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the  
**health**  
of young people  
in care and leaving care  
in glasgow



the big step  
research report 2001

The full Scottish Health Feedback report is available on request, this includes graphs, tables, detailed demographic information and survey questionnaire.

An executive summary and young persons publication are also available from the big step.

These reports and further aspects of the research findings will also be available for download via the big step website at: <http://www.thebigstep.org.uk>

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# Background to the study

This study was commissioned by the big step (Glasgow Alliance Social Inclusion Partnership for young people leaving care) to examine the health needs and issues of a sample of young people who were 'looked-after' by the local authority in Glasgow. 'Health and well-being' has been established as a key theme for the big step, and this research formed part of a programme of activities in this area. At the same time, health inequalities and young people's access to health services generally, were receiving increasing national attention (e.g. "Walk the Talk", 2000).

It is now widely acknowledged that health inequalities are affected by gender, ethnicity, disability, sexuality, and socio-economic conditions, and that young people who are 'looked after' by the local authority are particularly vulnerable to social exclusion. Addressing health issues as part of a broader agenda to tackle inequalities and social exclusion is reflected in government policy and strategy. The Independent Inquiry into Inequalities in Health chaired by Sir Acheson (1998), established the need for local authorities to identify and address the physical and psychological health needs of young people in their care.

The consensus of recent research involving young people in care is that there is a clearly identified urgency to develop appropriate and accessible health services and information tailored to their particular needs which improves health outcomes. This research is concerned with providing information which will inform the big steps strategic and operational response to the requirements of local health plans where they relate to tackling health inequalities and social exclusion.

While it is commonly assumed that teenagers are generally a fit and healthy group, relatively little is known about their health and the behaviours they adopt that will later determine their health in adulthood (West & Sweeting, 1996). The West of Scotland 11 to 16 Study has begun to address this knowledge gap in Scotland. However, whilst this

research throws light on the health issues for teenagers generally, there is still relatively little known of the particular health needs, issues and concerns of young people with experience of care. A recent study of the health needs of looked after young people in Edinburgh (Robinson et al, 1999), concluded that there were major gaps in knowledge about their health needs and that this should be addressed urgently.

The big step's Health Working Group, which advises and steers the partnership's health activity and development, identified the need to conduct local research to inform and take forward local initiatives, and provided the initial impetus for this study.

## Key Issues

The World Health Organisation (1948) defined health as "a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity" which is also "a positive concept emphasising social and personal resources as well as physical capabilities." Professionals involved in the big step had identified specific health issues before initiating the research and these directly influenced the development of the health survey instrument. In addition to the views of service planners and providers, it was important to obtain an understanding of how young people themselves construct their health experiences and their attitudes towards health and health services. The research literature identified particular concerns in relation to these young people around issues such as access to services and information, mental health, sexual health, substance use, smoking, diet and nutrition, dental health, immunisation, physical activity, and social isolation and support. The missing link was whether young people with experience of care in Glasgow shared these same concerns and issues.

Specific health issues of young people with experience of care Research has found that while general levels of health among 'looked after' young





people are worse than in the general population, they are also less likely to get the services they need or to have their health monitored.

These young people typically experience a high degree of disadvantage before coming into care, and their health in care is a matter of concern (Brodie et al, 1997). Saunders and Broad (1995) found two out of five young people leaving care had long-term physical illnesses.

There is a higher rate of certain behaviours that carry a high risk of long-term ill health and disease such as smoking, problem drinking and drug taking among this group. Some studies have put teenage pregnancy at between 1 in 7 and 1 in 4 (Berridge, 1997). Furthermore, a survey conducted by Save the Children (1995) found that leaving care affected most young people's health badly. Poor diet and mental health problems have been highlighted as major issues for those leaving care. Furthermore, Neate (1996) argued that individuals' health needs while in care are neglected.

Studies have shown high prevalence of mental health problems in looked after young people, and have established a link between the experience of care and poor mental health. Bamford and Wolkind (1988) found the risk of developing mental illness for those who remained in care for any length of time was greater than that of any other group. Other studies maintain that a higher proportion of looked after young people than in the general population have emotional and/or behavioural problems, or have been sexually abused (Department of Health, 1992). It has been suggested by McCann et al (1996) that many looked after young people suffer severe mental health problems that remain undetected. There are established connections between mental

health problems such as depression and substance misuse, and the incidence of self-harm, particularly among young women.

### Access to health services

'Looked after' young people face a catalogue of barriers in accessing health services and appropriate information, guidance and support (Audit Commission, 1994). The problems that have been highlighted include poor record keeping by local authorities and health services; the transient nature of being in care and frequent placement changes; high staff turnover in Social Work Services and lack of training in how to tackle health needs; lack of awareness of young people's health needs generally; inaccessible health services; failed appointments and poor treatment compliance; isolation of residential units from other services; the lack of continuity of medical care; low use of services by young people; and a general mistrust of adults, services and professionals.

Persistent arguments have been presented for a designated person to be responsible for monitoring the health of looked after young people and improving health assessments and recording of health care needs. Ward (1995) showed that parents in the community were more effective in accessing resources on behalf of their child than local authorities were in accessing resources on behalf of children in their care. Despite a wealth of guidance and legislation, young people who experience being in care remain disadvantaged in accessing information and advice about healthy living and there are particular problems with bridging the gap between where young people are looked after and accessing community health services, particularly mental health services. This study aims to add to the body of knowledge about young people's barriers to health while looked after.

## Introduction to the study

Health is an integral feature of the big step Social Inclusion Partnership, particularly as it relates to the partnership's strategic aims in relation to its key themes: independent living/accommodation, education/employment/training and research & information. Responses which tackle health as part of a broad social inclusion agenda, reflect current government priorities and strategies, that aim to address unnecessary and avoidable differences in health status between certain social groups.

Young people who are looked after by local authorities are considered to be particularly vulnerable to systematic and personal barriers to good health, some authors have gone as far to suggest that they constitute 'some of the most vulnerable of young people in society (McCann 1996; GGHB 1997; Acheson 1998). Their health status is considered to be particularly compromised, due to a range of factors relating to their social and family backgrounds and by the very nature of being 'in care'. In this respect they are considered to be a group of young people who are at a greater disadvantage than the general youth population of achieving a reasonable standard of health and development.

The challenge for those concerned with the welfare of young people in and leaving care is therefore, to ensure that young people are afforded the same opportunities and aspirations in relation to their health and well-being as young people looked after at home. The research findings presented here are considered to offer a significant contribution to our existing understanding of young people's health at a local level. This information should be of interest to local policy makers, service planners and service providers and should enable key stakeholders to build upon areas of good practice that are currently taking place. Positive outcomes in relation to young people's health are highlighted and should continue to be developed. However, it is clear that there is a

need for health to be at the top of everyone's agenda when planning and delivering services to young people in and leaving care.

### Aims and objectives of the study

#### Research Aim

The main aim of the research was to broaden the big step's understanding at a local level of the health needs and issues for young people leaving care to inform future health planning and development to ensure that young people are able to make informed choices regarding their health and well-being and can access appropriate services.

#### Research Objectives

In considering both young people currently in care and those making the transition to independence, the research sought to:

- Survey young people about their health behaviours and knowledge
- Identify young people's perceived health needs and issues
- Explore the opportunities and barriers to achieving positive health as perceived by young people

A further aim of the research was to provide information that could be used to 'baseline' the work of the partnership in relation to health to provide a tool in which to monitor and measure the meeting of its objectives. Further consideration is being given to the usefulness of the data in respect of this aim and consideration of particular research issues to determine the desirability of using the data for this purpose. Issues that will need to be considered include: emulating original sample profile; sample size and validity; unknown variables and reliability.



# Methodology

## Involving Young People

The document, "Monitoring and Evaluation Report" (the big step 2000) identified a number of key principles underpinning the big step's overall approach to young people leaving care. These principles included partnership with young people and other key stakeholders, participation of young people and empowerment. It was therefore important that this research adopted such principles in its design.

Determining what young people with experience of care thought about their health needs and the issues of importance to them, was critical if this research was to be of use to planners of future services. Most of what is known about young people's health behaviours has been gleaned from large scale mainstream population surveys painting a generalised picture and framed more often than not from an adult perspective. Information relating to health and young people in and leaving care has tended to involve small localised samples in England and Wales. More qualitative methods have also been fraught with difficulties. This survey attempted to use a mixture of qualitative and quantitative methods to tap into the views and perspectives of young people about their particular experience of health.

The big step had involved young people and their advocates in a pilot of a draft questionnaire, and this approach was continued through involving a group of young people attending a drop-in organised by SW Leaving Care Services at the Launchpad project. This group helped revise the questionnaire and pilot a new version. The research itself draws solely on the views of young people with experience of care, both as respondents to a questionnaire survey and as participants in individual and group interviews. The high number of returns (96) compared to the original target of 100, would indicate that the research was successful in engaging with young people.

## Research stages

The study was undertaken in two distinct phases designed to take place in sequence. Stage one involved a health questionnaire survey of young people looked after and leaving care, carried out during January 2001 to gather a range of information about views of health, lifestyles and health behaviours, use and attitudes to health services, and what information and advice young people needed; stage two involved, focus groups with a sample of young people during March-April 2001 to further explore a range of issues identified by the questionnaire.

## Target population

The target group for the survey was young people with experience of care who were aged 14 years upwards. This is a group of young people who are either experiencing, or would experience in the near future, the transition from care to independent living. A target of achieving 100 questionnaire returns from young people in specific placements was set: 70 from the residential in-care population, and 30 from among those known to Social Work Leaving Care Services (LCS) who were living variously in supported and independent tenancies, with supported carers, in hostels etc. In fact, a total of 96 responses were received. As at December 2000, there were known to be 234 young people in this age range recorded by Social Work Residential Services: of these, 110 were living in residential units and 124 were living in purchased or provided residential school placements in Glasgow. The target was to reach a sample of nearly a third of the total residential population in this age range. The gender distribution of the residential population at the time was equal male and female.

