

Further information on this research study can be obtained from Steven McCluskey, Senior Health Development Officer (LAC), NHS Greater Glasgow, 0141 201 4794 and/or *the big step*, 0141 572 0551.

Further copies of this full foster care research report, the executive summary and the 2001 health research study can be obtained from:

the big step
93 Candleriggs
Glasgow
G1 1NP

0141 572 0551
enquiries@thebigstep.org.uk

The full Scottish Health Feedback report is available on request; this includes graphs, tables, detailed demographic information and survey questionnaire. These reports and further aspects of the research findings will also be available for download via the big step web-site at: <http://www.thebigstep.org.uk>



the health needs and issues of
**Young
people 8**
from Glasgow
living in foster care settings



Scottish Health Feedback
for 'the big step'

2003

Acknowledgements

We are grateful to all the young people who took the time to complete our questionnaire and tell us about their health concerns and issues, and especially to those who, in addition, participated in focus group discussions or individual interviews. We would also like to thank the foster carers who participated in focus groups. It goes without saying that the successful completion of the survey would not have been possible without their co-operation and involvement.

We are indebted to Glasgow City Council Families for Children Team in carrying out this research, especially to Stephanie Stone and Phyllis Bannerman for coordinating the distribution of questionnaires and helping arrange focus groups with foster carers.


We also wish to thank the Research Steering Group which guided the development of survey and kept the research grounded in the experience of young people and foster carers. Members of the Steering Group were: David McCormack, Katrina Weldon, Sabrina Gaie, Nicola McDade, Stephanie Stone, Linda Dickson, Mina Bedi, Julie Ridley, Lyn Jones and Steven McCluskey.

Lastly, we would like to take this opportunity to formally thank Scottish Health Feedback who were commissioned by the big step to conduct this piece of research. Particular thanks go to Julie Ridley (Senior Researcher) who oversaw the work, to Irene Miller and Katy Darroch who facilitated focus groups and interviews with young people and to Tish Chalmers, Fenella Hayes and Ann Rennie, who gave office support.

Contents

- Background to the study.....page 2
- Introduction to the study.....page 4
- Methodologypage 5
- Profile of Survey Respondentspage 7
- Perceptions of 'Health'page 9
- Mental Healthpage 12
- Diet & Nutritionpage 14
- Physical Activitypage 15
- Sexual Health & Relationshipspage 17
- Smokingpage 18
- Drug Takingpage 20
- Alcohol Usepage 21
- Health Services, Information and Advice.....page 23
- The Future.....page 26
- Foster Carers' Perspectives.....page 27
- Challenges for Foster Carerspage 32
- Synopsis of Findings.....page 37
- Discussion & Conclusionspage 39
- Recommendationspage 41
- References.....page 42

Background to the study



In 2000/1, "the big step" (Glasgow Alliance Social Inclusion Partnership for young people leaving care) commissioned Scottish Health Feedback to conduct a study examining the health needs and issues of a sample of young people who were 'looked-after' by the local authority in Glasgow, (Scottish Health Feedback, 2001, Ridley & McCluskey, 2003). *the big step* had identified 'health and well-being' as a key theme for its work, and this research was part of a programme of activity in this area. A further study was commissioned in 2003 specifically to examine the experience and perspectives of young people in foster care settings. This report describes the methods and findings of this second study.

The previous study had sought to include young people living in a variety of circumstances, but young people in foster care settings (except those living with Supported Carers) were not included, although some of the respondents would almost certainly have had previous experiences of foster care. *the big step* sought to address this gap in knowledge by focusing this second study specifically on the experiences of young people in foster care and to build upon and complement the research work to date. In addition to surveying young people in foster care, this research has also investigated the perspectives of foster carers and explored their experiences of supporting young people in relation to health.

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 (e.g. Government White Paper, "Towards a Healthier Scotland"). The Independent Inquiry into Inequalities in Health chaired by Sir Donald Acheson, 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 is that there is a clearly identified need to develop appropriate and accessible health services for them. *the big step* identified the need for appropriate and relevant health responses to be considered as part of any strategy to address the broader issues and needs of young people who have experience of being 'in-care' (Glasgow Alliance, 1999).

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, while throwing 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.

Key Issues

The World Health Organisation 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 starting both this research and the 2001 study, and these directly influenced the development of the health survey instruments used. In addition to the views of service providers, it was important to obtain an understanding of how young people themselves construct their health experiences and their attitudes towards health services. The research literature identified particular issues of concern in relation to these young people around mental health, sexual health, substance use, smoking, diet and nutrition, dental health, physical activity, and social isolation and support. The missing link was whether young people with experience of care shared these same concerns and issues.

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 et al (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 are emotionally and/or behaviourally disturbed or have been sexually abused (Department of Health, 1992). It has been suggested by McCann (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 in getting appropriate information and advice (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 and lack of training especially in how to meet health needs; lack of awareness of young people's health needs generally; inaccessible health services; failed appointments and poor treatment compliance; the lack of continuity of medical care; low use of services by young people; and a general mistrust of services and professionals.

Persistent arguments have been put forward for a designated person to be responsible for monitoring the health of looked after young people and for better 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. Through contrasting the findings of this study with the 2001 survey, the role of foster carers in acting as 'parents in the community' and its impact on young people's health needs and issues can be explored, thus adding to the body of knowledge about young people's health needs while looked after in Scotland.

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 and information. Responses which tackle health as part of a broad social inclusion agenda, reflect current government priorities and strategies, that aim to address the 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. 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 peoples health at a local level. This information should be of interest to national and local policy makers, service planners and service providers and should enable key stakeholders to build on the good practice that is currently taking place. Positive outcomes in relation to young peoples health are highlighted and should continue to be built upon. 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.

Research Aims and Objectives

Research Aim

The main aim of the research was to broaden *the big step* partnership's understanding at a local level, of the health behaviours, knowledge and needs of young people in foster care and to use this to improve their health outcomes.

