



On the Outskirts of the Charmed Circle—Challenges and Limitations of Sexual Health Promotion to Young People in Secure State Care

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Published online: 17 February 2020

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Abstract

Objectives Young people on the verge of, or in, secure state care or incarceration have reduced general and sexual health. The promoting of sexual health among young people in secure state care is therefore a responsibility for both the state-run agency responsible for this care and for the professionals who work there.

Methods This position paper discusses sexual and reproductive health and rights (SRHR) for young people in secure state care in Sweden. Four previous studies on sexual health of young people in secure state care are revisited, and governmental policy documents are examined.

Results Young people in secure state care face many threats to their sexual and reproductive health and rights. Some of these threats originate with the institutional placement itself and the lack of knowledge among the staff. Clashes on various levels between the subjectively desired (young people seeking pleasure from sex, alcohol, or other drugs) and the societally desired (sexual health, minimal alcohol use, and no drug use among young people) are described. In addition, clashes are seen between young people who want to be like everyone else in their social context and the staff with a mission (i.e. job description) to readjust young people into adopting socially accepted behaviour.

Conclusion I argue that young people in secure state care have sexual experiences that are marginalized and placed on the outskirts of the charmed (sexual) circle of societally accepted sexual behaviour. In addition, their experiences are surrounded by silence, a silence sustained by both young people and professionals. The readiness of professionals to handle SRHR for young people in secure state care in a knowledge-based and non-judgemental fashion is crucial. Future research should focus on this readiness and have the needs and wishes of young people as its departing point. Although the article involves a local context, it may be of interest to a wider audience, as the placement of young people in secure state care and other forms of incarceration occurs worldwide.

Keywords Correctional facilities · Incarceration · Institutions · Sexual and reproductive health and rights (SRHR) · State care · Young people

Introduction

It is a Thursday afternoon at the secure institution for young people in state care where I work as a school health nurse, and there is a knock on the door. I open, and there stands Kim. With a wide smile, she cuts to the

chase and says, “I’m on leave this weekend. Can I have some condoms?”

For the first time in almost a year, Kim will spend time outside the institution. She is going to make her first visit to a new foster home. She says that she really wants to have sex with someone this weekend and that it has been ages since the last time. She receives a package of condoms, and we chat about how the weekend might turn out. I try to neither discourage nor encourage her plans but rather just listen. After twenty minutes, she suddenly stands up, grabs the package of condoms and happily rushes away to the ward where she is staying. I hardly have time to call out and wish her a good and safe weekend before she disappears out of sight.

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A couple of weeks pass, and suddenly Kim is at the door again. This time she looks troubled and says, “Damn Malin, I think I have chlamydia”. This turns out to be the case, and when she is on treatment, we attempt to trace the person she met during her weekend of leave so that she can send him a letter advising him to be tested. Kim is irritated. She sighs and repeatedly laments, “This is soooo embarrassing”. When I ask her why the condoms were not used, she says with a miserable look, “I never brought the condoms. The staff at the ward searched my bag before I left, and George took the condoms. He said I can’t have sex since I’m only fourteen”.

Departing from this example, I intend to illuminate how secure state care limits young people’s expressions of sexuality—limitations that can affect their sexual health. Another aim is to examine the conditions for sexual health promotion during placement at a secure institution. The concepts of sexuality, sexual health, and sexual rights are central in this text, and sexual rights are understood to be a crucial part of human rights and a prerequisite for sexual health.

As shown above, I have clinical experience working at a secure institution for young people in state care for almost ten years, up until 2010. However, the empirical material of this paper comes from published research conducted thereafter. Over a period of six years, I have conducted four different studies with young people in secure state in Sweden: a survey on sexual health with 144 young persons aged 15 to 20, 36% girls and 64% boys (Lindroth, Tikkanen, & Löfgren-Mårtenson, 2013), an interview study on sexual health with 9 girls and 11 boys aged 15 to 20 (Lindroth & Löfgren-Mårtenson, 2013), a focus-group study on a sex education curriculum where input from 7 girls and 7 boys aged 14 to 19 were sought (Lindroth, 2014), and a survey on sexual health with 117 young persons aged 16 to 29, 47% girls/young women and 53% boys/young men (Lindroth & Schindele, *forthcoming*; Public Health Agency of Sweden, 2018). All studies had ethical approval from regional review boards and were conducted inside secure institutions run by the Swedish Board of Institutional Care (SiS). Throughout this position paper, data from the two surveys, and quotes from the two interview studies will be used in argument. Details allowing for recognisability of the young persons, including Kim above, are altered, and they are all given fictive names.

