated comic books” INTV9*

*“But we’ve had a lot parents speak to [project workers] about their own difficulties in terms of addressing the whole area with their sons and daughters”. INTV14*

Project workers also highlighted the problem of not having the time in work schedule to engage with parents to any large extent.

*“So if I was to do it again I would be pushing more to do a parenting programme. It doesn’t have to be an eight, ten week parenting programme but at least three sessions where you cover the usual listening skills and then go to the sexual health and then the mental health, you know what I mean?. And you give them that information as well because otherwise it’s not a very balanced approach..... We always talked about it but to be perfectly honest, we never got the physical time to actually [implement this]” INTV15*

## **5.5 Schools, Teachers & Social, Personal Health Education (SPHE)**

Following the Education Act, 1998 both primary and post-primary schools are obliged to promote the social and personal development of students and to provide them with health education. A programme was subsequently introduced to the curriculum entitled Social, Personal Health Education (SPHE). The Relationships and Sexuality Education (RSE) programme, introduced in secondary schools in 1997, was merged into the broader programme of Social, Personal and Health Education (SPHE). Prior to this, primary schools introduced the Stay Safe Programme (SSP) in the early 1990s. While the RSE programme consists of a set of procedures and guidelines, each school has the discretion to develop its own policies, programmes, resources and materials. These programmes represent a shift in moral teaching and sex education away from the Catholic Church to the state (Layte et al, 2006). Studies conducted by Morgan (2000) and Geary and McNamara (2002) on the implementation of SPHE and RSE in primary and post-primary schools point to significant gaps in programme provision, which increases as children move into adolescence.

The issue of providing sexual health education in the school setting by teachers was discussed in detail by interviewees. Most felt that teachers are put in a very difficult situation in terms of having to provide the SPHE programme. More specifically several drawbacks of the current delivery of the programme were highlighted. For instance, most of those who commented on this issue believed that sexual health and relationships are not being covered in schools or stated that they did not know.

*“....from what I was hearing, the teacher could have just skipped past that [sex education element] and not done it, you know what I mean like. It was very much tick the box”. INTV7*

*“So I just think the SPHE programme, and I know from a Health Board point of view everything is rosy with it, but in reality it isn’t being done” INTV11*

*“A big issue then in schools, like teachers being very uncomfortable actually ..... Skipping over the sexual education issue part it [the SPHE programme]” INTV14*

*“This is the question, are they? ..... Now I don’t know, I haven’t done all the schools but the vast majority said that they talk about relationships and they don’t touch the topics [regarding sexual health], even though, but from a policy point of view everyone thinks the box is ticked, SPHE is covering those things, but I don’t know if it is”. INTV15*

*“.....the reality is that teachers in schools are not doing the sexuality or the relationships. They are doing the friendships and the civic responsibility and all that kind of thing.....” INTV2*

Moreover, several of the interviewees questioned the appropriateness of expecting teachers to deliver the programme in the formal education setting, and highlighted the lack of appropriate training and skills on the part of teachers to deliver such a programme.

*“And then you have to question, is it appropriate that your English teacher on one hand, you know, and then the second time, you know, next period to turn around and say, right, let’s have a chat”. INTV15*

*“The teacher could come in from teaching Maths, and they’re meant to start doing that. It’s very hard” INTV7*

*“..... they’re probably not the most appropriate person as well. For young people it’s not the most appropriate setting because you’ve a teacher who is a History teacher.....I don’t think school teachers are the most appropriate people to deliver it”. INTV11*

*“..... they’ve been trained in wherever to be a Maths teacher, they’ve never been trained to be an SPHE teacher and you’ve got to ask them to talk about, or the*

*expectation to talk about sex and relationships with young people in this class and then go in and teach them Maths in the next class". INTV2*

The mandatory nature of the programme which removes an element of choice and flexibility for teachers, teenagers, and parents was criticised.

*"And the kids weren't given any choice in it, and the parents weren't given any choice and the teachers weren't given any choice in it". INTV9*

*".....the teachers had a big row with the vice principal because they didn't choose to actually do the SPHE, it was to fill up their hours.....I think it would be even counter productive if you're going to put somebody in that really is not that comfortable, filling their hours and their timetable, I mean what kind of message about sexual health and sexuality are they going to be sending?" INTV15*

*"..... SPHE as far as I understand it, is led by the curriculum, and that's what they are doing" INTV2*

Some project workers explained that they had been asked to come to schools and deliver sexual health and education programmes and workshops, usually arising from specific attitudinal or behavioural issues amongst groups of teenagers which teachers were concerned about. It was made clear that in these instances, it was important to develop a collaborative approach with the teachers, so that the project workers were seen as a support to the teacher.

*"I remember being in a meeting one day with four teachers and I was going to do some group work, linking into their SPHE course. ....We were always very aware that you don't replace the teacher, it was complementary" INTV15*

*"But I mean there is no reason in principle why the THI worker couldn't work with a teacher on the programme or with, and that would be maybe again, added value for the teacher as well as the worker.....It's not to replace the teacher but to again, give added value to what's already happening in the school". INTV1*

*"Well more on a consultative basis with the teachers and in terms of offering training for the teachers but not in terms of going into the schools and literally taking a class" INTV3*

The context in which the sexual education is provided to teenagers was raised. A number of interviewees felt that the in-school setting was not conducive to sexual education because of the formal, school-based setting, large class numbers, and overall ethos.

*"Plus, it's a very chalk and talk approach .....that's doesn't work in this area" INTV9*

*“I think the out of school aspect of it I think is good as well. I think that it should be a flexible programme because the out of school programme allows, when young people are removed from the school setting as well they’re much more likely to engage with a programme of that nature. The other side of it, for example, if you take a facility like the Gaf here, there’s no reason why students from the Pres or Mercy or some schools around here couldn’t come up and do the programme up here in school time if that, because we would find that delivering a programme like that in school, classroom setting, is not the most ideal”. INTV11*

*“I think it’s difficult for teachers. It’s formal education and then to have to turn around and do something that really requires informality, it requires creativity....” INTV14*

*“....there are maybe twenty or twenty four of them [teenagers] in there .....The class room dynamic, where we’d [THI project workers] have ten and we’d have them all sitting around in a circle.....You encourage young people to say it all out, whereas there is rules in the school, and they have their ethos around sex and stuff ....” INTV2*

*“..maybe they need another setting” INTV15*

The benefits of and need for a participatory, bottom-up approach giving both service providers and teenagers choices with regards to the programme and its delivery was also discussed by some project workers.

*“...[in term of the THI] whereas you’re off this way and that way, depending on where the young people want to bring it and you’re facilitating that and they’re learning and you’re discussing their attitudes and, but its very much led by them”. INTV2*

*“I just think we need to be more creative around that. I mean, in terms of, I do believe alright, yes that we don’t want to take the responsibility away from the school, that the school still has to take on the onus of the Social, Personal Health Education of young people. But that if we are to do something like this that it’s delivered in a context”. INTV11.*

Another manager explained that situations where schools and students approached the THI service providers for the programme was advantageous, as it took any potential element of stigma out of the scenario. This is particularly important, as the reluctance of teachers to refer individuals to the THI arose as a problematic issue.