Research Objectives

In considering young people currently in a range of foster care placements, the research sought to:

- Investigate the health needs and issues of foster children within foster care settings
- Investigate the views and experiences of foster carers in caring for foster children in relation to health
- Inform policy, planning and practice in relation to services concerned with the health of young people in care
- Provide baseline information for monitoring and evaluation purposes

It was envisaged that the research would support the broader objectives of *the big step*, Glasgow City Council (GCC) and NHS Greater Glasgow regarding health and well-being, in particular that it would ensure that the needs and issues identified by young people in foster care settings were promoted when developing any support, future programmes and systems to meet health needs.

Methodology

Involving Young People & Foster Carers

The Partnership document, "Young people leaving care Social Inclusion Partnership - Monitoring and Evaluation Report" (Consultation Draft, July 2000) had identified a number of key principles underpinning its overall approach to young people leaving care. These principles included partnership with young people and other key stakeholders, participation of young people and empowerment. As with the previous study, it was felt important the research adopted such principles as far as possible both in its general approach and the face-to-face contact with young people.


In the earlier study the project now known as 'Positive Futures: Leaving Care Services' and Who Cares? Scotland were consulted about early drafts of the questionnaire, which was a valuable process of validation of the research measures. For the present study, a Research Steering Group was set up to advise and comment on the research. Three older teenagers with experience of foster care and two foster carers participated in the Steering Group alongside professionals from *the big step*, Social Work's Families for Children¹ Team and Scottish Health Feedback. The Steering Group met three times during the research: at the beginning to help set the parameters and plan practical aspects; at the end of the Stage 1 survey to discuss emerging results from the questionnaire survey and help refine the content of Stage 2; and finally, during the early stages of data analysis to discuss emergent findings.

Research Stages

The research design incorporated both quantitative and qualitative elements as suggested in the Research Brief. This section outlines the main methods used to gather information about the health needs and issues of young people in foster care. These were a health questionnaire survey of young people in foster care along similar lines to the previous questionnaire survey with young people leaving care; and second, focus groups and interviews with young people in foster care, and foster families to add a qualitative dimension to the research.

Stage 1 - Questionnaire Survey

A health research questionnaire based on the previous instrument was adapted after discussion with the Research Steering Group and *the big step*. The questionnaire was concerned with investigating the same broad range of key health themes and topics as in the previous survey to enable comparison. Questions were adapted and new ones added to ensure the questionnaire was relevant to the experience of young people living in foster care settings.



As previously, the questionnaire comprised mainly quantifiable questions with a very small number of open-ended questions asking for young people's opinions of health priorities. Much of the data generated from the questionnaire was expected to provide no more than a useful 'starting point' for analysing local health needs and issues. Further exploration of qualitative dimensions of health would be carried out within Stage 2 of the study.

Target Population

The target population for the survey was young people aged 14 years and over and placed in foster care by Glasgow City Council. At the time of the survey, there were 176 young people in this category. It was hoped that it would be possible to achieve responses from about 100 young people, to match the size of the sample in the earlier survey, so questionnaires were sent to all 176 eligible young people. A "flyer" was sent to all young people in advance, explaining the purpose of the survey. The research team worked closely with Social Work Services to design an effective system for contacting young people and administering gift vouchers to those completing the questionnaire, whilst still ensuring respondents remained anonymous. The original cut-off point for receiving completed questionnaires was extended and reminders sent out to increase the rate of return. As it turned out, 66 young people responded, a response rate of approximately 38%. (A detailed profile of the respondents is given in the next Section).

Additionally, letters were sent to all foster carers/parents explaining the research and asking for their support in encouraging young people to complete and return the questionnaire. The majority (84%) of young people completed the questionnaire unaided, and the remainder (16%) received some help, primarily from their foster carers, to complete the questionnaire.

In discussing the response rate with the Steering Group, it was suggested that non-response might have been because another survey by the Office for National Statistics was taking place at the same time, which also involved interviews with young people and foster carers; or because of personal circumstances (both of young people and foster carers); or because the survey coincided with the run up to mock exams for some teenagers. Furthermore, despite efforts to assure young people of anonymity, some might still have perceived the survey as coming from 'Social Work' and not being confidential; and there may well have been a reluctance to engage in anything that reminded them of their looked-after status.

¹ "Families for Children" is the Social Work team of Glasgow City Council that organises and oversees foster care for looked-after children and young people.

Stage 2 - Focus Groups & interviews

Focus groups with both foster carers and young people in foster care, as well as one-to-one interviews with young people were conducted to add 'qualitative value' to the findings from the questionnaire survey. This was to allow comparisons and contrasts to be made between the health issues and needs identified by different respondents (young people and foster carers).

Only nine individual foster carers responded when invited to indicate their willingness to participate in focus groups. However, by working closely with the Families for Children Team, it was possible to involve 18 foster carers in four focus groups during April/May. Three of the groups took place at Centenary House in Glasgow, and one in a hotel setting in Ayrshire. The topic guide was developed with the Steering Group and explored foster carers perceptions of the health needs and issues of the young people, as well as their own role in supporting young people, the support they currently had to do this and how this could be improved.

Two single sex focus groups were arranged with young people and took place at *the big step* offices in Glasgow. Five young people participated (3 males: 2 females). In addition, six one-to-one interviews were arranged at times and venues to suit the young people. Both the focus groups and interviews explored issues emerging collectively from the questionnaire - for instance, young people's definitions of health and the reasons behind their health priorities, their views of health services and the support they received from foster families and others to promote healthy lifestyles.

Financial incentives were provided to each young person completing a questionnaire and an additional allowance for taking part in either focus groups or interviews. Gift vouchers were administered with the help of Social Work by referring to questionnaire numbers to ensure anonymity. An allowance to cover expenses was provided for foster carers to acknowledge their participation in the focus groups.

Profile of Survey Respondents

Description of the respondents

In total 66 young people living in foster care settings returned the questionnaire. Of these 65% were female and 35% were male. The proportion of females was higher than might have been expected given the overall population in foster care aged 14 years and over was 51% female and 49% male. In the previous survey the majority of respondents were male (53%), which was in large part, determined by the way the sample was selected with Leaving Care Services.