Every year, Swedish state-run secure institutions receive approximately 1000 young persons with psychosocial problems, problems of substance misuse and criminal behaviour (Swedish National Board of Institutional Care, 2020). Many have already received non-residential care in their home communities, or care in a foster home or an open residential home. Only when such interventions prove insufficient are young people placed at these secure institutions. Care is provided mainly under the terms of the Care of Young Persons

(Special Provisions) Act and is planned together with the young person, their family, and social services. Methods used are cognitive behavioural therapy, Aggression Replacement Training, Relapse Prevention, Motivational Interviewing, and individual psychotherapy. Some institutions also care for those under 18 years who have committed serious criminal offences and been sentenced to secure youth care under the Secure Youth Care Act (*ibid.*) Youth prisons for those under the age of 18 do not exist in Sweden. Although this article departs from a national context set in a welfare state, it may also be of interest to others. Young people are placed in secure state care, or prison, throughout the world, but their voices from within these correctional institutions are seldom heard.

In the World Health Organization’s definition of sexuality, a respectful approach and the possibility to have safe and consensual sex are central (World Health Organization, 2015). The definition is also strongly connected to sexual rights that shall be respected, protected, and fulfilled. Sexual and reproductive health and rights (SRHR) include among other things, the right to not be discriminated against, the right to sexual integrity, the right to be free from violence and coercion, and the right to education, information, and sexual health care (The Swedish government, 2020; World Association for Sexual Health, 2017). In addition and relevant to the Swedish context, sexual health is one of the eleven public health goals in Sweden, where it is stated that sexuality free from prejudice, discrimination, coercion, and violence is an important health promoter (Public Health Agency of Sweden, 2020). Therefore, the promoting of sexual health among young people in secure state care is a responsibility for both the state-run agency responsible for secure state care and for the professionals who work there.

Sexuality is intertwined with personal values, especially in adults’ views on young people’s sexuality in both private and professional contexts (Foucault, 2004; Males, 2010; Schaub, Willis, & West-Dunk, 2017). In a report on how sexual rights are respected globally, certain groups of people are defined as having an increased risk of not having their sexual rights respected: young people, people in incarceration, people who are migrating, people living with HIV, people with disabilities, lesbian, gay, bisexual or transgender people, and sex workers (World Health Organization, 2015). The report underscores how important it is that those in the surrounding society, such as professionals, do not obstruct the people in these groups from seeking care or support. All young persons in secure state care have at least two of these group categories in common: they are young and they are incarcerated.

In Sweden, the views of young people on sexuality, in contrast to those of adults, have been studied: young people and adults do not always attribute the same meaning to or have the same aim with what would be similar sexual activities (Helmius, 2010). In addition I claim that the timing (the age when they have sex), the setting (under what circumstances

they have sex), and the actual experiences of young people in secure state care differ from what is regarded as conventional sexuality among young people in Sweden today. This can also be illuminated drawing from Rubin's sexual hierarchy where the concept of socially accepted ("good", "normal", and "natural") sexuality and unaccepted ("bad", "unnatural", "abnormal") sexuality or sexual behaviour are described in juxtaposition (Rubin, 2007). A person exhibiting the societally unwanted sexual behaviour is regarded as being outside the charmed (sexual) circle, and this attracts attention. The reaction of society to this can result in that the person's social or physical space may be restricted (Rubin, 2007). The initial example of Kim's experience shows that her desire to have sex before the age of legal consent caused a reaction that restricted her right to pleasurable and safe sexual experiences. This indicates that an incarcerated young person is vulnerable to the views on sexuality that prevail where they are placed, as in, the views of the different adults who work there. Therefore, departing from young people's experiences, it is of the utmost importance to examine the conditions for sexual health and rights promotion during their stay. I do this by focusing on rationality and rewards rather than irrationality and risk (Douglas, 2005). In this perspective, young people are understood as rational actors who gain something of value from their actions, even though their actions contravene what is conventionally regarded as socially acceptable sexuality for young people.

The following section gives a brief overview of studies on general and sexual health among young people in secure state care. Thereafter, a description of the responsibilities of the state-run agency in charge of secure state care, SiS, is provided, followed by a description of gender-segregated care and its possible consequences. Following that is a section on the staff competencies when working with sexual health among young people in secure state care.