## 5.6 Summary

The THI programme is delivered in a flexible, participatory and in some instances innovative manner, and is needs-led. Such an approach is highly appropriate given the nature of the service and the profile of service users.

While a broad template, in the form of a THI programme manual exists, nonetheless a range of materials from other relevant programmes and organisations were used and adapted by project workers in developing the programme. This requires an element of innovation and creativity on the part of the THI workers.

The requirement for a trained professional with a medical or nursing background to deliver some of the more 'technical' or 'clinical' aspects of the THI was the general policy of Foróige, whereas Youthwork Ireland, Galway did not require this. The situation has subsequently changed, with both service provider organisations working from the perspective that the THI project workers can cover all aspects of the programme, and if deemed necessary, medical/nursing professionals are requested to deliver some parts of the programme or answer specific questions and queries as needed. Indeed the synergy between the project workers and the health professionals was commented on positively.

The THI programme has evolved from focusing mainly on primary prevention, aimed at delaying the early onset of sexual activity, towards more secondary prevention, as more and more teenagers are sexually active when referred to/entering the programme. Based on this finding, the question needs to be asked as to whether adolescents should be receiving the THI programme at an earlier age, as preventative work in this area is very important.

A mixture of individual and group work currently characterise the THI programme delivery. It has evolved from primarily group approach when initially designed, to one which now entails a one-to-one dimension also. The group work was regarded as most appropriate from a preventative perspective, often targeting young people who were not yet sexually active. In contrast, the individual based work was described as being needed mainly in cases where young people were displaying inappropriate or risky sexual attitudes and behaviours. It was also used in cases where group work did not suit some young people, or in order to prepare them to participate in a group setting.

The research found that the choice of service delivery approaches was very much dependent on the preferences of the THI project workers, with some preferring one type more than the other. Moreover, the intensive nature of one-to-one work and low staff numbers essentially means that irrespective of need, such an approach has been extremely difficult to provide due to the continuance of limited budgetary provisions. The pressure to get high numbers attending the programme resulted in some project workers favouring group work over individual work. While there were divergent opinions on which approach suited the genders best, both types of service delivery have

their own value and should be used as necessary, on a needs-led basis. The need for broadening the mode of service delivery, to incorporate more innovative approaches to teenage health dissemination was also highlighted.

Parental involvement in the THI is limited. Basically, the parents of teenagers are visited by project workers prior to the participation of their children on the programme. The content of the programme is shared with parents and their consent is obtained. More direct parental involvement has been rather ad hoc and limited, mainly due to lack of staff time and resources. The need for such intervention with parents of teenagers participating on the THI was regarded as an important issue.

Finally, most of those interviewed for this Review were critical of the SPHE programme in schools, on the basis that teachers were put in a difficult position in terms of having to deliver such a programme in a school setting. Interviewees felt therefore that the standard of sexual education in most schools was unsatisfactory. Suggestions were made regarding having others appropriately trained to deliver the programme in a neutral (out-of-school) setting. The participation and input from teenagers regarding the SPHE programme contents and mode of delivery was also proposed.

## Chapter 6 - THI Governance, Management & Administrative Issues - analysis of primary data

In this Chapter, the serious funding problems associated with the programme, and the consequences of this in terms of staffing are discussed. With regards to THI project workers, a series of issues concerning staff training, support and supervision are outlined.

### 6.0 Funding of the THI Programme

The issue of funding was highly contentious, with several interviewees highlighting serious financial problems with regards to the THI programme. It was explained that during the early years of the programme the THI funding was managed by Regional Office for Child and Family Care in the former WHB, in Merlin Park. Some explained that the original plan was to mainstream THI into the health board structure, however when the health boards were dissolved under the health reforms in the mid-2000s, the situation regarding both mainstreaming and the overall funding of THI was left in an uncertain position.

*“My understanding is that THI was supposed to go mainstream into the HSE. That never happened. That really confused the water, muddled the waters, so that funding is still... in the regional office although it is in the process of going local.....I don't fully understand who is actually in charge of the money for THI at the moment”. INTV5*

*“.....the idea was that HQ [the Regional Child and Adolescent Centre, Merlin Park] would kind of fund and hold that programme [the THI] for three years, and then it would be evaluated and then it would be rolled out to the local areas”  
INTV4*

It was felt that the changes resulting from the health sector reforms at regional level has resulted in a vacuum of leadership with regards to the THI.

*“Somebody has to champion it” INTV12*

*“At a regional level that has just kind of evaporated really....I think it's very negative, very negative because it's taken a finger off the pulse.....There's no leadership, no. There isn't. I think that there is just a lack of interest in it for some reason. Maybe it's just not seen as a priority any more.....” INTV14*

It was explained that a major problem regarding the funding for the THI is that it was never index-linked and no incremental funding increases were secured. Therefore in real terms funding for the service has been decreasing every year. In each of the three counties, interviewees were critical of this shortfall in funding.



### THI Mayo

*“It was well flagged that there was a funding shortfall and there’s been an issue around funding shortfalls for a number of years.....Fund it properly, like to fund this project would probably take in the region of about €55,000 and not €37,000 and that’s to have a service that operate effectively.....There’s still the shortfall in funding.....”. INTV13*

*“.....The money doesn’t cover the full-time worker.....If every year I’m spending a week of my time trying to keep it, I might as well take unpaid leave and donate my salary for the week over” INTV12*

*“At the moment the way it is in the HSE there is money there and I can employ someone on a part-time and I am reluctant .....The fact is that €42,000 isn’t sufficient I would sooner not have it than have half it.....It’s just that the money for it isn’t there and I don’t think its any other issue to be honest”. INTV14*

### THI Roscommon

*“It [THI] should be reviewed but the decision to either fund it fully, because it’s not fully, the posts aren’t fully funded at the moment. They are only part funded I think about €35,000 a year or €38,000 a year which isn’t sufficient for one full time post. We were saying, well we would welcome more funding towards it .....” INTV1*

*“For the last number of years I don’t think there has been that much money coming through the family support budget” INTV3*

### THI Galway

*“Yeah, you know with incremental salary increases and PPS, PPF, all the various programmes that the costs have increased. I know that there was, there probably was some cuts in expenditure probably at some stage as well ....” INTV10*

*“I’d like to see THI being funded adequately to provide the service that is being provided for a number of years”. INTV5*

Consequential difficulties resulting from the problematic funding situation has been the loss of staff to work on THI for periods of time in all three counties, with no service currently in Mayo.

Moreover, the impossibility of planning the THI service into the future was emphasised. It was suggested that the incorporation of THI into 3 to 5 year service agreements, thereby securing ongoing funding would be a means of addressing this problem.