Eleven young people who completed the questionnaire also took part in either focus groups (3 males and 2 females) or one-to-one interviews (5 females and 1 male).

The ethnic origin of all but two of the respondents was 'White UK'. One identified themselves as Black-African and another as Chinese. At the time of the survey, Social Work statistics suggested there were in fact only three young people who were aged 14 years and over from ethnic minority communities living in foster care.

Eight respondents (12%) were young people with disabilities, predominantly learning disabilities (6 young people). This proportion was similar to the proportion of disabled young people (18%) in the wider population in foster care in this age group.

Respondents ages varied from 14 to 20 years, with the mean age being 16 years and the most common age 15 years (29%). The age profile of respondents to the survey was closely comparable to that of the total population in foster care in Glasgow and with the previous survey. The survey therefore did reach a cross-section of young people of different ages.

The experience of being 'in foster care'

The situation of young people in foster care settings appeared relatively stable compared to that of young people in residential care as found in the previous survey. The great majority (91%) had for example, been in their current foster care placement for over a year, 59% having been with their current foster family more than three years. Nearly a third (32%) had been there for six or more years. This contrasts sharply with the finding in the previous study that over half of the young people had been in their current placement for less than a year. Furthermore, young people in the current study had been in care for longer in total: 54% had been in care for more than 6 years, compared with 28% in the previous study. Because of the similar age profile of the two groups, this means that the young people in foster care had, on average, come into care at a younger age than those in the previous study.

Before their current foster family, the young people had experienced a variety of other care settings but typically, they had been in other foster homes (62%) or young people's units

(32%). Three out of five (61%) had lived in only one other foster home since being 10 years old and a further 27% had been in 2-3 different foster families. One young person was unusual in that they had been in twelve different foster families.

Although 28% of all fostered young people had been in their placements for less than 3 years, this was true of 40% of those who responded. At the other end of the scale, 49% of all fostered young people had been in their placements for more than 6 years; this was true of only 32% of those who responded. These differences were statistically significant. This means that the young people who responded tended to be those who had spent less time in their current placements than those who did not respond.

There is no way of knowing why this should be, though members of the Steering Group speculated that those who had been a long time in a placement might cease to regard themselves as being anything other than a member of the family, and see surveys about foster care as not relating to them; and that young people generally might be reluctant to be identified as "looked-after".

Young people's views of living in foster care

To obtain a general impression of young people's 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?'

Overall, the findings showed that young people in foster care were very positive about the experience: 93% were either 'very happy' or 'happy' with where they were living. This is in strong contrast with the previous survey, which found only 54% to be positive about their current placement. Taken with the finding that they were in relatively stable situations compared to young people in residential units and other settings, this would support a link between satisfaction with foster care settings, stability, and well being.

The reasons they gave for being happy with where they were living included feeling as if they had been 'treated well', feeling 'safe' and 'secure', feeling 'loved', and having a sense of normality. Comments included for example:

"I'm very happy here because I am treated very well and loved"

*"I have the opportunities of a normal person. I have a great future to come."
"Because it is somewhere safe, warm and my foster mum loves me"*



Problems that were highlighted in the brief comments provided by young people were related to individual relationship difficulties within the foster family, either with foster parents or their birth children. They were also related to feeling as if they were treated like a child instead of a young adult. This latter issue is a common one with teenagers in the general population and therefore is not considered unique to being in foster care:

"I am happy but I feel I can't do a lot, like I'm trapped. I want a bit of fun, I'm 16 not five"

"Because I dislike the children, they pick on me and I feel they're idiots"

"I have a few problems with my foster carer as we have had a few disagreements which makes me feel unhappy"

Response rates and the 2001 survey

The response rate of 38% was reasonable, given that it is nearly always difficult to get high response rates from young people except in controlled circumstances. The previous survey achieved a much higher rate (83%), because each prospective respondent was targeted and approached individually, either by one of the support workers known to them or by a Scottish Health Feedback (SHF) interviewer. In the present survey this was not appropriate, precisely because the young people were living in family homes and living ordinary lives: it would have been inappropriately intrusive for anyone from Social Work or SHF to visit specifically for the purpose of administering a questionnaire. This is, in a way, symptomatic of the differences between living in a residential home (or other staffed/supported setting) and living in a foster family.

The response rate means that the results have to be interpreted with caution. These respondents may be reasonably representative of the whole population of young people in foster care, or they may be a biased selection. We do know that their age distribution is representative, but they include relatively more females than in the foster care population as a whole, and they tended to have been in their current placements for less time than average. We do not know whether they differed from their peers in other respects as well.

Throughout the report, comparisons are made between percentages reported in the first (2001) survey and the present one. Tests of statistical significance have not necessarily been applied to these comparisons.

Summary of findings

- The 66 survey respondents were predominantly female (65%); their ethnic origin tended to be White UK (97%); and the majority were non-disabled (87%)
- Respondents ranged in age from 14 to 20 years, with an age distribution closely comparable to that of the total population of young people in foster care aged 14 years and over.
- The situation of young people in foster care settings appeared relatively stable compared to that of young people in residential care as found in the previous survey. A majority (59%) had been with their current foster family for three or more years
- Before being placed with their current foster family, they had predominantly been in other foster homes (62%) or young people's units (32%)
- Three out of five (61%) had lived in only one other foster home since being 10 years old and a further 27% had been in 2-3 different foster families. One young person was unique in this sample in that they had been in twelve different foster families
- Overall, the findings show young people in foster care settings as very positive about their placement: 93% were either 'very happy' or 'happy' with where they were living. This is in strong contrast with the previous survey, which found only 54% to be positive about their current placement
- The findings support a link between satisfaction with the placement, well-being and stability, and that young people 'in care' experience this more in foster care than in any other type of placement
- All the above findings, and those reported later based on the questionnaire survey, must be set in the context of the response rate of 38%; it is possible that the young people who responded are not wholly typical.

"I like it here, I'm treated as one of the family"

Perceptions of 'Health'

How healthy did young people think they were?