General and Sexual Health Among Young People in State Care

Research regarding young people in contact with social services clearly points to reduced physical and mental health and low vaccination rates (Golzari, Hunt, & Anoshiravani, 2006; Rodrigues, 2004; Simpson, 2006). The same was found in one of the few Swedish studies in this area. When 120 children and young persons (0–18 years) underwent a medical exam as part of their social services investigation, every other young person needed to be referred on to somatic, psychiatric, or dental care (Kling, Vinnerljung, & Hjern, 2016). In addition, intellectual and neuropsychiatric disabilities are overrepresented among young people in secure state care in Sweden (Anckarsäter, Nilsson, Saury, Råstam, & Gillberg, 2008; Kullman, 2007;

Olsson & Vilhelmsson, 2007; Ståhlberg, Anckarsäter, & Nilsson, 2010).

Regarding sexual health, sexually transmitted infections, STIs, unplanned pregnancy, experiences of parenthood, and sexual assault are common among young people in contact with social services or the legal system (Ahrens et al., 2010; American Academy of Pediatrics, 2011; Kahn et al., 2005; Svoboda, Shaw, Barth, & Bright, 2012). In 2010, young people placed in secure state institutions in Sweden answered a national survey on sexual health, and inequality was found in the results. Young people in secure state care took more sexual risks and were more sexually exposed and vulnerable compared with their same-aged peers (Lindroth et al., 2013). As a group, young people in secure state care have experiences that threaten their sexual health. At the same time, in research interviews they say that their sexual experiences are something they find to be "worth the risk" because the opportunity for pleasure, comfort, closeness, status, or feeling like everyone else outweighs the potential risks (Lindroth & Löfgren-Mårtenson, 2013).

In a 2016 follow-up survey on sexual health among young people in state care, young adults (18–29 years) placed in state care under the Care of Substance Abusers (Special Provisions) Act were also included (Lindroth & Schindele, *forthcoming*; Public Health Agency of Sweden, 2018). Again, the results confirm unequal sexual health: young people and young adults in secure state care are more sexually exposed and vulnerable than their same-aged peers in the national sample. None of the participants said they were transgender or non-binary, and within the group, the exposed position of girls and young women in state care is striking: far more than their same-aged peers, the girls and young women experience discrimination, endure physical violence and sexual assault, are diagnosed with an STI, receive reimbursement for sex, and are less likely to suggest using a condom or other forms of contraception when having sex (*ibid.*).

Sexual behaviour, sexual ill health, or the risk for sexual ill health is not a prerequisite for placement in secure state care in Sweden. Nevertheless, young people who have committed sexual crimes and been sentenced to care under the Secure Youth Care Act are placed in secure state care, although the number of individuals placed in secure state care is low. In 2016, nine young persons (under the age of 20) were sentenced to secure state care due to sexual offences (Swedish National Board of Institutional Care, 2017a). This paper is not about these specific individuals, but it is worth mentioning that young people who have committed sexual crimes also have the right to information and knowledge, for instance, thorough comprehensive sex education and the right to contraception counselling and testing during their placement.

Previous research clearly exhibits a health disparity and inequality: young people on the verge of, or in, secure state care have reduced general and sexual health. Sexual

behaviours or sexual ill health is not a reason for placement and therefore not a given part of the professional work at the institutions. Nevertheless, the sexual rights of young people in placement must be respected and sexual health must be promoted. Therefore, the existing conditions for promoting sexual health during a placement are of interest and will be examined below.

Equal Opportunities to Sexual Health?

Government Agency Responsibility

In 2016, young people and young adults (16–29 years) placed at secure state institutions in Sweden answered the survey question, “Where have you mainly received information on relations, sexuality, contraception and STIs?” The most common reply was “from friends and acquaintances” (47%), followed by “from the youth clinic” (45%), and “from the internet” (38%) (Public Health Agency of Sweden, 2018). Among same-aged peers, the most common answers were “from the internet (70%), followed by “from friends and acquaintances” (60%) and “from school education on gender and gender equality, sexuality, gender and relations” (55%) (Public Health Agency of Sweden, 2017). This indicates that fewer young people in secure state care claim that they have ever received knowledge, possibly due to absence from school or lack of access to the internet. Moreover, it points to how friends play a key role in their lives, and while in care, they lack access to this most used source of information. Additionally, they cannot easily access a youth clinic while in care, and given restrictions on computer use, they cannot go online to seek information. These constraints during their placement must be counteracted; therefore, it is vital to offer them the knowledge they want within the field of sexuality as well as promote sexual health (e.g. testing, contraception, counselling) during their placement. Two central arenas for this at secure youth institutions are health care and school.