With the agreement of Residential Services, 9 of the 25 units managed by Social Work and two residential schools, one run by Social Work and the other by a

voluntary organisation, were approached. All agreed to participate in the survey. We aimed to reach a representative sample of young people of both sexes and different ages across the selected units and schools.

Since the population of young people in contact with LCS tends to be older than the general population living in residential care settings, the potential target population from this team was aged 16 years and upward. There were 215 young people known to LCS living in a range of different accommodation and support settings. There were slightly more males in this population (51%) than living in residential care settings. A sample of 30 individuals with support workers was sought from LCS, that is around 14% of the total population known to this service. Although individuals living in a range of accommodation types were included in the survey, the main criteria for inclusion after consent was that the young person had a support worker. This of course meant that our sample from LCS was not randomly selected.

## Questionnaires

Young people were given the option of completing the questionnaire and returning it independently, or with help from the Scottish Health Feedback interviewer or their LCS support worker. In the event, a mixture of methods of administration were used including:

- self-completion by the young person unaided and questionnaire returned by post
- self-completion by the young person with the encouragement/support of a residential worker or LCS support worker and returned by post
- self-completion by the young person in the presence of the Scottish Health Feedback interviewer and collected by the interviewer.

Most questionnaires were self-completed by the young person with support from residential or LCS staff, with under 10 completed in the presence of the

Scottish Health Feedback interviewer. A separate form was included with the questionnaire asking whether the respondent would be willing to take part in future group discussions. Those indicating agreement were asked to give contact details, either their own or their social worker, and were sent a letter of invitation to one of five focus groups.

## Focus Groups

The initial response to our invitation to take part in a focus group was encouraging. Thirty-five responses were received indicating preferred times and whether a mixed or single sex group was preferred. Five focus groups were arranged in advance ensuring mixed male and female and single sex groups, younger and older age groups, and people living in the same residential unit could attend the same group.

In practice, the focus groups were poorly attended despite our best efforts. Groups were arranged both at the big step and at residential units, providing a financial incentive and travel expenses to attend, and the provision of food. Places and times that were suitable for teenagers were arranged. Three of the groups took place at the big step offices in Candleriggs, while one took place at a residential school and another at one of the residential units. Half the number planned (14 rather than 30 young people) took part in these groups. The same focus group facilitator was involved with all the groups, as well as individual interviews when only one young person turned up.

The experience of this research would strongly suggest that focus groups have limited effectiveness as a method for gathering the opinions of looked after young people. However, despite the small numbers participating in focus groups, some interesting information emerged. Nevertheless, there was a sense that participants were closely guarded and suspicious of the researchers whom they were meeting for the first time, perhaps of why the questions were being asked and what might happen to the information. For future exercises of





this kind it would be worth considering building in more time to establish rapport, trust and involvement and/or working with established groups through known and trusted people/staff. One of the main reasons for establishing focus groups was to attempt to involve a wider range of young people than were currently involved in existing groups, but this was only achieved in a limited way.

Each group addressed one issue in detail that had emerged from the questionnaire survey. Topics were influenced by the findings from the questionnaire but were centrally interested in exploring young people's perceptions of health, being healthy and what improves health; lifestyle issues, health and independence, views of health services and social aspects of health. Two groups had only one person attending, which necessitated individual interviews; another had seven participants (at residential school); another had three participants (residential unit); and the fifth was a paired interview.

**Access to young people with experience of care**  
The study necessarily relied heavily on the good offices of Glasgow City Council Social Work Services, and of individual Resource Workers within its Leaving Care Services to arrange identification of, and the initial approach to young people. There were practical difficulties concerning research access due to two main problems and this set back the research by around six weeks. Firstly, a number of other research studies were taking place, including a major national study of arrangements for leaving care, which placed heavy demands on Social Work staff, and at around the same time as quality measures and best value review studies were being undertaken. Second, LCS was moving offices, which caused additional practical difficulties for workers.

Meetings were arranged with staff from both LCS and Residential Services to discuss the research with them and how to access young people known to their services. Information about the in-care population was obtained through Residential Services. A poster and leaflet were designed by the big step and Scottish Health Feedback to be distributed before copies of the questionnaire were sent out. These were discussed fully with Social Work staff.

**Attracting and keeping young people's attention**  
In order to attract young people and keep their attention it was imperative that they were treated with respect and that the survey was relevant to their situation and concerns. A better response was anticipated by ensuring that the purpose of the questionnaire and focus groups was clear and relevant to young people's own agendas. We attempted to do this by:

- Ensuring topics addressed by the questionnaire were relevant and appropriate to the concerns and issues of young people. A balance had to be struck between gathering the detailed level of information sought by the big step and ensuring the process was straightforward and the questionnaire was not too complex or overly long;
- Ensuring there was an explanatory statement at the beginning of the questionnaire explaining the aims and objectives of the research, the importance of hearing their opinions, and how the results would be used by the big step to support looked after young people more effectively;
- Making a researcher/interviewer available at specified times in the residential units and other agreed venues to explain the purpose of the survey as above, briefly going over how to complete the questionnaire, answering any questions, and making arrangements for collection of completed questionnaires and the distribution of vouchers.

## Profile of survey respondents

### Gender & age

Ninety-six young people with experience of care in Glasgow returned our questionnaire. Of these 53% were male and 47% female. This closely reflected the known gender distribution amongst the residential population at the time, which had equal proportions of male and female residents, while the known Leaving Care Services population was 51% male and 49% female. Comparing respondents with the known populations in residential care and those supported by LCS, shows that while the gender profile of respondents compares well with the overall residential population, a higher proportion of males known to LCS than might be expected were approached and responded to the survey.

Fourteen young people who responded to the survey took part in focus group discussions about aspects of health issues raised by the questionnaire responses: that is, eight females and six males.

Respondents' ages varied from 14 years (17%) to 19 years or over (19%). The age profile of respondents who were living in residential care compared well with the overall residential in-care population. Although the age distribution was also similar for LCS sample, 10 respondents were aged 15 years, when statistics obtained by the big step from LCS, which were used to draw the sample, did not identify any 15 year olds. Four of the 18 respondents over 19 years known to LCS were aged 20 years or over, and two of these were aged 24 years. The survey therefore had reached a cross section of young people of different ages. The mean or average age for both males and females was 16.5 years, while the most common age was 15 years (26% of respondents).

### The experience of being 'in-care'

Out of the total questionnaire respondents, 74 identified themselves as being "in-care". Excluding those living in residential schools or units (54 individuals), and a further six who were either in foster care or with supported carers, a considerable number of young people (14) who technically must have left care, considered themselves as 'in-care'. This included some of those living in supported tenancies. One explanation is that even though agencies classify such young people as having left care, because they are still on supervision or being supported by LCS or a voluntary organisation such as Barnardos 16+ Project, they define themselves as being 'in-care'.

Questionnaire respondents were living in a range of settings, but predominantly in three main placements: children's or young people's units (29%), residential schools (27%) or supported tenancies (21%). Clearly, how the sample was drawn through the Residential Services and LCS had a significant bearing upon the spread of placements across the respondents. Given that 81 young people living in residential care settings agreed to complete the questionnaire, the bias towards those in children's units or residential schools among respondents is unsurprising.

The length of time in the current placement was typically under two years; in fact, over half had been in their current placement for under one year. In contrast, only 10% had been in care for under a year in total and the total length of time in care generally was three years or more. A problem identified by previous studies is that of maintaining the health of looked after young people when there is lack of continuity of carers, with the result that no one member of staff is consistently responsible for keeping a check on health. This finding suggests that lack of continuity was indeed a feature of the lives of the survey respondents.



# Where Young People Live

To obtain a general impression of respondents' views of their current placement, they were asked to indicate their feelings by circling one of five happy-unhappy faces in response to the question 'how do you feel about where you're living now?' The findings are summarised below.

Just over half (54%) circled either a happy or very happy face. This positive view was most consistent among those living in supported tenancies - "it's good to have my own independence" - and least positive for those living in residential care settings - "I hate it and I don't feel right staying here". Just under a fifth (17%) indicated that they were unhappy or very unhappy with their current placement. More than half of these were living in either a residential school or young people's unit (10 respondents).

In all placements, at least one person felt unhappy suggesting that satisfaction with placements is associated with a range of other factors external to the placement, including how respondents felt about being separated from family and friends. There were for example, contrasting views about life in residential care settings: ten young people were unhappy with living in either a residential unit or school, while an equal number felt very happy with this placement (that is, 7 living in residential units, and 3 living in a residential school). A third of those in residential care settings felt neither happy nor unhappy.

The quality of relationships with staff and other young people living in the same setting was a critical factor influencing the overall quality of the experience. Views about staff ranged from being "supportive" or "they care for me" to "staff can do your head in". The experience of separation from family and poor links with natural families was a major problem for the young people in the survey. Young people complained that, "I hardly get out to

see my family"; "I miss my family, friends and freedom"; and "most of the time I want to be with my mum." Comments were made about the importance of making friends in care and its impact on feelings about the placement:

*"I can talk to everyone about things and everyone sticks together like a family"*

A general comment about residential placements was that it was just "not that good". Some "did not like the care system", and complained that "it's boring a lot of the time" or "life could be better". One person living with a supported carer was very unhappy in this placement because "I need my own space and they still treat me like a child". Comments made by those living in the secure units at a residential school tended to be neutral, typified by the comment, "there are some good points and some bad points". Though one person felt they had "been in better", another felt that "it's the best place for me at the moment."

In general, those living in supported tenancies were happiest with their placement. They received the support they needed and liked the independence of having their own place:

*"We live in a big flat in a brilliant area. We have all the freedom we need and we only pay a small amount of rent!!"*

However, some supported tenancies were in areas that were environmentally poor and some had "neighbours who are a pain". Moving into a supported tenancy in a familiar area such as the one the young person had grown up sometimes had a negative effect on well-being - "I know that in this area I tend to self-destruct."

# Perceptions of Health

## How healthy did they think they were?

To measure perceptions of health overall, the questionnaire included a general question, 'how healthy do you think you are?', and invited the following responses: very healthy, quite healthy or not very healthy. The question was taken from the Scottish Health Behaviours of Scottish Schoolchildren surveys (Currie, Todd and Smith, 1999) and had been used in other local surveys. Another question asked 'how fit do you think you are? - very fit, quite fit or not very fit', and this was taken from the Glasgow 11 to 16 Study (West & Sweeting, 1996).