To measure overall perceptions of health, 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. As in the previous survey, the question was taken from the Scottish HBSC surveys 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).

As before in the survey of young people 'in care' and leaving care, the teenagers in this study perceived themselves as generally healthy and fit: 97% thought they were 'very healthy' or 'quite healthy', which compares with around 80% in the previous survey. Further, around 94% saw themselves as either 'very fit' or 'quite fit', which compares with around 78% of respondents in the last survey.

In contrast to the respondents of the previous survey, there was an overall sense that young people in foster care settings had a stronger positive understanding of health as "being in top form both physically and mentally", reaching their potential and being "fit to do things like running". While some did still refer to the absence of illness, for example, "not seeing the doctor too often", and "not being ill" when defining the concept of 'health', as a group, they had a more rounded or holistic view of health. So, for example, one young person defined health as:

"I think that I'm alive and well. Being strong and lively inside and outside my body"
(16-year-old male)

Their definitions of health frequently included aspects of physical, mental and emotional well being. While, as before, several young people highlighted the importance of keeping fit and eating the right foods as contributing to good health, many highlighted aspects that could be interpreted as relating more to mental well being such as a state of happiness and "living life to the full".

The impact of the social environment and having support was highlighted. One young person commented:

"Health means to me that you are looked after properly and given all the basic necessities that you need, for example, medical help, education"
(14-year-old female)

For a minority, health also meant being clean, and not being clean could contribute to them feeling bad about themselves. Foster carers' comments suggest that some

children and young people coming into foster care were both malnourished and badly neglected, which would seem to support young people's assertion that health meant cleanliness and eating well. The following comments illustrate this:

"Health means washed and dressed tidy"
(18-year-old male)

"What health means to me is try and keep yourself clean and tidy and eat healthy foods"
(17-year-old female)

As in the previous survey, they also were very aware of what made them feel good and what made them feel bad, that is, what promotes and demotes health.

What promotes health?

Again the respondents to the survey appeared knowledgeable about the factors health educators might identify as promoting health:

*"Eating the right foods",
"Being physically active",
"Not smoking, drinking or taking drugs",
"Getting plenty of sleep"*

This included aspects of positive mental well-being such as personal achievement, receiving praise and making a contribution, as well as eating healthily and taking exercise:

*"When I achieve something - passing exams, achieving goals",
"When relationships with family and friends are good",
"Being confident"*

It was suggested by several respondents that their relationship with their foster family affected their health positively. For instance, they said that foster parents encouraged them to eat healthily and when they felt part of the family, they were more at ease and therefore had less health problems. Others said living in foster care was good for their health but were unsure exactly how:

"they help it but I don't know how"

What demotes health?

In describing their perceptions of what demotes health or what makes people unhealthy, respondents put more emphasis on mental health aspects than did those in the last survey. These included factors such as bullying, pressure at school, boyfriend problems, feeling "a failure", upsetting other people, "getting into trouble" and so on, rather than physical health aspects (such as not eating properly or not

doing enough exercise). They talked about "falling out with my friends and my mum", "I make my mum upset", "I do something bad and I'm told off" as having a detrimental affect on health. Bullying and being "put down" by others was a common experience.

When asked to think of a time when they felt unhealthy and what had stopped them from being healthy, they also mentioned "feeling down" or "feeling depressed" and "being lazy" as resulting in them not wanting to exercise or eat properly. They were clear that lifestyle issues such as poor diet, lack of exercise, and smoking, affected health adversely. A couple of respondents mentioned the situation they found themselves in at home with their birth families as being bad for their health:

"In the past when I never ate a lot with my real family and felt weak"
(16-year-old female)

"When staying with my dad I was malnourished"
(15-year-old female)

Although in this survey it was a unique experience, one 15-year-old female had been unhappy in her foster home and had expressed this by running away. It was rare for respondents to highlight aspects of their foster placement as having a negative impact on their health or how they felt.

Health role models

There was an interest in this research in exploring the theme of role models for health as in the earlier study respondents had mainly identified distant and idealistic role models. This suggested they would find it difficult to translate their ideals into their everyday lives. In the first survey, when asked to identify whom they thought of as a healthy person and what makes them so, they had named superstars, models, athletes, and other famous people. The following quotations from a group discussion with three young males living in foster care illustrates that they too related the concept of health to famous people such as the footballer, David Beckham:

"I'd have to go for David Beckham playing for Man U cause he's like, he's running up and down fields, packs kicks and that. What I find about him is that he doesn't smoke and he doesn't like take anything so that's what I'd call a healthy person"

"I'd probably say just another sports person cause they're right into sports cause they're always active and they're probably on a healthy diet and they all like some of them might not be taking drugs and other stuff like that"

"The same again. A couple of my friends are sports people, they go running and sprinting and that and I've asked them about have they ever tried anything, drugs and that and they said no, just ruin your health"

However, the one-to-one interviews with six other young people found that they identified their foster families as positive role models. Respondents clearly differentiated between the lifestyles they experienced with their birth family and that with foster families. In foster care, positive role models surrounded them, for instance they stated:

"My foster sister, she goes to dancing. She doesn't smoke or anything"
(15-year-old female)

"My foster dad cause he goes to David Lloyd. He eats healthily"
(15-year-old male)

Many young people reported coming from families where their parents smoked, their diet was poor, and the family was not particularly physically active. They contrasted this with life with their foster families, where they generally ate a healthier diet, were naturally more physically active and had opportunities to cook and choose the food they ate. Not surprisingly then, the people who they identified as unhealthy tended to be members of their birth families:

"One of my real brothers, he smokes and eats a lot of stuff from the chippy, he should eat more veg"
(15-year-old male)

"My dad (birth dad). He doesn't look after himself, doesn't even bother to get washed most of the time"
(14-year-old female)

Specific health problems

Twenty-two (33%) respondents identified having some type of medical or health problem; typically, this was a physical health problem. This is a higher proportion both than the previous survey (26%) and in the general teenage population in the 11-16 Study who identified long-standing illnesses, disabilities or infirmity (Young et al, 2000). Several reported more than one health problem.