The governmental agency, SiS, state the following about health care: “Health care is not part of our commission. However, we have taken on the responsibility to conduct health care and are therefore caregivers. As caregivers, SiS are responsible for primary and optional health care and we shall abide to current legislation in health care” (Swedish National Board of Institutional Care, 2017b). SiS state that they do not have this responsibility but nevertheless accept it. However, agency guidelines on testing for STIs and on access to contraception for young people’s sexual health are lacking. This indicates that young people’s access to testing and contraception counselling differs depending on what institution they are placed at. Therefore, the health care teams working in the institutions and their views on sexuality and

sexual health promotion may have an impact on how the work regarding these issues is performed.

Regarding school, SiS states that “According to the Education Act all children and young people in Sweden have equal access to education. This also applies to children and young people placed with us. Relevant regulations in the school constitutions shall be applied in our schools” (Swedish National Board of Institutional Care, 2017c). The right to knowledge on gender, sexuality, and relations also applies to all (The Swedish Government, 2020; World Association for Sexual Health, 2017) and is stated in curricula for different school forms (Swedish National Agency for Education, 2020). However, guidelines within SiS on how to provide knowledge on gender, sexuality and relations are lacking. A research-based methods material for comprehensive sex education exists, which was developed in cooperation with young people in state care (Lindroth, 2014). In addition, a handbook for the staff on how to hold norm-critical group meetings exists, in which it is underlined that gender differences, norms, and their effect on sexuality should be broached (Swedish National Board of Institutional Care, 2016). However, information is lacking on if and how these materials are used, and of how young people and the staff (social workers, health care personnel, pedagogues) experience the use of them.

Organized Heteronormative (A)sexuality

Even though sexual behaviour is rarely a pronounced reason for placing a young person in secure state care, sexuality and sexual practices have been an informal qualifier in decisions on placement in Sweden for decades. When Jonsson (1980) examined grounds for placement between 1947 and 1962, gender and sexuality was a major factor, especially for girls. In three out of four girls, notes were made about their sexual behaviour, yet notes regarding boys’ sexual behaviour were rare. Similar unregulated ideas of what constitutes a societally acceptable sexuality for girls and boys was found when court orders on placements in secure state care in Sweden were investigated (Schlytter, 2000). Girls were deemed to break sexual norms to a higher extent than boys were. A more recent study is lacking, but to this day, there is reason to believe that the sexual behaviour of girls has an impact on the decision process leading to placement in state care.

When a young person is admitted to an institution, most are placed on a ward for either girls or boys. Thus, the structure or organization of the institution is both heteronormative and cishnormative, and in addition, desexualizing. Strict girl and boy wards mirror a heteronormative stance that excludes same-sex relations, and originate from the unspoken idea that the gender-separated wards minimize sexual relations. In a study on difficulties and dilemmas among staff working at a secure state institution for girls with experiences of sexual

assault, the concept of a “rest from sexuality” was described. The staff articulated that a “rest from sexuality” could provide the girls with the opportunity to restore their sexuality from a dysfunctional and inappropriate one to a healthy and normal one (Överlien, 2004, p. 72; see also Rubin, 2007). In light of the gender-segregated wards, and its desired desexualizing effect, two out of ten young persons (16–29 years) placed in secure state care define themselves outside the hetero norm. In particular, 28% of the young women and 2% of the young men identified as bisexual (Public Health Agency of Sweden, 2018). If the gender-segregated care is organized with the aim to minimize sexual relations between young people, these numbers are thought-provoking, and the same-sex relations that do exist risk being seen as problematic. However, this is not necessarily because they are problematic (although non-consensual sexual relations can occur at an institution) but rather because they challenge the gendered organization of care that aims for young people, girls in particular, to “rest from sexuality”.

Young people who define themselves as other than heterosexual face risks, especially on wards for boys. In a research interview, 17-year-old Andreas describes how (the other) boys view same-sex relations, and that homonegativity is common among them. He explains that it is important to not come across as gay, and out of this fear, a collective homonegativity is displayed:

Here we are – thirty-one guys, if all were present. If someone, I mean, were gay here, that person would not have an easy time. That’s why the guys clearly state, “We don’t want fags here”. And they are really unsure of themselves.

When organizing care into female and male wards, gender-separated institutions not only risk reproducing traditional ideas of heterosexuality but also reinforce cisnormativity that may exclude transgender and non-binary gendered young people. A young transgender or non-binary gendered person risks being placed on a ward that does not fall in line with their gender identity. In addition, transgender and non-binary gendered young people risk having their gender identity mixed up with their sexual orientation, and this potential lack of knowledge could have negative effects on their sexual health.