Overall respondents felt that they were healthy and fit: 80% of respondents felt they were quite healthy or very healthy, while a slightly lower percentage considered themselves to be quite fit or very fit (78%). This is in contrast to the findings of other studies. In 1999 Fast Forward Positive Lifestyles cited in 'Walk the Talk' (2000), found that young people excluded from mainstream activities generally perceived themselves as unhealthy and "saw their unhealthy lifestyle choice as a necessary response to the pressures of their lives" (page 8).

Why respondents in this study should consider themselves fit and healthy in the face of other contradictory evidence may in part be explained how they understood the notion of 'health'. Respondents defined being healthy in terms of good physical health or as the absence of disease. In their terms, it meant being fit, good looking, and feeling energetic - "living a long life without a lot of illness", having "white teeth, wholesome foods and rosy cheeks", and "being full of energy and life".

Although some questionnaire respondents said that health "means a lot to me", the overriding conclusion was that 'health' as a concept did not hold much significance for them - "it means nothing to me, can't relate to it" was a typical comment. It was also difficult to get any discussion going about health in the focus groups. Physical fitness, healthy eating and physical attractiveness were the key dimensions of health they related to most. This

finding supports earlier research by Shucksmith et al (1997) that young people generally do not perceive health as a major life concern in the same way most adults perceive their health status. Perceptions centre on personal and physical appearance and maintaining a slim physique.

One respondent commented that the experience of care in general can adversely affect young people's health: "health means keeping fit but I don't feel fit in care." Taken together with other findings about lifestyle issues reported elsewhere in this report, it might be concluded that there is only a limited focus on health while young people are in care. There was an alternative view however, that being looked after afforded new opportunities for being healthy:

*"In care you're healthier than others 'cause if you're on the streets you're in an out the chippies an' that."*

## What promotes health?

Respondents overall appeared knowledgeable about the factors health educators might identify as promoting or demoting health. This included aspects of positive mental well-being such as personal achievement, praise and contribution - "helping someone with a problem" or "being happy" - and social aspects like "having good friends", as well as general lifestyles issues such as eating the right foods, taking exercise, and good personal hygiene. However, this was not entirely mirrored in responses to completing the sentence "I feel good about myself when..."

Although feeling fit and taking exercise, eating the right foods, positive encouragement and good friends did feature, what was also mentioned was how taking drugs and drink helped them to feel good: responses included feeling good about myself "when I'm mad wae it", "when I'm steaming", "I'm

stoned", or "when I smoke a joint". In addition, respondents touched on aspects of social deprivation - as more than one respondent said "having money" was important to feeling good.

### What demotes health?

The list of respondents' perceptions of what demotes health, or what makes people unhealthy, included taking drugs, too much alcohol, junk food and lack of exercise. In this list a number of other issues appeared related to aspects of social exclusion or deprivation and social stressors. Unemployment, not having enough money, and problems in relationships with other people were identified as negatively affecting health.

One theme to emerge was the profound impact that getting into trouble with the authorities and problems in family and other relationships had on their feelings about themselves: "feel bad about myself when I'm horrible to someone"; "I start shouting at my dad"; "I take my anger out on someone else"; "I have let someone down"; "when I do bad things"; "I f...k up with my family or the police". They were also clear that a poor diet, lack of exercise, smoking and drinking too much, affected how healthy they felt. However once again, not having drugs contributed to feeling bad. The situation of being in care itself, coupled with feelings of boredom and not having any money, combined to negatively affect health.

As one person aptly reflected, "You get unfit a lot easier", hinting that other factors including social and environmental factors have a strong influence on whether healthy choices are made. This suggests that the main issue is not simply one of health education but of tackling the underlying psycho-social causes of adopting unhealthy lifestyles. In other contexts, for example in relation to slimming diets, several authors have offered powerful psycho-social explanations about why people choose unhealthy options when they have the knowledge of what is good for them (Goldin, 1995). Efforts to

support young people with experience of care in making healthy living choices should therefore attempt to address the underlying psycho-social reasons for poor motivation.

### Summary of findings

- Four out of five respondents felt they were "quite healthy" or "very healthy", and a similar proportion felt they were "quite fit" or "very fit";
- The key dimensions of health that young people with experience of care could best relate to were physical fitness, healthy eating and physical attractiveness;
- Role models for 'good health' tended to be remote superstars or athletes, which suggests that good health may be perceived as something that is difficult to obtain;
- As well as eating the right foods and taking regular exercise, having friends and receiving praise and encouragement were thought to promote health or 'make you healthy';
- Conversely, eating junk foods, not exercising, taking drugs, alcohol, smoking, and not getting on well with other people was thought to demote health or 'make you unhealthy'. In addition, not having a job or enough money was also bad for health;
- Respondents felt good about themselves when they adopted healthy lifestyles, when they ate properly and exercised, but also when other people praised and encouraged them and when they had enough money. For some, they only felt good when they took drugs or drank alcohol;
- They felt bad about themselves when they got into trouble with authorities, had problems in their relationships with family and other people, when they were bored and when they didn't have any drugs

## Mental Health

Research evidence suggests 'looked after' young people are vulnerable to poor mental health. Studies have found a high degree of emotional or behavioural problems among this group. Others have found a high incidence of psychiatric disorder and evidence of persistent mental health problems (Robinson et al, 1999).

### Depression

The questionnaire used a measure of depression, a 10-item scale by Kandel & Davies (1982), who had used it with American teenagers. Sweeting & West (2000) had also included it in the 11-16 Study with Scottish teenagers. Although the depression scale should not be taken to measure specific, diagnosable, mental health problems, it is considered a reliable indicator of mental distress. It asks respondents how often in the past month (most of the time, sometimes, never), each of the following occurred: felt too tired to do things; had trouble going to or staying asleep; felt unhappy, sad or depressed; felt hopeless about the future; felt tense or nervous; and worried too much about things. A score between 10 and 30 is calculated for each respondent.

The results showed a youth population with high levels of possible depressive illness, which may be going undiagnosed given only four of the respondents had been identified as having mental health problems. Using the same cut off point as other studies (scores of 21.7 or more), the incidence of depressive illness was far higher than in the Kandel & Davies (1982) clinical samples of depressive mood in adolescent populations. Overall, 28% were found to be highly depressed compared to 18% of the American teenagers. More females (33%) than males (23%) were highly depressed or at risk for diagnosis of major depressive illness.

Younger teenagers had the highest scores though not exclusively: 75% of males and 64% of females aged 16 years or under had scores of 23 or more. Most (78%), though not all, of these younger females lived in an institutional setting, including young people's units, residential schools or hostels. Males who scored high

on the depression scale were living in a range of settings. Respondents' scores were high for both males and females aged 14-15 years compared with 12-15 year olds in Greater Glasgow NHS Board's New Community Schools Survey (2001). While 7.1% of males and 14% of females aged 14 years in the New Community Schools Survey had high scores, 17% of males and 55% of females of the same age in this survey did. Similarly, while 6.3% of males and 15.4% of females aged 15 years had high scores in the New Community Schools Survey, 23% of males and 27% of females of the same age in this survey had high scores.

In summary, both male and female respondents in this study had high negative scores for many items when compared with other teenage populations, but particularly in terms of feeling hopeless about the future and having trouble going to or staying asleep. Males scored highest on both these separate items, and in addition were more likely than females to say they felt unhappy, sad or depressed in the past month, or that they worried too much about things.

### Self esteem

An adapted Rosenberg (1965) measure of self-esteem was used in this questionnaire. The scale comprised ten items with four options (strongly agree, agree, disagree, strongly disagree). Respondents were asked how much they agreed with the following statements: I am pretty sure about myself; I often wish I was someone else; I am easy to like; I have a low opinion of myself; I am a failure; There are lots of things about myself that I would like to change; I am able to do things well; Most of the time I am satisfied with myself; I like myself; and I feel I have a number of good qualities. The copy sent to SHF however missed off the last item. Consequently nine items rather than ten were included in the questionnaire. The final scoring of the scale has had to be adapted accordingly so that the maximum score is 27 rather than 30. In view of this adjustment, and because respondents were not exposed to the full scale, the results should be treated with a degree of caution, particularly when making comparisons with other studies.





In spite of the stated margin error, the self esteem scores provide an interesting proxy measure of self esteem among the respondents. The average score for both male and females was between 15-19. Females tended to score lower for self esteem than males, especially those under 16 years. Males living in supported tenancies tended to have the highest self esteem scores. Females in all settings tended to have low scores. When compared with other teenage populations the respondents in this survey are a low self esteem group: 25% of respondents scored 20 or more on the self esteem measure compared to 56% of teenagers in the 11-16 Study (Young et al, 2000).

## Self-Injurious behaviour

A worrying proportion of respondents (45%) had deliberately self-harmed at some point in their lives, and a third of these (37%) had asked for help. While some had sought and received help, others did not need help, as they no longer harmed themselves. They looked to family, friends, staff, or "anyone" for help.

Females were more likely than males to deliberately harm or injure themselves: the ratio of those who deliberately injured themselves was 3 female to 2 male respondents. It was also most common among younger teenagers, that is 14-15 year olds and again, particularly younger females. Those who deliberately self harmed were living in a range of settings but predominantly young people's units or residential schools (70%). This was more the case for females (in 73% of cases of self harm) than males (47% of self harm cases).

With the caveat that scores obtained from the measure of self-esteem are to be treated with a degree of caution, a link was found between self-injurious behaviour and high scores on the depression scale in over a third (37%) of cases. The link with low self-esteem was even more staggering, with 85% of those who had self-harmed scoring below 20 on the Rosenberg self-esteem scale.