*“If you’re going to put somebody in place, what’s going to happen next year?. They’re going to be pulled again?”. INTV13*

*“It’s very hard to look forward and it’s very hard to plan on a long-term basis when you don’t know if you’re going to have any money or if the project is still going to be up and running in some ways”. INTV8*

*“I mean the most important thing for me is that, whatever is there, if it comes along that we can make sure that for five years we still have enough for that project, because you cannot plan services.....” INTV12*

## **6.1 THI Staff Training**

Interviewees were asked about the training of THI project workers. The project workers generally had a qualification in the area of Child Care, Social Studies, Social Care, or Social Science. It was noted that core traits required for a THI post were good communication and group facilitation skills, and experience of working with young people. None had specialist background in the area of sexual health prior to taking up the THI posts.

Interviewees explained that both Foróige and YWI provided the opportunity for THI project workers to avail of training, and this tended to be built-into the supervision and support of the THI staff. The type of training most commonly discussed was on-the-job sexual health training for THI workers after they had taken up the job. Three agencies specifically mentioned in terms of training were the National Youth Council, the HSE (health promotion), and Aids West.

Some described participating in formal training courses, with the following short programmes referred to:

- ‘Boys Don’t Cry’,
- ‘Too Hot to Handle’,
- ‘Sense and Sexuality’
- ‘Nuts’
- ‘Copping On’
- ‘Crimewatch awareness’
- HSE Sexual Health Promotion
- Suicide – Assist
- Houghton Institute, St James Hospital
- Working with young people therapeutically
- materials of the Crisis Pregnancy Agency, Aids West.

Others discussed self-learning, learning informally from other colleagues and other practitioners working in the area. It was pointed out that in the past, there was comradeship between the THI project workers in the three counties:

*“....there would have been a network of THI workers would have met regularly and would have supported each other” INTV14*

However, for a variety of reasons including geography, transport, travel, the health reforms and dissolution of the health boards this network is no longer in existence, and now each county works in a predominately independent manner in terms of THI service provision.

Finally, the need for more on-the-job training and re-training was specifically mentioned.

*“I would love to go back and update myself around, the new, in terms of the patterns that are developing around sexually transmitted infections back to the Houghton Institute again, I’d love to update”. INTV9.*

*“So it’s very hard to get away to do the training, but it is a thing that I’d like to be able to do more of because I think it’s important for progression to be able to have the access to that” INTV6*

*“I think there should be maybe some re-training and up-skilling in relation to the project staff”. INTV8*

A number of interviewees suggested the value of having a single specific training programme for THI workers from both Foróige and GYF, as a means of standardising the approach taken.

*“I think if there was a central training that was provided regardless of who you work for, that there was a core training module that any THI worker that takes up a post gets.....That there is core components that they’re trained in, a sort of centralised training, even in terms of... shadowing someone for a week or two that is in the job longer, but I think there should be centralised. And skills development should be part and parcel of [it]” INTV11*

*“There needs to be very specific training for workers” INTV14*

The issue of lack of funding for training was highlighted by one interviewee whose service has been withdrawn.

*“I think what is lacking in terms of more training or more guidelines, yeah? We were in the process of working on those. So I think the structures are there for it.....It’s a money issue” INTV14*

## **6.2 Staff Supervision & Support**

A range of issues were identified and discussed in terms of THI staff supervision and support in their work. From a governance perspective, it was explained that in the early years of the Programme, HSE managers in the Regional Child and Family Support Care Office in the former WHB provided a high level of support to project workers, and had a “hands-on” approach, whereby they were easily contactable and held quarterly review

meetings. In contrast, it was pointed out that the reformed health service has meant that such high-level managerial support for THI project workers has basically diminished.

*“At regional level that has just kind of evaporated really..... There’s no leadership, no. There isn’t. I think that there is just a lack of interest in it for some reason. Maybe it’s just not seen as a priority any more, maybe it’s seen to be running ok so leave well enough alone.....”* INTV9

At a more micro level, THI project workers gave varying accounts of the types of supervision they received and their needs in this regard. On a day-to-day basis, line managers in both Foróige and YWI were the main source of supervisory support, whereby project workers would discuss the types of cases and type of work they were involved in with their employers. In addition, because of the situation regarding THI in Galway city, where the THI project worker is based in the Gaf Youth Café, supervision and support was also provided by the manager of the Café, and other Gaff staff. If deemed necessary, some managers pointed out that the appropriateness of various referrals were assessed with some cases and referred onto other more generic type youth services.

Peer support from other THI workers was also mentioned. However it was noted that the varying approaches of the two service provider organisations, in particular with Foróige mainly concentrating on group work, and YWI was mainly involved in individual work, meant that the project workers from the two organisations tended not to have a lot in common. Additionally, with only one THI worker in County Galway, Mayo and Roscommon, and one in Galway city it is not surprising that the isolation aspect of the THI work was also mentioned by some of the staff as a reason for possibly not actively seeking support. As one project worker explained:

*“See, probably on reflection, you’re so used to working in isolation, you’re so used to making decisions, you just get on with it.....I just became so independent”* INTV15

More in-depth support in the form of clinical supervision and de-briefing was also discussed. Because of the intensive nature of the THI programme, it was explained that project workers have occasionally had to deal with traumatic situations such as suicidal and self-harm threats, and highly promiscuous behaviours. Some interviewees felt that access to this type of support service was important.

*“Its [clinical supervision/debriefing] something the project definitely needs, you know”* INTV9

*“It’s something I know we are pushing for and yeah I would support it definitely”* INTV15

*“I know a couple of cases did come up for [project worker name]. Really she [a THI project worker] could have done with additional support. That kind of intensive de-briefing definitely. I would think so”. INTV14*

Furthermore, there were contradictory accounts given with regards to the availability of this type of intensive supports for project workers. For instance, the project worker in Galway County explained that up to 2005, she could avail of external clinical supervision provided by the HSE, however this was withdrawn as a result of funding shortages. She explained that her employer subsequently arranged for the provision of private supervision for half an hour every six weeks. A HSE manager with responsibility for THI in Galway city stated that de-briefing services were available to THI workers if requested, however she did not think that such supports had been requested to date. An informal supervisory arrangement was described in the Mayo THI, whereby the project worker had access to a HSE manager and social workers for de-briefing purposes if necessary.

### **6.3 Summary**

The very problematic funding situation regarding the THI was discussed in great detail by interviewees. The health reforms which began in the mid-2000s resulted in the future of the programme being left in an indeterminate state, without clear leadership. The programme which was originally funded by the Regional Office for Child and Family Care, Merlin Park, Galway was subsequently decentralised to the Local Health Offices (LHOs) in counties Galway, Mayo and Roscommon, following the health reforms in the mid 2000s. However, confusion remained as to the role of the Regional Office with regards to the programme. In addition, it was explained that over the years, the funding was neither sufficient to cover one full-time salary and was not incremental/index-linked, with the result that shortfalls resulted, and the turn-over of THI staff has been high. Furthermore, the programme was not included in the 3-5 year service agreements between the HSE and service providers which made it impossible to future plan.