Finally, the gendered organization of care to avoid presumed heterosexual relations can also be seen as desexualising. When sexuality is organized to not exist, or at least not display itself, it can be a challenge to be sexual with anyone other than oneself. However, the privacy needed to masturbate can be difficult to find at a secure institution. For instance, regular surveillance occurs, where the staff have the young person within eye contact for shorter (hours) or longer (weeks) periods. For young people about to be discharged from the institution, and for periods of time spent in society

outside, the issue of sexuality can become abruptly actualized. Much like Kim’s experiences in the “Introduction” section, the commuting between worlds—the institution, where sexuality should be abstained from, and the real world, where sexuality may be viewed as important—can be demanding for both the young person and for the staff.

Young People’s Experiences and Staff Competencies

In this section, different areas related to sexuality are examined. I argue that these areas can be troublesome for the staff at secure institutions. Young people in state care can express thoughts and opinions or share experiences that differ from the values or experiences of the staff, in terms of what is legal or from a conventional or societally accepted youth sexuality. When the staff lack education or training in sexual issues or sexual health, personal values or morals may slip into their professional encounters. Kim’s experiences in the “Introduction” section of the paper are a telling example of this. In Sweden, education within SRHR in higher health care, law, police, and social work education is inadequate. In 2016, an examination of the occurrence of concepts connected to SRHR in all higher education in Sweden in regard to qualifying to be, for instance, a lawyer, midwife, nurse, police officer, psychologist, physician, and social worker was conducted (Areskoug Josefsson, Schindele, Deogan, & Lindroth, 2019). The results suggest that these different students—future professionals that young people in secure state care will encounter—receive little training in SRHR. Young people additionally risk meeting staff who completely lack a higher education suitable for youth work. When educational levels among staff working with young people in state care was examined, half had no education relevant for working with young people and a third had no education after high school (The Health and Social Care Inspectorate, 2013). A person who lacks education about SRHR or youth work is left to base their judgements on their personal values, experiences, and knowledge.

In Sweden, 15 is the age for legal sexual consent, and therefore, it is ascribed a certain meaning, especially by adults. At the same time, most young people placed in secure state care have stated in repeated studies that they have had sex before the age of 15. The mean age for their sexual debut is 13 compared with 16 among same-aged peers (Lindroth et al., 2013). When young people in placement were asked about the 15-year rule and if that is something that they have considered when having sex with someone else, most made similar statements like that of 15-year-old Eve:

Naaaah, you do not. You really do not. I did not either.

Eve and others said that sex before the age of 15 is something that “everyone has had”. Seventeen-year-old Ellen says she was eleven the first time she had consensual sex with someone else. She is not sure but thinks she may have been drunk too, as it was around that age that she started using alcohol.

Well, I was so nervous. Shit, I was twelve. I hadn't turned twelve yet, but... and he was nervous too. But he, well, we knew each other. It wasn't anything else, and we had sex just that once. We both felt we wanted to get rid of it. And we knew each other.

Ellen looks back at her sexual debut with someone else as something she and her partner wanted to do. However, she also appears to feel the need to justify her actions. That she does not reflect on the occasion as something negative is, despite being eleven and possibly drunk, an experience she is entitled to. She has this right even if her behaviour breaks the norms for conventional youth sexuality in Sweden today.

In repeated surveys, every other young person in secure state care answers that their last sexual intercourse was without hormonal contraception or a condom, and ever being diagnosed with chlamydia is more common than among their same-aged peers (Lindroth et al., 2013; Lindroth & Schindele, [forthcoming](#); Public Health Agency of Sweden, 2018). Their attitudes to, and potential fear of, different STIs can be a hindrance and may prevent them from raising the issue of screening at the institution. Sixteen-year-old Fanny presents her reasoning:

If I'd get, like, Chlamydia, my world wouldn't fall apart. I would feel disgusted. But if I'd get AIDS or something, HIV or like herpes...I would, well, I wouldn't want to live. I'd be totally destroyed. I would, you know, I would never have sex. I'd join a nun convent or something.

As Fanny's reasoning indicates, the inclination to initiate the need for testing may be low. It might be even lower among those under the age of legal consent, as it could draw unwanted attention to their sexual activities. For a young person diagnosed with an STI, for instance, chlamydia, the obligation to trace the partner is mandatory under the Diseases Act. This can be difficult for several reasons; 17-year-old Andreas tells of how he experienced partner tracing:

Tough! Half of them, I didn't know. I knew their first names, or nicknames. Then there were a couple...you knew, well, you knew she's called this and that, but where does she live? So...yeah, you felt [like], “I have no fucking idea”.