## Summary of findings

- There were high levels of depressive illness as measured by a self-reported Depression Scale especially among females and younger teenagers. Depression scores were high compared with both the 11-16 Study and the New Community Schools Survey samples, especially for 14-year-old females. While 14% of females of this age in the New Community Schools Survey had high scores (21.7 or more), this compares with 55% of 14-year-old females in this survey;
- The average scores for 75% of respondents for self-esteem as measured by the Rosenberg scale were low, that is, between 15-19. Just 25% of respondents scored 20 or more compared to 56% in the 11-16 Study by Young et al, (2000). Females under 16 years had the lowest self esteem scores;
- 45% of respondents had self harmed or injured themselves at some point in their lives, and a third had asked for help in relation to this behaviour;
- They mostly wanted help from family and friends, but also staff, and some would accept help "from anyone";
- Females were most likely to deliberately self harm, especially younger females aged 14-15 years;
- Those who self-harmed were predominantly, though not exclusively, living in residential care settings (70% were in young people's units or residential schools);
- There was a link between deliberate self-harm and depression in 37% of cases, and with low self esteem in 85% of cases

There is growing concern over the diet of young people generally. Eating habits established in early life set the scene for chronic diet-related diseases such as heart problems and obesity in later adult years. A recent survey of school meals and healthy eating conducted by Scottish Health Feedback (Ridley et al, 2001), found that school pupils generally tend to eat unhealthily. Other national surveys of diet and nutrition have similarly found that the most popular types of foods with young people are fast foods and this is coupled with a growing problem of childhood and adolescent obesity.

## Control and Choice

A survey (Market Research Scotland, 1998) that specifically focused on the concerns of residential childcare workers, found that choice of what to eat in residential care settings was generally left up to young people. They felt it was particularly difficult to encourage children to eat more fruit and vegetables and were reluctant to adopt an interventionist approach in this setting. Many children had not eaten vegetables and fruit before coming into care. In reflecting current national recommendations that a healthy diet should contain five portions of fruit and vegetables every day, we asked young people in this survey to indicate the number of pieces of fruit and vegetables they ate daily. This could include fresh, frozen or tinned fruit and vegetables and fruit juice.

Around a third (32%) of respondents did not eat fruit at all, another third (33%) had one piece of fruit a day and the remaining 35% ate between two to five pieces of fruit a day. A similar pattern emerged with the amount of vegetables consumed daily: just under a third (29%) did not consume vegetables at all, while around a third (34%) ate one portion of vegetables daily, and just over a third (37%) ate two or more portions. The 11 to 16 West of Scotland Study found those teenagers who ate less healthily also did little or no exercise. In this survey, 22 out of the 29 who did not take any exercise also either did not eat any fruit or vegetables at all, or only ate one portion a day. There was little difference between male and female respondents, except males reported eating fewer vegetables.

Over half the young people (54%) reported that they chose what they ate most of the time and a further 34% did so some of the time. Only 12% of respondents either hardly

ever or never, chose what they ate. Those who had less control and choice were living in residential schools, including those in secure units. They had the opportunity to cook for themselves: that is, 53% said they were able to cook quite often and 36% were able to cook some of the time. Having both the choice of what to eat and the opportunity to cook however was no guarantee that young people would choose healthy eating options, quite the reverse in fact. Making healthy choices is largely dependent upon having the knowledge and awareness of what 'healthy eating' is, and having access to healthy foods. Two out of five in our survey did not receive any advice or information on healthy eating, and a third of respondents did not get any advice or help on how to cook. 70% received help with budgeting, but not all had any help with shopping for healthy foods. As the majority (68%) did not shop for their food, this is perhaps unsurprising.


## Perceptions of Weight

The questionnaire asked respondents how happy they were with their current weight. Three out of five were happy with their current weight, with only 8 respondents saying they were on slimming diets, 6 of which were females. Of those who were unhappy with their weight, slightly more had a problem with being underweight: 53% felt they were underweight and 47% felt they were overweight. Young women in general worried most about being, or becoming, overweight: "It's mostly lassies that worry about their weight because they think they're fat, they always see the models on telly and that and they're all pure skinny." (female, 16 years)

## Summary of findings

- While 35% ate between 2-5 portions of fruit and 37% ate 2-5 portions of vegetables daily, around one third didn't eat any fruit or vegetables at all and many ate very little. These same individuals tended also not to take any or much exercise;
- Generally, females ate a healthier diet. Males ate fewer vegetables but ate similar amounts of fruit to females;
- Respondents were able to choose what they ate & often cooked for themselves, but had less guidance on how to eat healthily. They received more help with managing on a budget than with shopping for healthy foods

# Physical Activity



This survey was interested in measuring general levels of physical activity. We asked respondents to say how often in the past week they had taken part in any sports or exercise that had made them breathe harder or sweat - never, once, twice, 3-4 times, or 5 times or more, without distinguishing between activities in or out of school. We also asked for the average length of time they spent exercising, and asked them to identify from a list, the types of activities or sports they took part in.

## Levels of Activity

The overall level of physical activity was low, especially among female respondents. Just over one third (34%) of respondents never took part in any exercise or sports, and three out of five of these were female. Nearly three quarters of those who only took part in exercise or sports just once a week were female. Young et al (2000) found that participation in all common sports except running or jogging decreased between 13 and 15 years, and that females and smokers were less likely to engage in any form of exercise. This survey found males to be twice as likely to take regular exercise and for longer periods.

Of those taking some form of exercise, 62% were exercising for more than thirty minutes at a time, which is not surprising given the most common types of physical activity were football (43%), swimming (34%), running and jogging (32%).

## Barriers to Exercising

There was evidence that respondents wanted to be more active. One young male wanted to play football but couldn't because the young people's unit he lived in "didn't have a ball". The common types of

activities they wanted to do, but couldn't for whatever reason, were activities such as football, running, cycling, dancing, and basketball. Others mentioned activities such as ice skating, roller-blading, kick-boxing, snowboarding, bungee jumping and sub aqua.

One in four or 25% were not interested in physical activity or sports. Being pregnant and living in units was a barrier to being more active for two young women aged 16 and 17 years, both living in the same unit - "I'd love to do gymnastics but I'm pregnant and I have no money". There were a number of other barriers to participation in physical activity or sport, most significant of which was the cost, both of equipment and fees. This was a particular obstacle for those in supported tenancies. Half of those who identified cost as a barrier were living in supported tenancies. Some young people couldn't afford basic equipment; for example, a 19 year old male wanted to go cycling but couldn't afford a bicycle, others couldn't afford the fees to visit a gym or take part in martial arts. Getting the support needed and physical access to public facilities such as a gym were a problem for a 19 year old male who was visually impaired.

## Motivation

The limiting factor for a quarter of respondents was a lack of motivation, they were "just not interested". The vast majority (88%) of these were also smokers and living either in a young people's unit or residential school (64% of respondents). The motivating factor for many young women was the desire to have a slim physique: "you don't want to get too fat do you" and "it's important to keep fit and exercise the body." From the discussion with three young women aged between 14-16 years, and

one young man aged 15 years, being in care created barriers to becoming more physically active. All felt they had been more active before coming into care, either because they had access to facilities such as a swimming pool when they were living at home and they no longer had this, or staff or other residents in young people's units did not encourage them to take part:

*"We're always too busy or there's not enough staff on, or other people misbehave then they don't let other people go."* (female, 14 years)

*"Say you're wantin' to play football, some people'll go 'Oh, you're crap, canna play football', it puts them off. They find somehin' else interestin' to do."* (male, 15 years)

Market Research Scotland (1998) have further suggested that a "culture of using taxis" and a feeling among staff that looked after young people could be "very lazy", expecting to be driven even to places that are near, inhibits young people's participation in physical activities.

## Summary of findings

- The survey found low levels of physical activity across the whole sample, and evidence that the experience of care was a barrier to being more active;
- Those who were least likely to engage in physical exercise or sports were females and smokers of both sexes;
- Barriers to participation in physical activities included the prohibitive cost of equipment or fees particularly for those in supported tenancies; needing support and help to join in activities; low levels of motivation; and features of life in young people's units or residential schools including staff and other residents' attitudes that deterred individuals from adopting more active lifestyles.

# Sexual Health & Relationships

Sexual health services, in conjunction with sex and relationships education, is known to delay the age at which young people start to be involved in sexual activity and can reduce teenage pregnancy rates (NHS Centre for Reviews and Dissemination, 1997). Access to information, guidance and support on sex, sexuality and relationships is also crucial to young people's development as adults. Barriers to young people accessing this support and information whilst in care are known to exist. Many young people have histories of sexual, physical and emotional abuse which can contribute to a distorted view and understanding of sex and personal relationships (Patel-Kanwal and Lenderyou, 1998). Young people may also lack the necessary social skills and confidence to access appropriate services and information and in which to negotiate positive personal relationships. They are also more likely to have missed school-based sex-education as well as guidance and support from parents and families (Teenage Pregnancy Unit 2002).

In this survey there appeared to be a gap in information and advice on sexual health generally. Apart from information/advice about safer sex, the spread of information about the broad topic of sexual health appeared patchy. Furthermore, it was reported that those in contact with family planning or contraceptive services within the past year were in the minority (just 28% of respondents) and 40% of respondents did not know where the nearest young people's sexual health or contraception service was.

Young people with experience of public care are known to experience early pregnancy and be vulnerable to sexually transmitted infections. Figures for teenage pregnancy show that young women at highest risk of unintended pregnancy and teenage motherhood are likely to have had experience of being looked after away from home (Biehal et al, 1992). The Biehal study indicated that 25% of young women were mothers by the time they had ceased to be looked after, compared to a national average of 3% for young women aged 16-19yrs.

This survey indicated that twenty-six percent of respondents 'often worried' about getting pregnant or getting their girlfriend pregnant. Another 36% worried

about this 'sometimes' and the rest did not 'usually worry'. Although contraceptives were known to be widely available in public toilets and chemist shops, some young men did not know where to get condoms or were embarrassed to buy them:

*"My pal's sister she's going out with a boy just now and he didn't have a clue where to get condoms. I mean my pal's sister just said 'you're so stupid. She took him to a chemist and said to him you get them right here and he's saying right. She leaves him in the chemist and a few minutes later he says there weren't any and they had a big stack of them, when he was saying they never had any."*

One young woman told us that she had learnt about sex from another young person in care who was pregnant:

*"When C found out that she was pregnant she was a bit panicky. She found it a bit hard to take in...She taught us about sex. H and C sat in the hall with me and they explained everything about sex."*

Taken together, these findings suggest that more information, guidance and support on sexual health and relationships and contraceptive services could be targeted to good effect at teenagers with experience of care. Interventions need to take into account the particular backgrounds and experiences of young people.