The most common physical health problems identified across the respondents were asthma (6 respondents) and chronic health conditions (6 respondents) such as diabetes, irritable bowel syndrome and an under-active thyroid. Only one respondent identified having general mental health problems - "I think I have mental health problems". The range of health problems identified matched the most common long-standing illnesses identified within the general teenage population identified by Young et al (2000).

One respondent with "weak bones and joints" commented:

"The reason why I have weak bones and joints is because when I was younger I never got the correct food or treatment"
(19-year-old female)

Over 90% of respondents stated that they were getting the help they needed with medical or health problems, which is a higher proportion than in the previous survey when 80% stated they were getting the help needed. One person stated they used to be on medication for epilepsy but no longer took it; another that they had not been diagnosed even though they had "seen enough doctors" and believed themselves to have bone and joint problems; and another person who had asthma stated they also had back problems for which they were receiving no health treatment.

Summary of findings

- 97% felt they were "quite healthy" or "very healthy", and approximately 94% felt they were "quite fit" or "very fit"
- Young people generally had a positive and holistic sense of 'health' as being "in top form both physically and mentally."
- Role models for 'good health' were famous people like the footballer Beckham, but they also mentioned foster family members, which was often contrasted with the lifestyle of their birth family
- In addition to general lifestyle issues (e.g. eating the right foods, exercising), they were strongly aware of aspects of positive mental health such as personal achievement, praise and contribution, social support and relationships as contributing to health
- Living in foster care was suggested by young people as good for their health
- Respondents felt good when they achieved something, spent time with friends, felt they had made a contribution, they "did something worthwhile", as well as exercised and ate healthy foods
- They felt bad for a range of reasons - when there were difficulties in their relationships, they did not exercise, they ate too much junk or fatty foods, they "let someone down", they were being bullied, when they were on their own, and when they didn't do as well as they felt they could
- 33% identified specific health problems typically physical health problems and most commonly asthma or chronic health problems. Over 90% felt they were getting the help they needed, which was a higher proportion than in the previous survey

Mental Health



Much of the available research suggests that 'looked after' young people are vulnerable to poor mental health. This was confirmed by the findings of the previous study (Scottish Health Feedback, 2001, Ridley and McCluskey, 2003), which found high indicative levels of depressive illness among young people leaving care in Glasgow. Some studies have found a high degree of emotional or behavioural problems among this group and others have found a high incidence of psychiatric disorder and evidence of persistent mental health problems (Robinson et al, 1999).

Depression

As in the previous survey, a standardised measure of depression was used in the questionnaire. This was a 10-item scale by Kandel & Davies (1982), validated in studies of American teenagers. This measure was included in the 11-16 Study with Scottish teenagers (Young et al, 2000; West & Sweeting, 1996). 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: a high score indicates a high level of depressive symptoms.

To compare the results with the previous and other studies, a cut-off score of 21.7 or more was used. Using this benchmark, the percentage with a high level of depressive symptoms among the sample overall was 21%. While lower than the previous study in which 28% had scores of 21.7 or more, this was slightly higher than the prevalence of 18% found by Kandel and Davies (1982) in American teenagers. It was again found that more females (30%) than males (4%) had a high level of depressive symptoms. The difference between the sexes was higher than in the previous survey (33% females compared to 23% males scored 21.7 or more). Both females and males had high negative scores on two items - having 'trouble going/staying asleep' and feeling 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. A high score indicates high self-esteem.

The results of the self-esteem measure were very striking, especially when placed alongside the previous survey results. Overall, young people in this survey had high self-esteem. Seven out of ten (71.2%) scored 20 or more compared to just 25% of the previous sample. This result is even more positive than the 56% found by Young et al (2000) in respect of the general teenage population. Within this overall positive result, lower proportions of females scored 20 or more (62% of females compared to 86% of males).

It should be remembered however that this result should be interpreted in light of the response rate of 38%: it is possible that those young people who felt happier and more confident were more likely to respond. Certainly girls were more likely to respond than boys, which will have affected these results to some extent.

Self injurious behaviour

The questionnaire asked young people whether they had ever thought of deliberately self-harming and 35% stated that they had. Of those who had, a third had sought help (8 respondents). Nine respondents stated that they had received help and support with self-harming behaviour. One in five (20%) stated that they had deliberately self-harmed at some point in their lives as opposed to considering doing so. While still of concern, this reported level of self-injurious behaviour was lower than in the previous survey (45%). Although small numbers (12 respondents) mean it would be unwise to over-generalise, it appeared that professionals such as psychiatrists and counsellors, followed by foster families, siblings and friends would be whom they would turn to for help.

As found previously, females were far more likely than males to deliberately self-harm: 29% of all female respondents compared to 5% of male respondents had self-harmed. The highest level of reporting was among 16 year olds while in the last survey it was 14-15 year olds. Nearly half of those who had deliberately self-harmed (46%) had high scores on the depression scale, which compares with 37% of cases in the previous survey. There was some association between low self esteem and self-harm, but this was less marked than in the previous survey: 55% of those who had deliberately self-harmed had self-esteem scores below 20 compared to 85% in the previous survey.