As Fanny's and Andreas' experiences imply, routines for testing and partner tracing for everyone are important and need to be carried out in a non-judgemental fashion.

Young people in secure state care have experiences of pregnancy, or to have had a pregnant partner, to a higher extent than their same-aged peers (Lindroth et al., 2013; Lindroth & Schindele, [forthcoming](#); Public Health Agency of Sweden, 2018). Regarding parenthood, an awareness of what this could entail and of how adults would react, is evident. Some say that an abortion is out of the question, while others feel that it is the only conceivable alternative. Sixteen-year-old Rebecca explains,

Well, I've never ever wanted to have a child. I think it's creepy, with the belly and all. Plus, I'm not mature enough. And if I'd have it, of course, the social services would take it away from me, and I don't want that. I want to be able to, I kind of want my kid to grow up in a safe...I mean, I want to have a lot of money so that I can live, a good guy, and an apartment, and a job. Stuff like that. So, you should be able to take care of yourself before you take care of a child. I think it's wrong, so I would take it away. It might be mean, but...

Rebecca is aware of the exposed situation she is in, and that her hypothetical child would probably be taken into care by social services.

Young people in secure state care have had experiences regarding the giving or receiving of reimbursement for sex more often than their same-aged peers (Lindroth et al., 2013; Lindroth & Schindele, [forthcoming](#); Public Health Agency of Sweden, 2018). Girls are more likely to receive reimbursement for sex, and boys are more likely to pay it. This contrasts with the repeated studies of Swedish high school students, where 2% of the boys and 1% of the girls say they have experiences of receiving reimbursement for sex (Svedin & Priebe, 2004, 2009). To give or receive reimbursement in exchange for sex is an issue that evokes strong emotions and polarized opinions, especially when it concerns young people. When young people in secure state care reflect on their experiences, they do not always see sex for reimbursement as problematic. Nineteen-year-old Fadi tells of what he refers to as “a win-win situation” when a woman in his neighbourhood paid him for having sex with her and he later used the money to buy drugs.

I was sixteen, and there was this girl, or how shall I put it, an older girl, she might have been twenty-three. She was a mum. I remember she had a small child in the room, or in the apartment. So, I was standing there with my friends and she called out to my mate and asked: “Who is that guy?” I mean, she asked about me. Then she said, “Do you want to come up to my place? I can

pay you”. And I needed the money. I checked her out – she was nice and sexy and everything. She wouldn’t have had to pay, but the cash came in handy.

Fadi’s experiences can challenge the more traditional image of selling sex, where (older) men buy and (younger) women sell sex. Therefore, his experience may not be given attention or problematized in the same way as when girls have similar experiences. Ellen has been using drugs for many years and describes her involvement in what can be seen as the trading of sex for drugs, which is something she says others have worried about. She says this is not a problem for her, as she has never been forced to have sex:

Of course, I’ve had sex with almost all my male friends. That’s how we are. And they sometimes offer, they usually offer, me drugs and stuff most of the time. They are a lot older than me. But, I’ve never felt like [how] others see it as, “Well, they’re with you ‘cause they get sex from you”. But if I say no, it is no. They respect that, and I still get drugs from them.

Compared with Fadi’s experience, Ellen’s are more traditional in the sense that she is a (younger) woman receiving reimbursement from (older) men. Perhaps that is why she has been the target of professionals’ worry and concern, which she emphasizes she does not need.

Experiences of sexual assault are more common among young people in secure state care than that of their same-aged peers, especially among the girls (Lindroth et al., 2013; Lindroth & Schindele, forthcoming; Public Health Agency of Sweden, 2018). In interviews, sexual assaults are described as difficult past experiences, but these experiences do not always affect the contemporary sex life. Fifteen-year-old Sarah tells of experiences of sexual violence. When she was 12 years old, she was raped—something she has decided to “not call the first time”. She says, “I took my virginity back” when, at age fourteen, she decided to have sex again—an experience she says she is happy with:

He was very careful, and he knew what had happened to me before and all, so he was thinking about that. He didn’t force me or anything.

Apart from describing how she reclaimed her sexual debut with another partner, she explains that she recently fell in love with another boy and they have sex that they both want. Her experiences, and strategies for handling them, show the importance to not pathologize or ascribe experiences to young people that they do not have, for instance, the idea that they are sexual victims who need to rest from sexuality (see Överlien, 2004 above). Girls placed at secure institutions have experienced that they are placed in the role of a victim—a position

they do not recognize, which they oppose (Vogel, 2017). It is clear that sexually exposed young people must be protected from new assaults, but it must also be acknowledged that sexual trauma is experienced differently. Young people with previous negative experiences can be resilient and have present positive experiences too. Trauma-informed counselling, or to receive information about sexuality, is a right (Fava & Bay-Cheng, 2013; Levenson, 2017). Moreover, no one is obliged to rest from sexuality.