## Summary of findings

- the survey found gaps in young peoples access to information and advice on sexual health generally and safer sex in particular;
- 40% of respondents did not know where the nearest young people's sexual health or contraception service was;
- the survey found that a significant number (26%) of young people 'often worried' about getting pregnant or getting their girlfriend pregnant and another 36% worried about this 'sometimes';
- barriers to accessing condoms were evident, particularly amongst young men.

# Smoking

Other recent research has found marked increases in smoking and drinking among young people generally, with significant increases in the proportion of girls taking up smoking (Currie et al, 1999). In the present survey, 75% of respondents smoked. While the majority of smokers (73%) first started smoking before going into care, just over a quarter started while in care. Slightly more females were smokers (79% of females compared to 73% of males smoked).

The majority (71%) of all smokers were 16 years or under. Seventy four percent of female smokers and 69% of male smokers were in this age range. The highest number of smokers were aged 15 years (23 or 33% of smokers). This trend is echoed in the findings of the Glasgow New Community Schools Survey (GGNHSB 2001) but is more exaggerated in this survey. The New Community Schools Survey found 13% of males and 25% of females aged 14 years were smokers. In this survey, 100% of males and 89% of females of the same age were smokers. Furthermore, while 15% of males and 24% of females aged 15 years were smokers in the schools population, this survey found 93% of males and 100% of females of the same age to be smokers.

Given that one in four young people had taken up smoking while they were in care, and that other research (West and Sweeting, 1996) finds the most frequent reason teenagers give for having tried their first cigarette is 'to see what it was like' and to fit in with peers, these findings are a cause for concern. Young people commented in focus groups that they smoked "'cos they're stressed out that they're in care" and because smoking "keeps me happy". Whether they smoked or not depended on whom they were with:

*"Boys do it to act hard and all that, and lassies just do it to be part of the gang."*

*"It all depends what kind of people you hang about with an' all. If your pals don't smoke then you won't but if your pals smoke then you will."*

Lower levels of smoking have been found in the general teenage population. For example, the 11 to 16 Study

(Young et al, 2000) found just over a fifth of teenagers (22%) were regular smokers, although this increased to 25% at 15 years. Surveys of secondary school pupils in England (Haseldon, 1997) have found lower levels of smoking (19% of pupils), while surveys in Scotland have found higher general levels of smoking among school pupils, as shown by Miller and Plant (1996) who found that around a third of pupils aged 15 to 16 were smokers.

Just over half (52%) of smokers wanted to stop and wanted more information on how to quit smoking. Two respondents who reported using cannabis every day did not consider themselves tobacco smokers. Neither did six others who used cannabis regularly but less often than weekly.

## Summary of findings

- The survey found a high rate of smoking among the respondents. Three out of four or 75% were smokers, which is significantly higher than rates found by other surveys of teenagers;
- Slightly more female respondents were smokers than male (79% of females compared to 73% of males). The majority were aged under 16 years, and the highest number were aged 15 years (23 respondents or 33%);
- The New Community Schools Survey found 13% of males and 25% of females aged 14 years were smokers, while in this survey, 100% of males and 89% of females of the same age were smokers. Further, while 15% of males and 24% of females aged 15 years were smokers in the schools population, this survey found 93% of males and 100% of females of the same age to be smokers.
- Just over a quarter (27%) had started smoking while they were in care, while 73% had started smoking before entering care;
- Just over half (52%) of the smokers said they wanted help to stop smoking;

# Drug taking

Respondents were asked how often, if at all, they had used specific drugs in the past year; whether they had tried it once, or used but not in the past year, or if they had never taken these drugs. A dummy drug 'semeron' (mop) was included in the questionnaire to test the reliability of the data. Only a couple of respondents reported ever taking this drug, which suggests reliability of data.

## Prevalance

Drug use of all kinds, but particularly cannabis, was prevalent among the study sample. More respondents in this study than in the general teenage population appeared to have tried all types of drugs. This is a similar finding to Robinson et al (1999) about 'looked after' young people in Edinburgh. Eighty four percent of respondents in this survey had used cannabis/marijuana at least once, compared to 61% of young people in the 11 to 16 West of Scotland Study (Young et al, 2000). However, it should be remembered that 38% of respondents in this sample were over 16 years and incidence of drug-taking increases with age.

Seventy three percent of respondents in this survey reported using cannabis in the past year, compared to 31% of 16 to 19 year olds in another survey in Greater Glasgow (GGHB, 1995). In the current study, 60% had tried ecstasy at least once, compared to 3% of the 11-16 Study (Young et al, 2000) and 9% of 16 to 19 year olds reported by another study (GGHB, 1995). Again, the age profile of respondents will have affected this result.

A recent survey of residential childcare staff (Market Research Scotland, 1998) confirmed that from a staff perspective, taking drugs (predominantly 'soft' drugs) is a problem in all young people's residential units. Staff have linked the high levels of drug taking to problems with self-esteem, problems within families and at school.

Young people were said to take drugs to remove emotional distress. Certainly young people in our study talked about using substances less as a social activity, and more to "forget the bad things". Researchers Kandel & Davies (1982) have established a link between depressive mood and illicit drug use other than cannabis. In addition, they argued that some adolescents, to relieve their depressed state, might use drugs as self-medication. Other young people in this survey talked about drink and drugs giving them self-confidence and helping them to relax.

Other research has suggested that young people with experience of care have a higher risk of developing chronic illicit drug use than those in the community. Drug taking was widespread across this sample, a small percentage reported using 'hard drugs' such as opiates, 'crack' (2%) and cocaine (3%) on a daily or weekly basis and 17% used ecstasy on a weekly basis. As with smoking and alcohol, the majority (66%) who had used any drug, first tried drugs before going into care. Nevertheless, of the 73 respondents who answered this question, nearly a third (31%) first tried drugs while they were in care. Two (3%) had tried drugs after they had left care. Four had injected drugs and two of these had shared needles.

## Education and Support

An interesting theme to emerge from the focus groups was the apparent desire among participants for more adult control especially, in young people's units, to curb smoking, excessive drinking and drug-taking. Young people did not feel residential staff took incidents relating to alcohol or drug abuse seriously enough, and this only served to encourage them to carry on with their drug using behaviour:

*"Because the staff don't treat you the way your ma treated you."*  
(female, 14 years old)

*"Staff told me they don't play a parenting role. If you come in drunk they just tell you 'what are you doing drinking?'. If you're at home and you get caught drinking your ma'll keep you for a weekend or whatever, but the staff just let you back out and don't tell you not to drink again or nothing."* (female, 16)

There was an indication that being in care offered a freedom that could easily be abused, and some young people would prefer stricter rules regarding drinking and drugs in particular. Participants wanted staff to "teach people to be social drinkers" or "not to be drinkers at all". Specialist drug and alcohol workers going into residential units explaining "all the bad things it (drink) can do to people" was considered helpful. Participants praised the interventions of a female worker who had established a rapport with the young women in one unit and had helped them address individual issues with alcohol and drugs.

## Summary of findings

- The survey found a significant uptake of drugs by young people with experience of care compared to other teenagers;
- Some of the reasons respondents gave for taking drugs were to "forget the bad things", as well as "to get a buzz", because it gave them self-confidence or helped them relax;
- Around a third (31%) had first tried drugs while in care, while 66% had been taking drugs before coming into care, and 3% first took drugs after leaving care;
- there was an evident desire among participants for more adult control especially in young people's units to curb smoking, excessive drinking and drug-taking.



## Alcohol Use

Nine out of ten young people across the whole sample drank alcohol to some degree: Only 4% never drank any alcohol. The level of weekly or more frequent drinking was particularly high (50% of respondents) compared with other studies. Half of all respondents drank alcohol once a week or more compared to 16% of the sample of 12-15 year olds in a recent Greater Glasgow New Community Schools Survey (GGNHSB 2001). Furthermore, 79% of males and 55% of females aged 15 years drank alcohol once a week or more, compared to 23% and 19% of males and females of the same age in the New Community Schools Survey (2001).

It was common to have started drinking alcohol before going into care (63% of respondents), although nearly a third (29%) first tried alcohol while in care. The main reasons they drank, sometimes to excess, were to alleviate emotional pain and increase self-confidence, and because other people did:

*"Getting a buzz. You're feeling different sometimes. It takes all your bad things away, you just mellow out and all the stars become clearer."*

(female, 14 years old)

*"If you've got a drink in you, you've got a choice. If you decide you want to do something you just go ahead and do it, lose your inhibitions and that."*

(female, 16 years old)

Fourteen percent were consuming large quantities of alcohol and were drunk most days. Commonly this was 14 to 17 year old males and 14 to 15 year old

females. Another third reported being drunk at least once a week, particularly males aged 15 years, and females aged 15-16 years. There did not appear to be any marked differences in the pattern of getting drunk between the sexes. Other surveys have found that the incidence of drinking and drug-taking tends to increase with age (Scottish Health Feedback, 1997). A significant minority (16%) of 14-20 year olds drank alcohol but did not get drunk. Many of those who drank alcohol at least once a week were living in young people's units or residential schools (i.e. 56% of males, and 80% of females).

### Summary of findings

- There was a high incidence of under-age and problem drinking among the sample: 50% of respondents drank alcohol once a week or more. This included 79% of 15 year old male respondents and 55% of female respondents. This compares with 23% and 19% for males and females of the same age in the New Community Schools Survey;
- 29% had first tried alcohol whilst in care, although 63% had tried it before coming into care and 8% after leaving care;
- 14% of the sample was drunk most days. Commonly this was 14-17 year old males and 14-15 year old females; The survey found no particular differences between the sexes in the frequency of getting drunk;
- 80% of females and 56% of males who drank alcohol at least once a week were living in young people's units or residential schools;

## Views of health services, information and advice

This study sought to find out which health services young people with experience of care had used, what they thought of them, and what ideas they have for improving them. The circumstances of being 'in-care' or 'looked-after' by the local authority frequently result in a lack of continuity of health care, for example, not all such young people will have received regular immunisations. As reported earlier, the sample of respondents clearly had a history of transience in care and this may have affected their experiences with health services.