Also at the macro level, it was felt that a void exists in terms of leadership and support for the programme and project workers, resulting from the decentralisation of the THI to each of the three LHOs, with the Regional Office no longer directly involved.

- THI needs to be championed and supported at a senior level in the HSE.
- Coordination and delivery of the service in the three counties would benefit from direction centrally (perhaps akin to the Regional Office type structure).
- Realistic, adequate funding needs to be made available to hire THI project workers on a medium-term to long-term basis.
- The incorporation of the THI into the HSE service agreements would provide the programme with a more secure future, and would allow managers and delivers to plan the service.

The THI project workers generally had qualifications in the areas of Childcare, Social Studies, Social Care, or Social Science, and possessed generic skills and experience working with young people, and communication and facilitation. However, none had sexual health training prior to taking up the THI post. This specialised knowledge was acquired through a mix of formal and informal training and on-the-job learning on the part of THI staff.

While project workers seemed to be satisfied with the relatively flexible aspect of the programme in terms of content and approach, they would welcome more training and on-the-job learning opportunities to update themselves on various aspects of teenage sexual health. Furthermore, notwithstanding the maintenance of flexibility and autonomy, standardised training and retraining for THI project workers would be beneficial, from the point of view of consistency amongst the two service provider organisations, and bringing project staff together to update their skills and learn new or different content and/or approaches. Indeed, a deficit with regards to peer support is the individualised nature of the work, with just one project worker in Mayo and Roscommon, one in Galway city and one in Galway county. Over the years a vacuum of communication between the project workers has occurred, with the THI run in an independent manner in the three counties.

At the micro level, THI staff were generally satisfied with the level of support and supervision which they received from their line managers. As mentioned above, peer support is largely lacking. The need for specialised support in the form of clinical supervision and de-briefing was highlighted by some project workers, given the intensive nature of their work and caseloads. The availability of such support needs to be clarified as confusion currently exists in relation to this matter, both on the part of service providers and managers.

## Chapter 7 - Perceived Impacts of the THI Programme and Where to From Here? - analysis of primary data

Social programmes should be evaluated according to their merit and worth of their actual effects, independent of their intended effects, posing the question ‘In what ways does this programme effectively meet an important need among the designated beneficiaries?’ (Scriven, 1967).

In this Chapter, this issue is addressed, whereby an account of stakeholders perceptions of the broad outcomes of the programme to date and how they would like to see it change or develop in the future is presented. The Chapter begins by discussing stakeholder opinions on the perceived impacts of the THI on teenage participants. It concludes with a discussion of core reflections regarding how the programme should be changed and adapted going forward.

### 7.0 Is THI Making a Difference?

A core question in terms of the Review was to ascertain interviewees’ views on whether they thought that the THI was making a difference in the lives of the young people who participated in the programme. It should be noted that this type of programme comprising varying levels of prevention and focusing rather intangible dimensions such as attitude and behavioural change presents a challenge in terms of quantifiable evaluation. Notwithstanding this, some factual data relevant to this programme including teenage pregnancies, STIs/STDs are available for analysis. Timing is another factor, with the impacts of the THI being of a more long-term nature.

On the one hand, the difficulty of quantifying the outcomes of the preventative services and the overall value of such work was highlighted by several interviewees.

*“It’s very hard to measure if something is making a difference” INTV5*

*“It seems that it’s quite, very difficult in a way to monitor, you know, evaluate it, in inverted commas” INTV9*

*“It’s very hard to quantify, it’s very hard to measure.....” INTV15*

*“You see it’s very, very hard to measure prevention and in that regard I really couldn’t say with any scientific certainty what difference it’s made or not made..... I would have the view that prevention is hard to measure and sometimes people don’t get credit for the work that they do because it’s a bit invisible”. INTV13*

*“Now statistically I suppose, we don’t really have a way of analysing that [changes in behaviour], I suppose, you know?” INTV10*

*“It’s always difficult to defend and to measure outcomes for preventative programmes”. INTV4*

On the other hand, the “very measurable” “hard facts” in the form of statistics regarding both teenage pregnancies and sexually transmitted diseases were referred to by some interviewees as indicators of both the programme’s necessity (in the case of rising numbers) and impact (in the case where numbers were low or falling).

Notwithstanding the difficulties of quantitatively measuring the effects of the THI service, there was almost unanimous agreement that the THI is making a difference and is a very worthwhile service. In this regard, a broad range of examples were given by interviewees as positive indicators of the value of that the programme, including: increasing teenagers self-confidence, sexual knowledge and information, improving relationship, communication and decision-making skills, and behaviour.

*“If they left the group feeling better about themselves, you made a difference”  
INTV15*

*“.....from just the girls talking afterwards, knowing that they felt better, that they knew, and as well as that, what was great as well, getting rid of the false information that they had was very alarming.....I do think it got them thinking”  
INTV7*

*“Some of the kids you would see at the start where they wouldn’t open their mouths and at the end of it they’d be the one telling you the story about [a personal experience].....[and asking] what’ll I do?. You’re actually able to tell me something about yourself now” INTV6*

*“.....you discover that the outcomes for that young person is yeah, they’re not staying out so late, yeah, they are more informed about contraception or yes, they have sourced some form of contraception. I mean they are positive outcomes, hugely” INTV14*

*“I suppose it’s seeing your individual grow while you’re working with them and seeing them gain the skills to make decisions .....They’re able to cope with things better, it’s not like, you piss me off so that’s it, I’m never speaking to you again, absolutely, you know? ..... You’re trying to encourage them to see their own flaws and the flaws in others and to allow for that. I think it’s a fabulous programme, absolutely”. INTV2*

Some highlighted the importance of the THI programme in providing teenagers with a designated person to talk to about particularly personal and sensitive issues, and hence this relationship which is build up between the THI worker and the teenagers was regarded as highly important. As two interviewees commented:



*“..... the fact that there is somebody there for somebody at some stage might make some difference somewhere along the line, you know what I mean like? .....It’s very important there’s somebody there for these people [teenagers]”*  
INTV10

*“Somebody said, it’s not programmes that change people’s lives, it’s relationships and I think that’s the thing with the THI.....A very significant positive relationship they [THI participants] make is with the THI worker”* INTV2

It was also explained that as a result of funding problems, the temporary cessation of the THI programme in Roscommon for a period of four months, and the cessation of the THI programme in Mayo since 2006, has led to significant negative reaction from the general public, thereby indicating the perceived importance of the service to the public.

Moreover, from a managerial perspective, the need to convince the key decision-makers and funders that the service is worthwhile was mentioned.

*“Like I think the lead LHO who is dealing with this ..... She needs to be persuaded that this is a valuable, worthwhile service. The THI role in itself should be able to argue it’s own value”* INTV13

Finally, two HSE managers stated that they would base their overall decision on the value of the programme on the findings of this Review.

## **7.1 Ideal Future of the THI**

Views were gathered from participants on their aspirations regarding the future of the THI. A significant level of discussion resulted from this question, which can be summarised under the following headings: funding and staffing resources; accessibility and geography; and strategic collaboration, planning and training with other youth projects, relevant organisations and groups.