Finally, young people in secure state care have had sex under the influence of alcohol or other drugs to a greater extent than their same-aged peers, and eight out of ten state that they have used prescription drugs (e.g. analgesics, sedatives) without a prescription (Lindroth et al., 2013; Lindroth & Schindele, forthcoming; Public Health Agency of Sweden, 2018). This is not surprising; substance use is one common reason for placement. Therefore, alcohol and drug use need to be approached by staff during the placement. In this work, making the connection between alcohol, drugs, and sex is essential. In a focus group interview with five boys in their late teens, their reflections on a sex education material was sought. As the interview moderator, I described ten different themes or sessions, and when the content of the sixth session on sex, alcohol, and drugs was discussed, the following conversation unfolded:

Ibbe: We’re not even allowed to talk about drugs here.

Malin: No, I can imagine that.

Kevin: The staff, they just – “Noooooo”.

Malin: But I think it’s important to talk about alcohol and drugs – how does alcohol, for instance, affect feelings and sex and how...?

Ibbe: I can’t have sex when I’m drunk.

Malin: ...how do drugs affect feelings and sex? Are there pros to be drunk or stoned when you have sex? Are there cons?

Stani: When I’m drunk, I can have sex for hours. It’s sick, really.

Ibbe: And I can’t get it up.

Stani: I lost my virginity when I was drunk; I had sex for two and a half hours.

Tim: I also lost it when I was pissed.

Kevin: But it can also feel really bad. I know that if I take ‘lad’ and Viagra, if I mix it...

Malin: Lad?

Kevin: Yeah, coke, you know. Then you feel like a porn star. You are, you get totally fucked up.

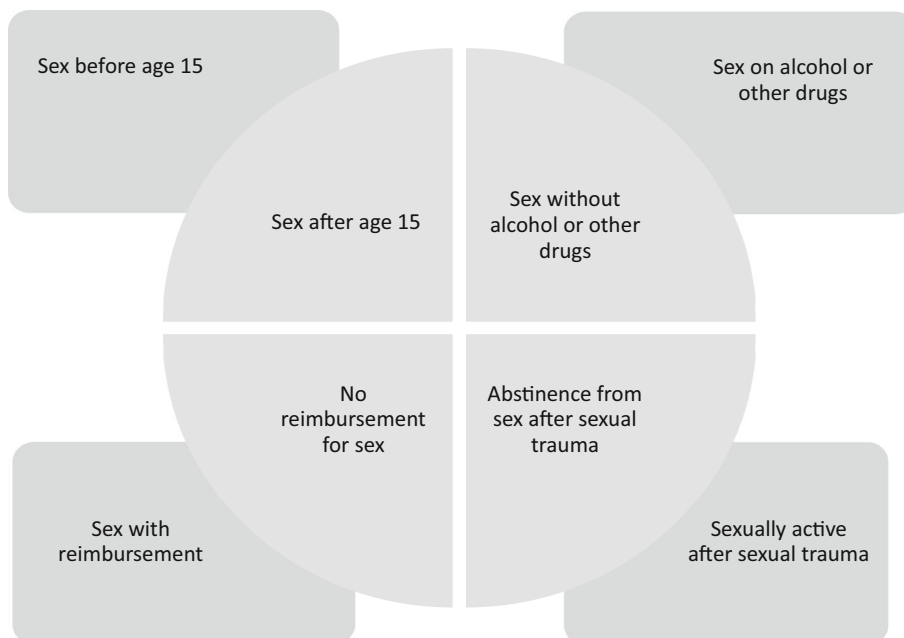
Max: Pump up some X and do your thing.

Kevin: Yeah, and then, if you do it a couple of times, if you do it with the same chick, at parties and so ... then it feels so boring when you don't do it [with drugs] – you feel so deprived when you have sex. Like, what the hell is this? It feels like you've had the best experience, and then when you do it clean, it's just so boring.

The boys discussed what is, according to them, a forbidden subject in a respectful way, and the conversation ended with Freddy receiving supportive advice from the others on how to have good sex without drugs. In this and several other interviews, young people express that they rarely discuss drug use with the staff because “drug talk is forbidden”. They also expressed anxiety about a future drug-free sex life. This implies a double dilemma, where young people are expected to not only rest from sexuality but also refrain from talking about alcohol or any other drugs. Some had almost never had sex clean and tell of how they miss the effect of certain drugs. Ellen explains:

Nowadays, if I'm having sex with someone who's not that good at it, I just [say], “No, I don't want to. This isn't working”. See, when I'm having sex with someone who's not good at it, I miss GHB even more, because even with the not-so-good ones, it was good sex, before.