Elsewhere in this report, it was stated that the young people in this survey perceived themselves in the main to be fit and healthy. They saw 'health' often in terms of the absence of illness or disease and in physical terms, for example as "rosy cheeks and white teeth", physical fitness and attractiveness. Respondents' perceptions of the role of health services was that they were services to meet the needs of ill people and were thus of marginal interest to them. They were somewhere to turn to only "when ill" and not when in good health.

Young people were asked about which health services they had contact with; in the last six months; between six months to one year; over a year ago; and never. One of the group discussions also focused on young people's views of health services and their comments are incorporated where appropriate.

### Health Services

#### GP's / Doctors

All respondents had seen a doctor/GP at some stage and the majority (83%) had seen a GP within the past six months. Other studies have not been so positive - Robinson et al (1999) found just 58% of the sample of looked after young people in Edinburgh had seen their doctor in the past six months. While experiences with GPs were mixed, most respondents appeared to be happy with the way their GP dealt

with their problem: 74% were either very happy or quite happy. Many had good experiences of visiting the GP: they had received the treatment they thought they needed, their problem was understood and dealt with appropriately, and the GP had been helpful:

*"They knew what they were doing and treated me first class."*

Others however were not quite so positive. Sixteen percent had been unhappy or very unhappy with the way their GP dealt with them or their problem at the last visit. They felt that GPs did not understand the problems of looked after young people, they didn't give them enough time to explain what was wrong and rushed consultations, young people were not given a choice of doctor, or the GP or health centre waiting room was off-putting:

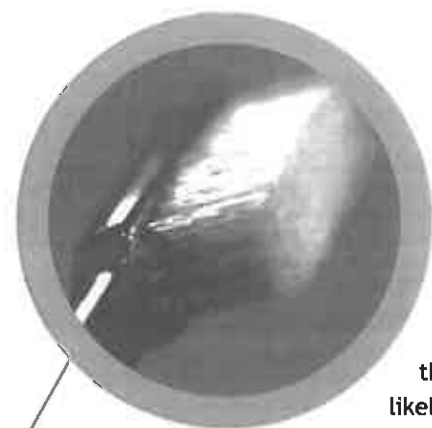
*"I felt that they never spend enough time with me, and they never explained what my condition was."*

*"It depends if it's a woman or if it's a guy. I'm no' really that keen on the guy doctors but the woman ones are alright. I don't get to choose, they just tell me and it's whoever I've got"*

### Dental Services & Oral Health

Dental health appeared to be a more neglected area: just 51% had seen a dentist within the recommended six months, and 24% within the past year. A minority said they had never seen a dentist, and 18% that the last time was over a year ago. Those who had never seen a dentist tended to be older females over 16 years (i.e. 5 out of 7 respondents), whereas those who had not seen a dentist in the past year tended to be males of all ages (12 out of 17 respondents). The majority of respondents possessed a toothbrush; just five did not. Over three quarters (77%) said they brushed their teeth daily, a further 10% brushed





alternate days, and 13% brushed less often than that. Males were twice as likely not to brush their teeth every day or even every other day, but age itself was not a factor. While clearly moving into a different area caused "a bit of a problem" when registering with a dentist or GP, individuals' fear of the dentist was acting as the main barrier:

"He's just so terrified of the dentist. He went down there and he was really terrified he said and just walked straight back out. And he was arguing with the dentist. The dentist guy was shouting at him."

### Use of other health services

Visits to hospital casualty departments in the previous 6 months appeared high (46% of respondents). The majority (65%) had never used a family planning or contraceptive service, and few had used a telephone help line (8%) or visited a drop-in centre for health information or advice (17%). Contact with the school nurse was infrequent, but as the majority were over 15 years and may have left school, this is hardly surprising. This also highlights that school may not be as important in terms of health education as it is for other young people.

A third (33%) had not had a medical check-up while being in care in the past year and 7% had never had one. Only 42% had had a medical check-up within the previous six months. Not surprisingly, those in residential care settings were most likely to have had a medical check up (63% of those in residential care settings had). Those who had never had a medical check up came from a variety of placements including residential units, residential schools, hostels, supported tenancy or with supported carers. In the absence of more information however, it is impossible to speculate on whether this was because they had refused a medical examination or they had been missed, as the research did not involve checking such information with foster carers or residential staff.

### Barriers to Access

Not all respondents completed the question about factors young people find off-putting about health services. The responses highlight a range of barriers. The most significant appeared to be "boring waiting rooms", a lack of choice in whether they could see male or female staff and feeling that the service might not be confidential.

Even those respondents who were satisfied with their GP sometimes commented that waiting rooms were boring, highlighted problems in respect of confidentiality, and the lack of choice of staff. Problems with confidentiality were not always a direct problem with the health service however, but with a lack of privacy within some young people's residential units:

*"Yesterday I came in and threw a brush, she was really annoyed because one of the other young people here knew something about her. And A really gets annoyed if somebody hears that he's been to the dentist or doctors or the hospital. They moan at the staff saying 'how does this young person know about my business and that'"*

It is argued by some that health services are too remote and that bringing services to where young people are may be more effective. In this questionnaire, we asked whether young people would be more or less likely to see health staff (like a nurse) if they were to visit residential units. The response was mixed. Just over half (52%) would be more likely to see health staff like a nurse, if they came to residential units for young people. Eleven percent said they would be less likely to see them than if they went to see them at a health clinic, and 22% didn't think the setting in which they saw health staff made much difference. There were relatively few other suggestions for improving health services.

Most respondents considered health services to be for ill people and would use them "only if I was injured or dying". The main suggestions were about improving the quality of relationship with health staff, and the importance of friendly and understanding staff that listen to the concerns of young people at all levels of health services. One person felt they needed a shorter waiting time for GP appointments - "I usually wait three to six days for an appointment."

### Summary of findings

- All the respondents had seen a doctor/GP recently and the majority (83%) within the past six months. While 74% were happy with the way their doctor had dealt with them, 16% were unhappy because the doctor did not seem to understand the problems young people with experience of care faced, or had not spent enough time listening to them. Other problems were that the young people couldn't choose which doctor they saw or found doctors' waiting rooms and surgeries off-putting;
- Oral health was a more neglected area. Just 51% had seen the dentist within the recommended 6 months. Seven respondents, mostly older females, had never been to see a dentist. Males were the least likely to visit the dentist regularly - 70% of those who had not seen the dentist in the past year were male;
- The survey found that all but 5 respondents had a toothbrush, and that the majority (77%) brushed their teeth daily. Males were twice as likely not to brush their teeth often;
- Other health services were used infrequently, except hospital casualty departments - 46% of respondents had been to this hospital department within the past 6 months and 79% had been at some time. There was infrequent use of family planning/contraceptive services (65% had not used these services), drop-in centres (83% had not used drop in centres) or telephone help-lines (92% of respondents had not used help lines);
- 7 respondents had never had a medical check up while in care, and it was over a year since a third (33%) had. Without more information, it is impossible to know whether this is because young people were refusing these check-ups or had been missed;
- The most significant barriers to using health services were boring waiting areas, lack of choice of staff, and feeling that the service may not be confidential. They wanted staff who are friendly and take the time to understand young people's problems, shorter waiting times for appointments and someone to discuss their health concerns with;
- There was a mixed response to the suggestion of health staff (such as a nurse) holding clinics or consultations within young people's units. However, more than half (52%) said they would be "more likely" to see health staff if they came to the units.



## INFORMATION & ADVICE

The questionnaire asked whether respondents had been given information or advice on a range of health related topics while they were or had been in care. They were given a list of 26 health-related topics and asked to tick boxes in three columns to indicate: 1) if they had received information on the topic; 2) to indicate whether this had been useful; and 3) whether information on any of these topics would be of future use to them. The list of health related topics was compiled from the original questionnaire and by examining issues raised by the literature.

The format of the question was perhaps too complex or long as some responses were ambiguous to interpret. Consequently, the findings regarding satisfaction should be interpreted with a degree of caution. A 'tick' in the second column only, might indicate that a respondent had both received information on the topic and found it useful, or it might mean he/she had simply received information on the topic. Further, while younger teenagers in residential care settings overall will have found it easier to remember what information or advice they received, those aged 19 years or more may have struggled.

At least 45% of respondents had received information or advice on a range of health related topics, most notably on healthy eating, getting fit and exercise, personal hygiene, coming off or cutting down on drugs, effects of drinking alcohol, quitting smoking, relationships, contraceptives and safer sex. The responses suggested a high satisfaction with all the information/advice received in general but as already acknowledged, these results should be treated with some caution. Satisfaction was expressed most strongly in respect of information on aspects of sexual health, healthy eating, personal hygiene, violence

and bullying. Although information on many of these topics was not widespread, those who received some information/advice found it helpful.

There was a demand for information/advice on all health related topics in the future including some that had been distributed widely already, but especially on aspects of mental well-being, help with addictions and physical well-being. Several respondents had identified the need for particular information/advice that did not seem to be widely available - for instance, some wanted help with cooking healthy food on a budget, coping with stress and anxiety, feelings of depression, violence and bullying, improving self-confidence and self-esteem. Findings in relation to information and advice are also highlighted and discussed elsewhere within this report where they relate to other health topics and themes i.e. sexual health.

## Summary of findings

- While in care, young people had received a wide range of health information/advice but in some cases this was neither comprehensive nor helpful. There was a demand for providing more information/advice on a range of health topics, but especially on mental health issues, sexual health, drug and alcohol problems and aspects of physical well-being;
- Information/advice about sexual health tended to focus on safer sex, to the detriment of broader sexual health topics. Those in contact with family planning or contraceptive services within the past year were in the minority (just 28% of respondents), and 40% did not know where the nearest young people's sexual health or contraception service was.