Summary of findings

- Levels of depressive symptoms as measured by a self-reported Depression Scale were lower than the previous survey - 21% compared to 28% had scores of 21.7 or more
- More females (30%) than males (4%) showed symptoms of being depressed or at risk for diagnosis of major depressive illness
- Both females and males had high negative scores on two items - having 'trouble going/staying asleep' and feeling they 'worried too much about things.'
- The average scores for self-esteem as measured by the Rosenberg scale were high with 71% having a score of 20 or more compared to 25% in the previous survey and 56% in the 11-16 Study by Young et al (2000)
- Lower proportions of females scored 20 or more on the Rosenberg scale - 62% of females compared to 86% of males
- 35% stated that they had thought of deliberately self-harming but a lower proportion (20%) stated they had actually self-harmed. This is also a lower proportion than the previous survey
- Of those who had thought of deliberately self-harming, a third had sought help (8 respondents)
- Nine respondents stated that they had received help and support with self-harming behaviour
- Professionals such as psychiatrists and counsellors, followed by foster families, siblings and friends were the most likely to be approached for help regarding self harming behaviour
- As before, females were far more likely than males to deliberately harm or injure themselves: 29% of all female respondents compared to 5% of male respondents had self-harmed
- Self-harming behaviour was most commonly reported by 16 year olds
- As found in the previous survey, those who deliberately self-harmed were more likely to score high on the depression scale (46%) and to have low self-esteem (55%)

Diet & Nutrition

'Five-a-day'

Previous research in residential settings (Market Research Scotland, 1998) has found that choice of what to eat generally is left up to young people and staff found it particularly difficult to encourage children to eat more fruit and vegetables. Before entering residential care, many young people did not eat vegetables or fruit and so came into care having already established unhealthy eating habits.

In reflecting current health promotion recommendations that a healthy diet should contain five portions of fruit and vegetables every day, respondents were asked to indicate how many portions of fruit and vegetables they ate daily. This could include fresh, frozen or tinned fruit and vegetables and fruit juice.

Respondents commonly ate one or two pieces of fruit a day (64%), and nearly three quarters (74%) were eating between 1-3 vegetables daily. This was a far healthier dietary pattern than revealed in the previous survey when for example, around a third of respondents did not eat any vegetables or fruit at all. While some were still making poor dietary choices and thus reflected the growing national trend towards unhealthy eating, young people in foster care generally had a healthier diet than those in residential care settings. Clearly while research has found residential staff to be reluctant to adopt an interventionist approach, foster families were being more proactive in promoting healthy eating habits.

Support to eat healthily

That foster parents seem to exert positive pressure on what young people eat, seems to be borne out by the finding that just 47% chose what they ate most of the time and 41% some of the time. This compares with 54% of respondents in the previous survey reporting that they chose what they ate most of the time, and a further 34% that they did so some of the time. Exactly the same proportion in both surveys, 12%, hardly ever or never, chose what they ate. In this survey they also appeared to have less opportunity to cook for themselves: that is, 30% compared to 53% in the last survey, reported they were able to cook quite often and 41% compared to 36% were able to cook some of the time. In short, young people in foster care were slightly less likely to have a direct choice of what to eat, and had somewhat less opportunity to cook while overall they ate a healthier daily diet.

Interestingly, the young people in foster care reported having better access to help and support to eat healthily than those in residential settings. A high proportion (88%) received advice or information on healthy eating, and the majority (83%) received advice or help on how to cook. Fewer (2 out of 10 compared to 7 out of 10) had received help with cooking on a budget, and they rarely did food shopping - only 14% did food shopping compared to 32% in the previous survey.

Perceptions of weight

The questionnaire asked respondents how happy they were with their weight. The majority (79%) were happy with their current weight, with only 4 respondents saying they were on slimming diets. Of those who were unhappy with their weight, a higher proportion (67%) had a problem with being overweight than underweight. This is in contrast with the 2001 survey, which found that a higher proportion of respondents had a problem with being underweight than overweight.

Summary of findings

- Young people generally ate healthily in foster care: 64% ate one or two pieces of fruit a day and nearly three quarters (74%) were eating between 1-3 vegetables daily. While there is still room for improvement, this is a more positive result than the last survey
- While research has found residential staff to be reluctant to adopt an interventionist approach, foster families were seen as proactive in promoting healthy eating habits
- The majority (79%) were happy with their current weight, with only 4 respondents saying they were on slimming diets. Of those who were unhappy with their weight, a higher proportion (67%) had a problem with being overweight than being under-weight
- Young people in foster care appeared to have less direct choice of what to eat and less opportunity to cook but overall they ate a healthier daily diet. This supports the earlier finding that foster parents are more likely than residential staff to encourage young people to eat healthily
- Young people in foster care reported having better access to help and support to eat healthily than those in residential settings. A high proportion (88%) received advice or information on healthy eating, and the majority (83%) received advice or help on how to cook
- Fewer had received help with cooking on a budget, and they rarely did food shopping - only 14% did food shopping compared to 32% in the previous survey

Physical Activity

The questionnaire sought to measure general levels of physical activity, regardless of whether this took place at school or outside school. Respondents were asked 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. They were also asked for the average length of time they spent exercising, and to identify from a list the types of activities or sports they took part in.

Levels of activity

General levels of physical activity among young people in foster care contrast sharply with the findings from the previous survey. Only 11% never took part in any exercise or sports, compared to 34% of the previous sample. The percentage of females in this category was slightly higher but the most significant gender difference was in terms of the intensity of physical activity on a weekly basis - 44% of males engaged in exercise or sport five times or more in the previous week compared to just 16% of females. Those who never took exercise ranged in age from 14 through to 18 years. Further a fifth of those who were smokers did not take any regular exercise.

Of those taking some form of exercise, the majority (68%) were exercising for more than thirty minutes at a time, which is not surprising given the most common types of physical activity were football or rugby (44%), racket sports (39%), swimming (38%), and basketball (36%). There appeared to be a broader range of physical activities, which included cross country skiing, air cadets, canoeing, and 'shinty' as well as football, jogging, gym, swimming, and rounders.

Motivation

They had ambitions to do more activities, which included wanting to join a female rugby team, play ice hockey, parachuting, scuba diving, sky diving, jet ski-ing, horse riding, taking up line dancing, yoga, hill walking and climbing. As before the primary reasons for not taking part in these things were cost, disinterest, and not having a companion. Lack of motivation was slightly less of a problem than with the previous sample: 11 young people (17%) were not interested in taking part in any physical activity or sports compared to 25% in the previous survey. Young people's comments also suggested that time was a key factor especially as some were busy with exams, and that health conditions (such as asthma) got in the way of exercising more.