### **7.1.1 Resources – funding and staffing**

By far the most problematic issue raised by most interviewees was the continuing problem of insufficient and insecure resources for the THI programme. It is not surprising therefore, that calls for “adequate” “appropriate” “realistic” “additional” and “secure” funding was called for. Interviewees in all three counties described a serious level of pressure on youth services, with words such as “struggle” and “stretched” being used to describe the situation. In terms of the future, one service manager stated:

*“Rather than trying to get THI carrying from day to day ..... it’s just barely struggling to survive, lets look at developing a really credible programme”*  
INTV11

The direct impact of the continual funding crisis and shortfall has been the loss of the THI service in Mayo and periods of service cessation for up to a number of months in the other counties. The ongoing uncertainty regarding the THI project worker posts was highlighted as an annually recurring problem. Retaining staff under such conditions is extremely challenging. In terms of relationship formation and trust building, the impact of the lack of continuity of THI staff for the teenagers using the service was highlighted as problematic.

Since inception, the staffing levels on the THI programme have been limited, with just one project worker in counties Mayo and Roscommon, and two in Galway. Several interviewees expressed their desire to have more staff to provide the service, given the vast geographic area of the region which the THI covers (including two of the biggest counties in Ireland) and the high level of demand and need for this service, as evidenced by the existence of waiting lists.

### ***7.1.2 Accessibility and geography***

Some interviewees described situations where referrals had to be assessed and prioritised, and waiting lists for the service existed in some areas. In Mayo, it was explained that referrals are still made, despite the cessation of the service, indicating the continuing need and current service gap. The high level of demand for outreach services in several towns throughout the region, the lack of services in large parts of the three counties, and the increased demands on the THI resulting from the lack of other services in the rural areas in particular were highlighted. In contrast, the availability of a much broader range of services in the city was referred to:

*“I think the city based THI is very different to the set up of the county based.....There are much more supports around, there are many more projects for the city.....I think there needs to be some support, be it, it may not necessarily mean setting up a whole programme or whatever but there needs to be some formalised system of support for the THI programme particularly in the rural areas” INTV8*

### ***7.1.3 Strategic collaboration, planning and training with other youth projects, relevant organisations and groups***

Since teenagers referred to the THI often display other socio-behavioural type problems such as alcohol and drug misuse, and come from dysfunctional families, THI staff frequently engage with other services in order to address a complex range of problems and issues in the lives of the teenagers. It was pointed out by several interviewees that while a specialised, targeted and dedicated service for sexual health matters should be retained, they would also like to see the THI involved in the formation closer collaborative relationships, links, working partnerships and training those working in services such as: health promotion, social work, mental health, drugs and alcohol misuse, traveller health. More specifically, a number of interviewees highlighted the lack of

involvement of Health Promotion, HSE in the THI to date, and stressed the key role of health promotion in the area of teenage health.

*“The whole notion of health promotion around this area, that link is there.....I would think health promotion in relation to young people is something they [Department of Health Promotion, HSE] should be doing. I don’t know what they do, that’s saying something in itself”. INTV13*

*“I think as well, if you look at it, this programme has been funded through child-care primarily. Where is the role of Health Promotion within it? Health Promotion aren’t playing any active role within this, within the HSE.....I think Health Promotion should be approached with regards to this programme [THI].....it should be build into their work”. INTV11*

Additionally, some interviewees explained that collaborations by THI staff with those working in various projects including: Neighbourhood Youth Projects (NYPs), the Edge, family support services, community development, adolescent support, crime prevention and so on would be a possible means of filling the current gap. It was felt that such collaborations would enable more widespread service provision by accessing larger numbers of teenagers in need of basic sexual health education, as an early identification and preventative measure.

*“Well I, my view whether or not you designate everybody as a THI, I think everybody probably does a bit of THI work anyway, and they should be doing that .....I prefer that option, having a named, designated person doing it. But I think everybody else should have, and does have, that brief”. INTV13*

*“But if you were maybe to even just gather all the department heads, psychology, social work, family support, even PHN’s who would have a direct link with families and look at some sort of a resource that you could develop in the area so that [the project worker] could link in with them.....And there is a lot of good people working on the ground who have the skills and just a little bit of training around the THI programme that would down the road have a huge preventive aspect to it and would save a lot of effort later..... You can link in with these[professionals or non-professionals working with families] and identify, even the early identification of those working in families where they’d have concerns long before they’d become known to the social workers or the schools or whatever. Schools are another one, and everyone is busy and burdened..... ” INTV8*

Other related suggestions were made in terms expanding the service in the future, including enabling THI staff to train other professionals working with young people including youth workers, social workers, teachers, parents, and so on.

*“That there could be something like train the trainer programme, that she [the THI project worker] would actually do it. If we want to get the most out of it she*

*[the THI project worker] could train youth workers, teachers, whoever. That they would be able to deliver it and if then they needed the specialists, involvement from a nurse or GP, then so be it, we'd bring that it" INTV11*

*"..... THI expanding in terms of training, so that there is a lot of training with, and a lot of time dedicated to training with teachers. And a lot more work done with the parents ..... I would love to see it expand so that we could cater for the amount of training that needs to be done with teachers and parents". INTV3*

*"They [THI project workers] should have a relationship with somebody in mental health services and drugs and alcohol, that is not just sexual health. You link in with other professionals as an opportunity I think for the THI to bring in other professionals and have them do a session with you or explain who they are and what they are about". INTV15*

However, the very high level of current work and case loads which those working in these services and sectors have, and hence the feasibility of taking on additional work regarding sexual health was also acknowledged.

In contrast, two HSE managers stated that they would like to see the THI service fully merged into the above mentioned types of existing projects:

*"If you said to me, look, I'm giving you an extra post, what would you do with it? I'd have a look at the family support project.....it would be a family support project worker first who as part of their brief targets this group [of teenagers at risk in terms of sexuality]" INTV12*

*"I don't think it [THI] should be separated out. If someone is working on sexual health then she should be part of their emotional health. It's a tool that every project worker, I mean they're working with kids around things like alcohol, around bullying, so they should be working with them around sexual matters?. I mean they do it with, you know, if a young person presents to them who is dabbling in drugs or sniffing or stuff like that, they deal with that, if it is bullying they deal with that so if it's a sexual health matter they deal with that?." INTV4*

The difficulty of planning and developing the THI service as a result of the annual uncertainty over resources (budget and staff) has been a serious challenge over the years. A number of interviewees suggested the need to strategically review and plan for the future of the THI service. It was explained that this should be done in conjunction with key players including those in health promotion, social work, family support, and community development.