# Leaving Care

The Save the Children Fund (1995) survey suggested that leaving care affects young people's health badly. This assertion was supported by a recent consultation event with young people with experience of care in Glasgow (the big step, 2000). Once more, the transition from care to independent living emerged as a key health concern for the young people with experience of care who responded to our survey. The overwhelming response we received to the question 'what's the most important thing that looked after young people or who have recently left care, need information about?' was that they needed information on all aspects of independent living or "standing on my own two feet", including "healthy eating, cooking on a budget, how to manage living alone, relationships and how to run their own home."

In addition they wanted more information about drugs, safe sex and contraception, and aspects of mental well-being. They were looking for advice or information on managing anger, being assertive, getting help with depression and increasing self confidence:

*"Who to go to if you are feeling unhappy or depressed because there is not a lot of people you can talk to about it."*

Peer support was suggested as the best way of providing this kind information/advice:

*"Open up a like community wee club that everybody can play pool and just get all the kids that are in care and have been in care because I seem to find that if you get them together, there is a lot that we know. If kids in care can get together they can sort themselves out, they can understand people better and I think you can make friends that understand."*

The consequences of not giving enough information and support were plain to see:

*"Why do you think they are all being homeless? It's because they're no doing enough education to be independent."*

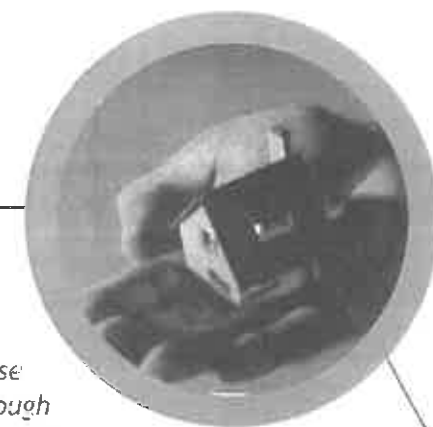
Respondents believed that poor preparation for leaving care was resulting in ill health. In short, the key message from respondents was that leaving care was the biggest health issue for young people with experience of care.

## Future Aspirations

A final question, taken from the West of Scotland 11 to 16 Study (Young et al, 2000) asked respondents what might happen to them in the future. The question listed nine items and asked respondents to tick all those that might apply. The list included: be at university/college, have been in trouble with the police, be in good health, be overweight, be unemployed, own a car, be married, be a mum or dad myself, and have a job. While it is not directly comparable with the 11 to 16 Study, given the different age profile of the sample, responses showed that, overall, that young people were positive about their future: 81% thought they would have a job, 68% that they would be in good health, 60% that they would own a car and 50% that they would be a student at university or college. This contrasts markedly with the finding from the Depression Scale, that a high percentage of respondents felt "hopeless about the future" and scored high on this scale.

## Summary of findings

- Respondents believed that poor preparation for leaving care was resulting in ill health. This was cited as one of the most pressing health concerns for young people. The transition from care to independent living on health was considered to be detrimental.
- In contrast with the survey's findings regarding depression and hopelessness, the majority of respondents were positive about their future in relation to key areas such as health, prosperity, education, employment.



# Synopsis of Findings

## Perceptions of Health

- Four out of five respondents felt they were "quite healthy" or "very healthy", and a similar proportion felt they were "quite fit" or "very fit";
- The key dimensions of health that young people with experience of care could best relate to were physical fitness, healthy eating and physical attractiveness;
- Role models for 'good health' tended to be remote superstars or athletes, which suggests that good health may be perceived as something that is difficult to obtain;
- As well as eating the right foods and taking regular exercise, having friends and receiving praise and encouragement were thought to promote health or 'make you healthy';
- Conversely, eating junk foods, not exercising, taking drugs, alcohol, smoking, and not getting on well with other people was thought to demote health or 'make you unhealthy'. In addition, not having a job or enough money was also bad for health;
- Respondents felt good about themselves when they adopted healthy lifestyles, when they ate properly and exercised, but also when other people praised and encouraged them and when they had enough money. For some, they only felt good when they took drugs or drank alcohol;
- They felt bad about themselves when they got into trouble with authorities, had problems in their relationships with family and other people, when they were bored and when they didn't have any drugs

## Mental Health

- There were high levels of depressive illness as measured by a self-reported Depression Scale especially among females and younger teenagers. Depression scores were high compared with both the 11-16 Study and the New Community Schools Survey samples, especially for 14-year-old females. While 14% of females of this age in the New Community Schools Survey had high scores (21.7 or more), this compares with 55% of 14-year-old females in this survey;
- The average scores for 75% of respondents for self-esteem as measured by the Rosenberg scale were low, that is, between 15-19. Just 25% of respondents scored 20 or more compared to 56% in the 11-16 Study by Young et al, (2000). Females under 16 years had the lowest self esteem scores;
- 45% of respondents had self harmed or injured themselves at some point in their lives, and a third had asked for help in relation to this behaviour;
- They mostly wanted help from family and friends, but also staff, and some would accept help "from anyone";
- Females were most likely to deliberately self harm, especially younger females aged 14-15 years;
- Those who self-harmed were predominantly, though not exclusively, living in residential care settings (70% were in young people's units or residential schools);
- There was a link between deliberate self-harm and depression in 37% of cases, and with low self esteem in 85% of cases

## Diet and Nutrition

- While 35% ate between 2-5 portions of fruit and 37% ate 2-5 portions of vegetables daily, around one third didn't eat any fruit or vegetables at all and many ate very little. These same individuals tended also not to take any or much exercise;
- Generally, females ate a healthier diet. Males ate fewer vegetables but ate similar amounts of fruit to females;
- Respondents were able to choose what they ate & often cooked for themselves, but had less guidance on how to eat healthily. They received more help with managing on a budget than with shopping for healthy foods

## Physical Activity

- The survey found low levels of physical activity across the whole sample, and evidence that the experience of care was a barrier to being more active;
- Those who were least likely to engage in physical exercise or sports were females and smokers of both sexes;
- Barriers to participation in physical activities included the prohibitive cost of equipment or fees particularly for those in supported tenancies; needing support and help to join in activities; low levels of motivation; and features of life in young people's units or residential schools including staff and other residents' attitudes that deterred individuals from adopting more active lifestyles.

## Sexual Health & Relationships

- the survey found gaps in young peoples access to information and advice on sexual health generally and safer sex in particular;
- 40% of respondents did not know where the nearest young people's sexual health or contraception service was;
- the survey found that a significant number (26%) of young people 'often worried' about getting pregnant or getting their girlfriend pregnant and another 36% worried about this 'sometimes';
- barriers to accessing condoms were evident, particularly amongst young men.

## Smoking

- The survey found a high rate of smoking among the respondents. Three out of four or 75% were smokers, which is significantly higher than rates found by other surveys of teenagers;
- Slightly more female respondents were smokers than male (79% of females compared to 73% of males). The majority were aged under 16 years, and the highest number were aged 15 years (23 respondents or 33%);
- The New Community Schools Survey found 13% of males and 25% of females aged 14 years were smokers, while in this survey, 100% of males and 89% of females of the same age were smokers. Further, while 15% of males and 24% of females aged 15 years were smokers in the schools population, this survey found 93% of males and 100% of females of the same age to be smokers.
- Just over a quarter (27%) had started smoking while they were in care, while 73% had started smoking before entering care;
- Just over half (52%) of the smokers said they wanted help to stop smoking;

## Drug taking

- The survey found a significant uptake of drugs by young people with experience of care compared to other teenagers;
- Some of the reasons respondents gave for taking drugs were to "forget the bad things", as well as "to get a buzz", because it gave them self-confidence or helped them relax;
- Around a third (31%) had first tried drugs while in care, while 66% had been taking drugs before coming into care, and 3% first took drugs after leaving care;
- there was an evident desire among participants for more adult control especially in young people's units to curb smoking, excessive drinking and drug-taking.

## Alcohol Use

- There **was** a high incidence of under-age and problem drinking among the sample: 50% of respondents drank alcohol once a week or more. This included 79% of 15 year old male respondents and 55% of female respondents. This compares with 23% and 19% for males and females of the same age in the New Community Schools Survey;
- 29% had first tried alcohol whilst in care, although 63% had tried it before coming into care and 8% after leaving care;
- 14% of the sample was drunk most days. Commonly this was 14-17 year old males and 14-15 year old females; The survey found no particular differences between the sexes in the frequency of getting drunk;
- 80% of females and 56% of males who drank alcohol at least once a week were living in young people's units or residential schools;

## Views of health services

- All the respondents had seen a doctor/GP recently and the majority (83%) within the past six months. While 74% were happy with the way their doctor had dealt with them, 16% were unhappy because the doctor did not seem to understand the problems young people with experience of care faced, or had not spent enough time listening to them. Other problems were that the young people couldn't choose which doctor they saw or found doctors' waiting rooms and surgeries off-putting;
- Oral health was a more neglected area. Just 51% had seen the dentist within the recommended 6 months. Seven respondents, mostly older females, had never been to see a dentist. Males were the least likely to visit the dentist regularly - 70% of those who had not seen the dentist in the past year were male;
- The survey found that all but 5 respondents had a toothbrush, and that the majority (77%) brushed their teeth daily. Males were twice as likely not to brush their teeth often;
- Other health services were used infrequently, except hospital casualty departments - 46% of respondents had been to this hospital department within the past 6 months and 79% had been at some time. There was infrequent use of family planning/contraceptive services (65% had not used these services), drop-in centres (83% had not used drop in centres) or telephone help-lines (92% of respondents had not used help lines);
- 7 respondents had never had a medical check up while in care, and it was over a year since a third (33%) had. Without more information, it is impossible to know whether this is because young people were refusing these check-ups or had been missed;

## Leaving Care

- The most significant barriers to using health services were boring waiting areas, lack of choice of staff, and feeling that the service may not be confidential. They wanted staff who are friendly and take the time to understand young people's problems, shorter waiting times for appointments and someone to discuss their health concerns with;
- There was a mixed response to the suggestion of health staff (such as a nurse) holding clinics or consultations within young people's units. However, more than half (52%) said they would be "more likely" to see health staff if they came to the units.
- Respondents believed that poor preparation for leaving care was resulting in ill health. This was cited as one of the most pressing health concerns for young people. The transition from care to independent living on health was considered to be detrimental.
- In contrast with the survey's findings regarding depression and hopelessness, the majority of respondents were positive about their future in relation to key areas such as health, prosperity, education, employment.