Increases in activity

While in the previous survey, interviews with young people suggested they had been more active before coming into care; the opposite was true for those in foster care. All stated they had been more active whilst in foster care:

"I'm more active, I've got my life together now. I'm not into all the stuff I was"
(16-year-old female)

"I do more PE at school and I take the dog out walking"
(14-year-old female)

"I didn't do much before I was fostered due to my circumstances"
(18-year-old female)

Further, there were clear indications that foster families were positively encouraging young people to be more active. The following quotations from a group interview with young males illustrates this:

"They persuade me to go out and that, they just say go out with your friends, get a bit of fresh air in you and they reward me as well 'cause during the week-end that's the only time I'm allowed to go on the computer and Monday to Friday I do study for my standard grades and because we're in most of the time, my foster parents will tell me to go out and when I come back in I maybe get an hour on the computer"

"My (foster) dad is always like 'why don't you phone one of your pals and go swimming or something' and if we've no got any money he'll say 'aye here's some money and just go along to the swimming'. If I'm no doing anything he'll just say 'why don't you just go a walk?'"

Sexual Health & Relationships

Summary of findings

- General levels of physical activity among young people in foster care contrast sharply with the findings from the previous survey. Only 11% never took part in any exercise or sports, compared to 34% of the previous sample
- The most significant gender difference was in terms of the intensity of physical activity on a weekly basis - 44% of males engaged in exercise or sport five times or more in the previous week compared to just 16% of females
- Those who never took exercise ranged in age from 14 through to 18 years
- A fifth of those who were smokers did not take any regular exercise
- The majority (68%) were exercising for more than thirty minutes at a time, which is not surprising given the most common types of physical activity were football or rugby (44%), racket sports (39%), swimming (38%), and basketball (36%)
- There was a broader range of physical activities reported, which included cross-country skiing, activities with air cadet, canoeing, and 'shinty' as well as football, jogging, going to the gym, swimming, and rounders
- Ambitions included wanting to join a female rugby team, to play ice hockey, parachuting, scuba diving, sky diving, jet skiing, horse riding, taking up line dancing, yoga, hill walking and climbing
- As before, the primary reasons for not taking part in these things were cost, disinterest or lack of motivation, and not having anyone to go with them. However, lack of motivation was slightly less of a problem - 11 young people (17%) compared to 25% in the previous survey
- Young people's comments also suggested that time was a key factor especially if studying for exams, and that health conditions got in the way
- While young people in the previous survey suggested they had been more active before coming into care, the opposite was true for those in foster care. All stated they had become more active whilst in foster care
- Young people reported foster parents as actively encouraging them to be more physically active

Barriers to accessing information, support, guidance and services relating to sex, sexuality and relationships whilst in care are known to exist. These barriers are known to result in young people experiencing early pregnancy and being vulnerable to sexually transmitted infections. Many young people in care will also have histories of sexual, emotional and physical abuse, which can contribute to a distorted view and understanding of sex and personal relationships (Patel-Kanwal and Lenderyou, 1999). 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, respondents were asked the same questions as in the 2001 survey to ensure comparability. The findings from these questions are referred to throughout this report where they relate to areas such as young people's use of health services, access to information/advice and foster carers' perspectives. These findings are also summarised here in this section of the report.

Fewer young people than in the last survey had been in touch with family planning or contraceptive services (25% compared with 35%). A similar proportion as in the last survey (41%) did not know where the nearest sexual health or contraception service for young people was.

Teenage pregnancy figures indicate 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). There were no comparative Glasgow City figures available at the point of compiling this research. There would therefore appear to be a gap in the monitoring and gathering of this information at a local level.

Slightly fewer of the respondents (18% compared to 26% in the last survey) worried 'often' about getting pregnant or getting their girlfriend pregnant. Another 44% worried 'sometimes' (compared to 36% in the last survey), while the rest - 38%, did not usually worry about getting pregnant. Nor was sexual health an area that young people particularly identified as a health concern for themselves in the questionnaire or during interviews. These findings may help to explain why there were less young people in this survey than the last survey, who had been in touch with family planning or contraceptive services. Furthermore, young people in this survey were also significantly better informed

on a range of health topics than those who took part in the last survey, including areas relating to sexual health. Young people did however highlight a need for more information relating to relationships and being a parent.

Sexual health information and support was also identified as an area which young people highlighted as a pressing need as part of their preparation for 'leaving care':

"Sexual relationships and the dangers and responsibilities it could involve"

(16-year-old female)

"Having sex because it usually happened to my friends, so if you are, use a condom"

(14-year-old male)

It is worthwhile briefly noting here the findings relating to foster carers' perspectives in relation to sexual health, sexuality and relationships, that are reported later in this report (see pages 27-36). This was identified as a key area in which carers felt that they lacked the necessary skills, confidence and knowledge to proactively engage with young people and where additional training, information and resources are needed. This hesitancy was in part related to the 'sensitivity' of the area in view of 'allegations' being made against foster carers in the past. However, it was highlighted that discussions in this area with young people had led to positive discussions and disclosures about past abuse that could then be addressed.

Summary of findings

- 75% of young people had had no contact with sexual health or contraceptive services
- 41% of respondents did not know where the nearest young people's sexual health or contraception service was
- 18% of young people 'often worried' about getting pregnant or getting their girlfriend pregnant and another 44% worried about this 'sometimes'
- young people reported being unprepared for 'leaving care' in relation to sexual health and relationships
- Foster carers expressed particular issues and needs in relation to being better supported in matters relating to sexual health

Smoking

Levels of smoking

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). Even though high levels of smoking among young people in care have been reported in other studies (Scottish Health Feedback, 2001; Robinson, 1999), lower levels of smoking have been found in the general teenage population. 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 and other Scottish surveys (e.g. Miller et al, 1996) report levels as high as a third of pupils aged 15 to 16 years.

In the present survey, just 10 or 16% of respondents were smokers. This contrasts sharply with the findings of the last survey, which found 75% of respondents to be smokers. Further, nine out of the ten smokers wanted help to cut down or stop smoking. The overall proportion of males and of females who smoked was similar (14% of males and 17% of females). The highest proportion of smokers was aged 16 years (40%), followed by those who were aged 18 years (30%).