*"I think it's kind of like, in terms of, we need to look at, ok, the original aims and objectives and see how they've evolved down through the years because I think they have evolved. I think we need to look at the likes of the players in this, whether it's Health Promotion, you know.....They need to come to the table on*

*this. And I think that's, and look at how the programme can develop, certainly".*  
INTV11

*".....that somebody that would have a strategic role as well as a hands on role in training and empowering others to deliver a THI service, whether it's in the community, in schools or a compilation of both.....But I think if you have the strategic element of it and you're working with other professionals in the field that's nearly as much as you can hope for....." INTV1*

It was also suggested that the role of the THI worker needs to be reviewed, as some pointed out that a more targeted approach and specific brief would help the worker establish work parameters (this was discussed with regards to Mayo specifically).

*"I would say more specific target and it was never actually named for a THI worker. It was kind of 'do whatever you can' ..... I think it has to be named for the worker, exactly what the level of expectation is" INTV14*

Finally, another interviewee discussed the need for service evaluation:

*"I'd love to see evaluations going on because there is no point in funding something that's not effective". INTV5*

## **7.2 Summary**

A common response to the question regarding whether THI is making a difference was the difficulty of quantifying the preventative outcomes for the teenage participants. However, some obvious indicators were referred to such as the numbers of teenage pregnancies and sexually transmitted diseases and infections. More generally, an overwhelming endorsement of the programme was given by interviewees, with a myriad of examples provided as a means of indicating how the programme has impacted upon the teenage participants, in terms of building self-esteem, self-awareness, assertiveness, developing relationships, communications, decision-making skills, and knowledge concerning personal and sexual health and well-being.

While the outcomes of some aspects of the service can be more readily quantified, alternative methods are required to capture the true essence of the in-depth prevention and intervention work of the THI programme. At the outset, the need for project workers and managers in Foróige and YWI to share this with HSE management through face-to-face dialogue and site visits could be a useful starting point.

In terms of future aspirations for the programme, three major aspects requiring urgent addressing were discussed by interviewees:

- (i) resources – funding and staffing
- (ii) accessibility and geography
- (iii) strategic collaboration, training and planning

Insufficient and insecure funding for programme has severely hampered the service over the past seven years, and the continuation of the THI into the future is not feasible unless the financial situation is rectified.

The very large geographic area which the THI covers makes it unfeasible for four staff to cover. As a result, the service is inaccessible to large sections of teenage populations in each of the three counties, with the rural areas particularly disadvantaged. Moreover, demand exceeds supply, with waiting lists a feature in some areas, while schools are not generally targeted as a result of inadequate resources.

The THI is a specialised, targeted service dedicated to sexual health and personal development matters. In order to protect the in-depth nature of the programme, the value of retaining the THI as a stand-alone programme was favoured by the vast majority of interviewees. At the same time, most were of the opinion that strategic collaborations and partnerships with other youth services and programmes/projects would be beneficial from an early identification and prevention perspective.

Training by THI staff of others working with adolescents in particular, teachers, and enabling THI staff to work more closely with the parents of teenagers was proposed.

Finally, in terms of planning the service in the future, the requirement for a security of funding was seen as paramount. In addition, interviewees highlighted the need to collaboratively plan the strategic direction of the service with other key players in areas such as health promotion, social work, family support, alcohol and drugs services, and community development. Establishing a clear role and specific functions for these key players would create a synergy with regards to teenage health service provision and considerably ease the onus on the child care services which are currently providing the THI in a unitary manner. It was suggested that such strategic review should incorporate a re-examination of the role of THI staff, and incorporate on-going evaluations of the service in the future.

## **Chapter 8 - Service Users Views of the THI - analysis of evaluation forms**

The opinions and experiences of those for whom the service is provided are a key stakeholder group in terms of service evaluation. A limitation of this Report is the lack of empirical data from teenage service users. Due to the timing factors associated with the Report deadline and the university's Ethical Committee meeting dates, it was not possible to conduct primary research with adolescents as originally planned.

However, evaluation sheets used by THI project workers were obtained for the three counties in order to assess the general opinions of the teenagers who participated in the programme over the years. A total of 115 evaluation forms were analysed for this purpose, with the feedback grouped into three headings:

- positives - things participants enjoyed regarding the THI Programme
- negatives - things participants disliked regarding the THI Programme
- suggestions - things participants would like included or changed in relation to the THI Programme

### **8.0 Positives - things participants enjoyed regarding the THI Programme**

The social aspect of the programme was frequently mentioned by participants, in terms of meeting and socialising with new people, and developing stronger friendships. The fun aspect of the programme was also commonly referred to, with teenagers describing it as good “*craic*” and a “*laugh*”.

Many of the participants highlighted the educational and discussion aspect of the programme as positive elements. In particular some of the most frequently mentioned things which they learned about and received information on were in relation to:

- relationships
- sexually transmitted infections and diseases
- safe sex
- underage sex
- risks
- respect
- trust
- personal health
- protection
- changing one's opinion

The THI participants also gave positive feedback about practical elements of the programme which involved items such as:

- dancing
- quizzes
- games
- group work

- arts/crafts
- condoms

Some of the teenagers pointed out that a positive feature of the THI was that it provided a “*comfortable setting*” and “*safe space*” to openly discuss these issues “*in confidence*”.

The THI was also described as “*helpful*”, “*interesting*” and “*exciting*”.

A number of the participants pointed out that their confidence, self-esteem, assertiveness increased as a result of the THI. Some stated that they felt “*more mature*” and “*responsible*”, had improved decision making skills and “*learnt to say ‘no’*”, and had become better listeners as a result of the programme.

The supervisors were frequently commended for their work on the Programme.

Finally, the food and trips were highlighted as other positive features.

### **8.1 Negatives - things participants disliked regarding the THI Programme**

In relation to negative features of the THI outlined by teenagers, feeling “*uncomfortable*” and “*embarrassed*” was cited. Some teenagers did not like the personal questions aspect of the programme.

The THI was described as “*boring*” by some, in the sense that “*they already knew*” a lot of the material covered in the programme.

Some were not happy with the timing of the programme, for instance it was pointed out that it clashed with the mock examinations, it was held late in the evening, and it was not held on Bank Holidays.

The cooperation required for the group work feature of the programme was regarded as difficult for some.

Attendance was raised as a problem, in terms of both “*non-attendees*” and “*the need for more attendees*”.

Finally, the perceived “*lack of discipline*” with examples such as “*rule breaking*”, “*laughing*”, “*not listening*”, “*missing*”, and “*interrupting*” highlighted.

### **8.2 Suggestions - things participants would like included or changed in relation to the THI Programme**

In relation to things teenagers would like to see changed, one of the most commonly mentioned things was time, with “*more time*” and “*longer*” programmes suggested.



Others were more specific, explaining that more time was needed “*for talking*” and “*for games*”.

Additional information on the following specific issues was also called for:

- teenage pregnancy
- rape
- child abuse
- drugs
- relationships/friendships, and
- personal safety.

Finally, some of the participants would like to have had additional elements included in the programme such as: sports, camping trips, and dance classes.

## Chapter 9 - Referrals to the THI

In this Chapter, the main sources of referrals to the THI are documented and the opinions of four 4 referrers who have used the service frequently in the past are presented.