## Views of information and advice

- While in care, young people had received a wide range of health information/advice but in some cases this was neither comprehensive nor helpful. There was a demand for providing more information/advice on a range of health topics, but especially on mental health issues, sexual health, drug and alcohol problems and aspects of physical well-being;
- Information/advice about sexual health tended to focus on safer sex, to the detriment of broader sexual health topics. Those in contact with family planning or contraceptive services within the past year were in the minority (just 28% of respondents), and 40% did not know where the nearest young people's sexual health or contraception service was.

# Conclusions

This study will contribute to increasing the knowledge of the health needs of young people with experience of care in Scotland. It attempted to listen directly to the voice of young people with this experience in Glasgow, and has done this with mixed success. The questionnaire survey had a target of 100 returns (i.e. approx 1/3 rd of the sample population) and 96 young people responded. This was achieved by targeting slightly more young people to allow for some refusals. Through focus groups, we had hoped to reach around 30 young people, but only managed to reach 14 and it was challenging to focus the discussion on health. We have learnt from this experience that attempts to bring together young people with experience of care, require far more time and the dedicated efforts of known and trusted staff than can be achieved by traditional focus groups, no matter how well planned. The aim had been to reach young people who did not normally take part in consultation exercises and to discuss topics identified by young people emerging from responses to the questionnaire. Despite methodological limitations however, a number of key themes have emerged from this study and these are now discussed briefly below, together with the implications for local policy and practice.

## Key Themes

Young people's experience and perception of where they live is considered to be a significant factor on health and well-being. The findings suggest that lack of continuity in the lives of young people had an impact on their health and health care. This was related to length of time in placements, frequency of placement moves and lack of continuity of carers. There were mixed responses and feelings concerning placements amongst young people. Poor preparation for leaving care was considered to be detrimental to health. This was considered to be one of the key health issues from young people.

Perhaps the most striking finding was that health was a difficult and uninteresting concept generally for the target group, who it must be said did not

perceive health to be a major life concern in the same way as most adults do. This is a similar finding to an earlier study by Shucksmith et al (1997), which explored the health issues and concerns of young people in the general population. Aspects of health that young people in this survey found most engaging were physical fitness and attractiveness, and healthy eating. The most pressing health issue was expressed as concerns around the transition from care to independent living, and a desire for greater support at this time. Young people felt that leaving care was affecting their health negatively. Role models for 'health' were distant and possibly unrealistic in many cases, which has implications for how far young people with experience of care feel empowered to influence their own health.

The findings suggest a number of areas for concerns in relation to specific health behaviours. In particular the survey found a worrying proportion of respondents (45%) had deliberately harmed or injured themselves. Females were more likely than males to self-harm, and it was also more common among younger teenagers, that is 14-15 year olds and again particularly among younger females and those who were living in either a young people's unit or residential school. There was also a link between self-injurious behaviour and high scores on the Depression scale, and even more commonly low scores on the self-esteem scale (85% of those who self harmed had scores below 20).

The survey found high levels of certain 'at risk' behaviours such as smoking, problem drinking and drug taking among this population; evidence of poor diet; and a chronic lack of physical activity. It should be remembered that over half the sample population were over 16 years and many of these behaviours have been found by other research to increase with age. The study also found high levels of depression and low self-esteem among both males and females. While this will be unsurprising to workers in the field, what may be more surprising is the magnitude of the problem and the fact that being in care appears to have such an influence on the incidence of smoking, drinking

alcohol to access and taking drugs. There appeared to be a 'window of opportunity' in relation to smoking, in that a significant proportion of smokers wanted help to quit smoking. The challenge for professionals then will be to find imaginative and effective ways to tackle these issues, particularly in the residential care environment. The recent appointment of specialist drug workers in young people's units and at Kerelaw Residential School represents an opportunity to focus on the high incidence of drug and alcohol problems identified by the survey and to capitalise on the finding that respondents stated they would welcome adults exerting more control in this area.

Young people with experience of care seem not to be encouraged generally, to maintain a physically active lifestyle and this has implications for their long-term health. Barriers were identified as lack of money, poor personal motivation, and access problems. The situation of being in care was felt by young people to actually militate against them being more physically active, and there was little evidence of a positive culture within care that perceives health in its widest sense as a priority issue.

Access to sources of information and advice was patchy across the sample and although many received information about a range of health issues including the risks associated with alcohol, smoking and taking drugs, health eating, safer sex etc, this was not sufficient in itself, particularly as evidence suggests that information only programmes in relation to mental health promotion are virtually ineffective (SNAP, 2000).

## Local Implications

It was important to seek the views of young people with experience of care on health and health services, but it is vital that their voice is now heard in planning and delivery of services. Many young people we spoke to were despondent about research and what would happen to what they said as they had negative experiences of consultation in the past. It will therefore be important to demonstrate the practical use of this research to young people. A first step might be to

disseminate the results of the study widely and encourage ongoing discussions with groups of young people with experience of care about the kinds of issues the study raises. It is also recommended that arrangements should be made to facilitate more opportunities for young people in this situation to come together regularly to share their views and experiences. This is an essential element of a holistic model of empowering young people to take control of their own health.

The key themes above demonstrate there is a wealth of specific health concerns that require to be addressed by multi-agency partnerships. While the emphasis of recent government policy has been to encourage services to promote health and well-being among young people and not focus solely on the detection of ill health, there was evidence from this research to suggest that young people did not feel empowered to develop responsibility for their own health. The literature in this area suggests that the health concerns of looked after young people would be better met by a wider group of professionals such as nurses and health promotion staff rather than registered medical practitioners. Because young people do find the in-care medical stigmatising and may refuse to attend, changing the focus of medicals so that they become 'health checks' might be more empowering to young people.

Given the central finding about young people's perceptions of health and the role played by health services in promoting health, there is support for the emphasis in health promotion on improving health by concentrating first on building self-esteem and self-confidence as a starting point for tackling other health issues. The main issue is not simply one of health education but of tackling the underlying psycho-social causes of adopting unhealthy lifestyles. Efforts to support young people with experience of care in making healthy living choices should therefore attempt to address the underlying psycho-social reasons for poor motivation and not only focus on health behaviours.





A key finding of the survey was a high level of depression, coupled with low self esteem. Studies (Hatfield et al, 1996) have described looked after young people as emotionally or behaviourally disturbed and about a third have been sexually abused. McCann et al (1996) commented that the most worrying finding of their survey was that a significant number of adolescents were suffering from severe, potentially treatable, psychiatric disorders which had gone undetected. In Glasgow, Chetwynd & Robb (1999) concluded that the level of psychological distress experienced by accommodated teenagers is so extensive that radical measures were required to ensure that their mental health needs were met.

The findings of this survey suggest that mental health is a key health concern for young people looked after in Glasgow. Young people with mental health problems featured among the few individuals who felt their health needs were not being met. The SNAP Report (2000) recommended a strategic

approach to be taken to mental health promotion among young people generally and that local authority-led Children's Services Plans should incorporate planning for mental health promotion. They also underlined the importance of tackling mental health promotion as a multi-disciplinary and multi-agency issue and coordinating initiatives. As this survey did not examine use of mental health services as such, or their satisfaction with these, we cannot make any comments on the impact of recent initiatives to tackle mental health issues.

To end on an encouraging note, the survey found a perhaps surprisingly positive view of the future aspirations held by young people with experience of care in Glasgow given the high scores on the depression scale. That so many believed the future would hold prospects of a job, studying, having a home of their own, relationships etc, should be a challenge for professionals and advocates working to improve the health and quality of life of young people in this situation.

## Recommendations

The findings from this study point to a number of practical recommendations for all those working to promote the health of young people with experience of care. The following list is intended to be a helpful starting point, it is not an exhaustive list. Our recommendations from the research are that:

- The findings of this research are disseminated widely especially among young people, and opportunities are created for young people in different care settings to discuss the kinds of issues the study raises;
- Ongoing opportunities are created for young people with experience of care, including those who have 'left care', to explore issues around health and healthy living. This will need to capitalise on young people's interests, for example it may be more effective to organise a dance group or football coaching, which would offer openings to look at key health concerns;
- Professionals working with young people with experience of care, particularly in residential care settings, find ways to actively address the high incidence of depressive illness among this population in partnership with other professionals;
- Health promotion efforts focus first on tackling the low self esteem of many young people with experience of care, particularly young females, as the foundation for tackling other health concerns such as drug-taking, problem drinking and self-injurious behaviour;
- More time is spent with young people in care settings giving information and advice on how to shop and cook healthy foods to help young people establish good dietary habits, as well as teaching them how to manage on a limited budget;
- Those who wish to promote fitness, physical activity and sports need to tackle the physical and other barriers to access identified by the survey, chiefly, the lack of money to engage in many activities including swimming and cycling; low motivation; and opportunity. This should be within the context of general health measures implemented across different agencies, including leisure departments.
- Residential staff examine how the Council's smoking policy is implemented in young people's units and residential schools, and consider ways that they could work with colleagues in health to tackle the high incidence of smoking in the units and to try and prevent those young people who do not smoke when they come into care, from starting smoking. This will have resource and staffing implications;
- More information/advice on sexual health is targeted at young people with experience of care as they appear to miss out on getting this information at school and learn (sometimes incorrectly) about sexual health and contraception from peers;
- The focus of medical assessments while in care should change to become more of a 'health check', taking a holistic approach to health and offering young people better opportunities to discuss general health concerns as well as specific health problems;
- Young people should have a designated keyworker or equivalent when they are in care who will monitor their health needs and be a trusted adult with whom they can discuss any health concerns;
- Authority-led Children Services Plans incorporate planning for mental health promotion and focus attention on meeting the health needs of young people with experience of care;
- Professionals working with young people with experience of care should work to improve their health and quality of life, and have high expectations of young people and their capabilities.



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