Fig. 1 On the outskirts of the charmed (sexual) circle: closed Pandora's boxes. Challenges and limitations of sexual health promotion to young people in secure state care



The importance of addressing sexuality when a person stops using alcohol or drugs has been detailed in studies regarding adults (Svensson & Skårner, 2014; Skårner, Månsson, & Svensson, 2016). Much indicates that sex under the influence of alcohol or other drugs is an area where young people placed in secure state care should also be offered professional support.

Concluding Reflections

In this paper, I have illuminated how young people in secure state care have experiences that differ from conventional youth sexuality in Sweden today. They are, using Rubin (2007), outside the charmed (sexual) circle. The reason why these specific experiences have been highlighted is twofold: they are common in this group and they can be difficult for the staff to handle. The experiences that young people see as opportunities for various kinds of pleasure or satisfaction and not necessarily risks, might be viewed differently by the staff who have other references or preferences. In addition, they may lack basic SRHR education.

With support from the empirical data, clashes on various levels between the subjectively desired (young people seeking pleasure from sex, alcohol, or other drugs) and the societally desired (sexual health, minimal alcohol use, and no drug use among young people) have been observed. In addition, clashes are seen between young people who want to be like everyone else in their social context and adults with a mission (i.e. job description) to readjust young people into adopting socially accepted behaviour. A readiness among professionals to handle these clashes in a knowledge-based and non-judgemental fashion is crucial, and future research should focus on this readiness.

Given that most young people are not in secure state care for reasons relating to their sexual behaviour, their sexuality is not to be treated or rehabilitated. Additionally, their sexual experiences and needs should neither be met with silence nor condemned. However, young people can use silence connected to sexuality as a strategy to avoid having their sexuality focused on or problematized. This may be because, due to prior experience, some young people might assume that the professionals will automatically regard their experiences as problematic. In a Scottish context, research shows a tendency among social workers to discuss young people's sexual experiences as problematic or risky even when they were not (Hyde et al., 2016). Moreover, it was shown that sexual information regarding young people in contact with social services was circulated among too many professionals. Young people were aware of this and strategically kept quiet about their experiences and needs (ibid.). Returning to Rubin (2007), it can be argued that young people in secure state care in Sweden have experiences that are on the outskirts of the charmed circle for youth sexuality. This paper outlines four central juxtaposed themes: sex before the age of legal consent of 15 and sex after 15, sex when affected by drugs or alcohol and sex without substances, sex for reimbursement and sex without reimbursement, and abstinence from sex after sexual trauma and continuing to have sex after sexual trauma.

The experiences of the young people in state care appear to not only have been marginalized on the outskirts of the charmed circle but also have been placed in boxes. Young people deem it unsafe to communicate their experiences, and professionals who lack competence may regard these as best left in Pandora's box—not to be opened for fear of what might come out (Fig. 1). For a description of professional fear of opening Pandora's box in another sexual health context involving vulnerable persons, see Wikström, Eriksson, and Lindroth (2018).

Sexual health is an area where young people in secure state care are much more vulnerable than their same-aged peers. It is vital to address this inequality during a young person's placement, as they lack the same opportunities as the young people who are not in placement. It must be ensured that a young person in state care can talk to friends, seek out a counsellor or a school health nurse, visit the youth clinic, or seek out information on the internet without the staff being aware or even required to approve this. Within the group, there is also an inequality; young girls have negative sexual experiences to a significantly larger extent. It is vital that professionals, in cooperation with the young girls, find the right balance between girls as actors in their own lives and the need for protection.

To conclude, sexual rights are universal. Therefore, this paper may be of interest outside the specific Swedish context. It illuminates circumstances in a welfare state where secure care is state-run and some access for outsiders is possible, for instance, for supervision by the Health and Social Care Inspectorate and access for researchers. Young people incarcerated in other

countries with different societal views on youth sexuality and on correctional care may face other adversities. Further adversities may also occur under different circumstances, for instance, in homes run by private corporations operating for a profit and in care where outsiders (e.g. supervisors or researchers) are not allowed. Sexual health challenges that incarcerated young people face worldwide must be acknowledged, and young people's experiences, needs, and wishes must always be the departure point in this enterprise.

Funding Information Open access funding provided by Malmö University.

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