### 9.0 Main Sources of Referrals to the THI Programme

We see from the Table below that referrals of teenagers to the THI programme come from a broad range of sources, including medial and health professionals, social and community care professionals, youth programmes, services and centres, family services, schools, as well as individual families and teenagers themselves.

<b>Galway City</b>	<b>Galway County</b>	<b>Mayo</b>	<b>Roscommon</b>
NYPs*	Social workers (HSE; Brothers of Charity)	Family	Self*
Youthreach (Claddagh)	Ballinasloe & Tuam Family Support Service	Child psychiatry	Family
Other Youth Projects/Programmes*	Schools	Social work department*	Social work
Social work	Youth Projects/Services	NYPs*	Schools*
Schools*	Self-referral by young person	Community Child Care	Voluntary Youth Work Services*
Psychology	Parent(s) of young person	Youthreach Centres	YAP
Self-referral	Area Medical Officer	St. Catherine's	John of Gods
Family support service	Psychology	Schools*	Family Welfare Conference
Residential (Fana Burca)		Gardaí	Foster Care Coordinator
Project Youth Nurse		Other Youth Projects*	Foster Case Conference
		Psychology	Family Support Service*
			Psychology
			NYPs
			Child Psychiatry
			Community Childcare
			Youthreach Centres*
			Youth Advocate Programme
			Traveller Training Centre*

\* denotes high level of referrals from these service areas

## **9.1 Referrers Views of the THI – analysis of telephone interviews**

Another perspective on the THI was gathered through discussions with those who have used the service to refer teenagers onto such a programme. In order to examine the views of those who refer teenagers to the THI, four telephone interviews were conducted with two NYP project workers (Mayo and Roscommon), a community care social worker (Galway county), and a family support service project leader (Galway city).

The main reason given for referrals of teenagers to the THI was as a result of teenagers promiscuous behaviour and early engagement in sexual activity. The lack of appropriate knowledge and education on the part of teenagers was cited as a factor in this regard. According to the referrers, the purpose of the THI was to share such information with the teenagers and provide them with a sense of appropriate and safe boundaries around sexuality. Enabling teenagers to develop decision making skills so that they can ‘say no’ with regards to sex, alcohol, drugs, and other criminal behaviours was highlighted as a core purpose of the THI.

In terms of the service user profile, all referrers explained that since they worked in areas which provided services for disadvantaged families, hence, many (although not all) of the referrals to the THI were teenagers from lower socio-economic groups. The age-range of teenagers referred to the service varied from between 14-17 years in general.

The predominance of females being referred to the services was commented on. The lack of services for boys was highlighted as a problem, despite the need for this, with most of the groups tailored to girls. It was also pointed out that professionals themselves do not refer boys often enough. Some felt that the individual, one-to-one work was best suited to the needs of boys.

Referrers had broadly positive perceptions of the programme in terms of its impact. The provision of children with the information, guidance, and help they need through the THI was commended. The THI was credited with enabling teenagers to become more comfortable talking about sexual and personal issues. The specialist role, and style and engagement methods of the THI project workers were highlighted as very important. It was pointed out that the THI worker often becomes a key person in the young person’s life, and an important influence on their social development, and perhaps other areas of their life such as education and family relationships.

Some noted that the outcomes of the programme were hard to gauge, given its focus on behavioural change. In addition, it would not be uncommon for teenagers involved in the THI to also be linked in with other support services, as part of an overall package of intervention. Therefore, attributing change to one particular intervention service could be difficult. Nonetheless, it was agreed that the purpose of such a programme was very important and valuable, and should be available to all children. The negative impact of the loss of the service in Mayo was referred to. The need for extra resources to facilitate the expansion of the service was highlighted.

## **Chapter 10 - Conclusion**

This final Section of the Report summarises some of the key issues arising from the Review. Such evidence is pertinent to any future decisions regarding the THI programme, and teenage health intervention services more generally.

### **10.0 Review Objectives**

The objectives of the THI Review by the CFRC have been met in terms of:

- (a) documenting the level of service provision and usage of the programmes in each of the three counties – Chapter 4
- (b) describing the type of educational and developmental work conducted under the programme – Chapter 5
- (c ) examining key stakeholders perceptions of the programme, including its purpose, content, outcomes - Chapters 4, 5, 7
- (d) examining key stakeholders opinions and experience of the programme in terms of governance, management and administrative issues – Chapter 6

### **10.1 Summary Reflections**

Recent research in Ireland has found a prevalence of misconceptions and low levels of knowledge about sexual health amongst the general population of teenagers. The high rates of teenage pregnancies and STIs/STDs are just one indication of such a gap in sexual health education. More specifically, the literature points to higher rates of teenage pregnancy, STIs/STDs, non-use of contraception, and earlier sexual initiation amongst teenagers from particular groups such as those from lower socio-economic backgrounds, and early-school leavers. In sum, the need for sexual education amongst both the general teenage population, and particular sections of this population group in particular is clearly evident.

This Review has found strong theoretical and experiential arguments in favour of teenage health intervention, in particular with regards to the area of sexual health. Adolescence is the period when values, attitudes and behaviours are being crucially formed with regards to sexuality. From a universal standpoint, the provision of accurate, normative based knowledge and education on such an important aspect of their development could be regarded as a basic requirement and indeed right for all teenagers. Within this general population however, sexual health and education services for young males and teenagers from disadvantaged areas and rural backgrounds have been found to be particularly lacking. Additionally, given the reality of finite and limited resources, a number of categories of teenagers can be identified from a targeting perspective as being at risk of promiscuity, sexual ill health and teenage pregnancy. These include, younger adolescents who have not matured enough to think about the future consequences of sexual behaviour; those who do not engage in 'safe' sex; those who are not achievement oriented; those whose mothers, sisters and friends have had an adolescent pregnancy; those whose fathers are absent from home; adolescents who lack emotional support and stability; and those who misuse alcohol and drugs.

An immediate question arising from this is what are the sources of such information? We know from the literature that parents are paramount in imparting such information, and those with lower levels of education tend to communicate less with their children about sexual health. Schools have responsibility for the SPHE programme, one element of which deals with relationships and sexuality. However, it appears that the consistency of provision of this is unclear. One's peers are another key influence in terms of sexual development, and negative peer influence can be detrimental in terms of sexual behaviours and attitudes.

A limitation of this Review is the lack of quantitative baseline data on various aspects of sexual health including teenage pregnancy, STIs/STDs, contraception use and so on. Indeed, the difficulties of quantifying preventative programmes such as this, and evaluating attitudinal and behavioural change has been referred to throughout the Report. Nonetheless a mixture of both quantitative and qualitative data on service provision, usage and experiences of the programme are set out in this Report in order to present an in-depth account of the THI in the former WHB.

## **10.2 THI – Possible Options for the Future?**

In conclusion, this Review found widespread support for the THI programme, from a broad range of actors including service users, service providers, service managers, funders, and referrers. It was felt that the continuation and further development of teenage sexual health educational programme is needed both from a primary and secondary prevention perspective, for teenagers of all ages, but particularly young males, younger aged teenagers, those from disadvantaged backgrounds, and from rural areas.

Therefore, based on the findings of this research, the researchers are of the opinion that the THI should continue providing what could be described as a highly important service to vulnerable teenagers. The programme itself was overwhelmingly endorsed by key stakeholders. The provision of sexual health information in the context of normative personal and social development constitutes an effective approach. Moreover, the flexible, needs-led, participatory characteristic is a core strength of the programme.

At the same time, the researchers are of the opinion that the programme content would benefit from a reassessment as a means of:

- (i) ensuring consistency of core elements of the programme
- (ii) updating the contents since the programme is 7 years old
- (iii) examining new, innovative approaches
- (iii) and building in a standard monitoring and evaluation component.

The THI arose at regional level in the former WHB, governed by the Regional Office for Children and Family Care. A subsequent vacuum was created following the dissolution of the health boards in the mid 2000s. Overall responsibility for teenage health now rests with the HSE. The reviewers are of the opinion that in the future, re-establishing a central governing hub for the THI would be important from a leadership perspective, and could lead to synergies between the service providers and managers in various counties.

While all those in social and health sectors working with teenagers should have a basic level of knowledge of teenage sexual health issues, the value of retaining a programme on teenage health (with a specific focus on sexual matters) delivered by specialist staff rather than fully merging it with existing teenage health services was the preference of most interviewees who took part in this Review. At the same time, it is crucial that any future, strategic development of this service is based on partnership approach, comprising collaboration between all the key stakeholders including the HSE managers, project workers and managers in Foróige and Youthwork Ireland, Galway, as well as other services and sectors working with young people, and referrers. The need for such collaboration and partnership working was stressed by interviewees. Finally, the inclusion of adolescents themselves and parents in reviewing and planning such services is also of fundamental importance.

Cognisant of the fact that managers in the HSE commissioned this Review in order to inform the decision making process regarding the future of the programme in the counties Galway, Mayo and Roscommon, the Review concludes with a matrix of possible options for consideration.

### 10.3 Matrix of Options for Future Service Development of the THI\*

THI programme content	Current – leave unchanged		Revise based on Review findings	
Service Users - who?	Targeted, specialised, at risk teenagers	Whole teenage population, generic	Parents	
Gender	Male	Female	Mixed	
Access – geography	Urban	Rural	Mixed	
Prevention/intervention level	Primary (note – target younger teenagers)	Secondary	Tertiary	
Service delivery approach	Individual, one-to-one	Group based	Other – innovative (drama, literature, film, internet etc.)	
Timeframe	10 weeks (approximately)		Unspecified - needs dependent with 'exit strategy'	
Service providers	Voluntary/community sector i.e. Foróige & YWI		HSE	
Service deliver	THI project worker (specialised programme)	Youth worker e.g. NYP (merged programme)	HSE staff (e.g. health promotion)	Medical/clinical professional (i.e. doctor/nurse)
Governance	Decentralised to individual LHOs of the HSE		Recentralised to HSE regional level	
Funding	Annual		3-5 yearly, secure, incremental, index-linked	
THI staffing levels	Mayo n=1 Roscommon n=1 Galway city n=1 Galway county n=1		Increase staffing levels to meet demand and take account of the geographic size of the region	
Settings	Outreach	Schools	Other – e.g. youth club, youth café	
Strategic cooperation & planning	HSE	Voluntary/community sector - service providers	Other disciplines and projects	
Staff supervision & support	Local level (line manager)	High level (HSE senior management)	Specialised, clinical	
Staff training	Formal	Informal (self/on-the-job)	Peer based	
Provision of training by THI project workers to	Others working in youth and community services	Parents	Teachers	

\*these options are not mutually exclusive

## **10.4 Final Comments**

This Review of the THI has established that the overall value of the programme from the perspective and experience of service providers, managers, service users and referrers justifies its continuance in some format. The matrix of options with regards to the future of the programme presents various possibilities with regards to organisational structure, governance, management, and delivery. One macro decision regarding the governance of THI would be to revert to a sub-regional structure, akin to the situation prior to the dissolution of the Health Boards, and use this to plan the future direction of the programme. A key consideration should be the convening of a means to plan and discuss decisions concerning the THI with other key players including Health Promotion, Social Work, Mental Health, Traveller Health, Drug and Alcohol Services, Aids West and so on. Finally, reflecting the limitation in this Review and from a good practice perspective, any future plans and decisions regarding the programme should utilise a participatory ‘bottom-up’ approach, by consulting and engaging with young people on specific aspects the THI. Crucially, parents and teachers should also be involved in this process.



## Appendix 1 - Key Informants Contacted for the THI Review

Name	Organisation	Job Position	Type of Contact
Trish O'Flynn	HSE West, Galway	A/Child Care Manager	Face-to-face interview
Orla Curran	HSE West, Galway	A/Family Support Service Manager	Face-to-face interview
Liam White	HSE West, Mayo	Children Act Services Manager	Face-to-face interview
Paul Murphy	HSE West, Mayo	Child Care Manager	Face-to-face interview
Georgina Kilcoyne	HSE West, Roscommon	Children Act Services Manager	Group interview
Paddy Gannon	HSE West, Roscommon	Child Care Manager	
Dick O'Donovan	Foróige, Galway city	Manager	Face-to-face interview
Marie O'Hehir	Foróige, Galway city (the Gaf)	THI project worker	Face-to-face interview
Caitriona Newell	Foróige, Galway city	Former THI project worker	Face-to-face interview
Michelle Reynolds	Foróige, Mayo	Manager	Face-to-face interview
Olivia McGuinness	Foróige, Mayo	Former THI project worker	Face-to-face interview
Siobhan Duane	Foróige, Roscommon	Manager	Face-to-face interview
Denise Kilkenny	Foróige, Roscommon	THI project worker	Group interview
Anne-Marie Kelly	Foróige, Roscommon	Former THI project worker	
Radeen Dunne	Foróige, Roscommon	Former THI project worker	
Seamus Kearns	Youth Work Ireland, Galway	Manager	Face-to-face interview
Maeve Gately	Youth Work Ireland, Galway	THI project worker	Face-to-face interview
John Fitzmaurice	The Gaf Youth Café, Galway city	Manager	Face-to-face interview
Mary Smith	Tuam Health Centre	Community Care Social Worker	Telephone interview
Stephanie Cooke	Ballina NYP, Mayo	NYP worker	Telephone interview
Noreen O' Callaghan	Roscommon NYP	NYP worker	Telephone interview
Geraldine Byrne	Westside, Galway city	Acting Project Leader, Family Support Services	Telephone interview
Mike Dijon	HSE, Roscommon	Child and Adolescent services	Unavailable
Caroline Boyd	HSE, Roscommon	Social worker	Unavailable
Donnacha O'Brien	Foróige - Ballybane NYP, Galway	Project worker	Unavailable
Aine Dunne	Foróige - Ballybane NYP, Galway	Project Co-ordinator	Unavailable

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