Smoking in foster care

During interviews, some of the issues around smoking were explored further and young people were asked if their birth parents and/or their foster parents were smokers, as well as their opinions about this. Additionally, they were asked what they thought their foster families' attitude would be towards them if they were to smoke.

Fewer foster parents than birth parents were reported as being smokers. However, young people who were non-smokers, did not really approve of foster parents' smoking:

"It's quite annoying cause see if you're going on a night out with your friends and say you get a jacket like all the smoke clings to it and it smells as though you've been smoking and your friends ask you"

(Male participant in focus group)

They also pointed out the dangers of "passive smoking" or the impact on them from living in a household where people smoked:

"I don't really like it cause it gets into your lungs and it's pure minging, clogs up your heart and everything"

"And passive smoking as well, you're still taking it in"

(Male participants in focus group)

The perception of young people in relation to their own smoking and foster parents' attitudes was that while foster parents did not stop them from smoking, they often pointed out the health risks involved and encouraged them to give up smoking:

"It does bother her but I was smoking before I came here"

(15-year-old female)

"I don't smoke but they would mind. They wouldn't want me to have black lungs, they want me to live longer"

(15-year-old male)

Foster parents were perceived as supporting young people in their decision whether or not to smoke, while making it clear that they would prefer the young person not to smoke:

"When I first came here, I checked if it was okay first. My own mum and dad have allowed me to smoke"

(16-year-old female)

Reasons for smoking

Out of the ten who were smokers, five started smoking before going into care, and five started while in care. Given that other research (Sweeting & West, 2000) has found one of the most frequent reasons teenagers give for having tried their first cigarette is to fit in with peers, an assertion also made by members of the Research Steering Group, the research set out to explore young people's opinions as to why some young people smoke.

What was found was that respondents also believed they and other young people smoked mainly because of "peer pressure", as they put it, a tendency for "just going with the crowd". They commented:

"They smoke just 'cause they think it's good, 'cause all their pals do it they think they have to as well"

(14-year-old female)

"When I was younger, when I first moved to my foster parents' and my foster mum actually smoked and I thought it was actually cool to smoke so I even tried it then but then my mum gave up, I gave up. But then my friend at college is buying me them, it's peer pressure now to get back into it"

(Male participant in focus group)

As in the previous study, some of the reasons for smoking included using it to appear more mature or "just to be cool", and because "they're a bit stressed", for instance:

"Maybe they're angry or upset about something and they think that the cigarettes will help them"

(Male participant in focus group)

The findings regarding smoking reflect the fact that in foster family settings, smoking was generally not the norm and this contrasted with young people's birth families' lifestyles. It also contrasted with the norms operating in residential settings as shown in the previous survey, where many staff were smokers, and there was strong peer pressure from other residents to smoke as well as to take drugs or drink alcohol.

Summary of findings

- Just 10 or 16% of respondents were smokers compared to 75% of respondents in the previous survey
- Further, nine out of the ten smokers wanted help to cut down or stop smoking
- The overall proportion of males and of females who smoked was similar (14% of males and 17% of females)
- The highest proportion of smokers was aged 16 years (40%), followed by those who were aged 18 years (30%)
- Fewer foster parents than birth parents were reported to be smokers, and respondents did not really like their foster parents to smoke, especially if they were non-smokers themselves
- In relation to their own smoking, they said foster parents did not stop them from smoking but they did point out the health risks involved and encouraged them to give up smoking
- As in the previous study, the main reason for smoking was "peer pressure", but also to appear more mature or to relieve stress

Drug taking



Respondents were asked the same questions about drug taking as in the previous survey to ensure comparability. However, the detailed question about drugs was preceded by, 'If you use drugs, when did you first try drugs?' They 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.

Prevalance

Reported drug use of any kind was rare among the respondents. This suggests that previous studies which have found a higher risk of developing chronic illicit drug use among young people in care than those in the community (Robinson et al, 1999, Greater Glasgow Health Board, 1995) have sampled mainly from the residential in care population. However, the difference may also be indicative of under-reporting of drug use among the respondents in this survey. It may have been that some respondents were worried about confidentiality and unconvinced by the assurances given. The following response from one of the young people interviewed suggests confidentiality was a key issue:

"A young person should have a drugs worker, somewhere they don't need to involve foster parents, somewhere to talk discreetly"
(16-year-old female)

Only 47 out of 66 respondents answered the initial question about drugs. Out of these, 41 (87%) stated they never used drugs. Only six respondents reported trying cannabis at least once. One of the six had also tried ecstasy and solvents. Another had also tried magic mushrooms. None of the respondents had injected drugs.

The picture here contrasts sharply with the picture obtained in the previous survey when drug use, particularly cannabis use was found to be prevalent - 84% had used cannabis/marijuana at least once. It perhaps confirms the finding of other research (Market Research Scotland, 1998) that taking drugs (predominantly soft drugs) is a major problem in young people's residential units in particular rather than 'in care' in general. Five out of the six who had used drugs first tried drugs while in care. Four of these five had been in other foster homes and at some stage, had lived in residential or young people's units.

Education and Support

In the previous survey, it emerged from the focus groups that participants wanted more adult control especially in young people's units to curb smoking, excessive drinking and drug-taking. They indicated 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. A different picture emerged from surveying young people in foster care settings.

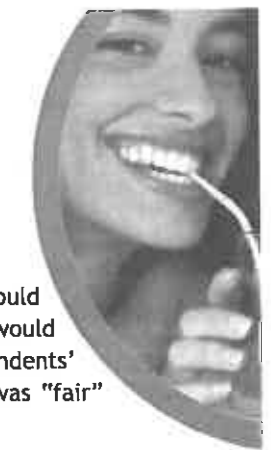
Generally, respondents felt that if foster parents found out they were taking drugs they would be "disappointed" in them and "be upset", and more seriously, that they may even want to move them onto another placement. It was suggested however that it would depend on what kind of drugs and the nature of the problems:

If it was like Ecstasy or something 'cause it's like in the paper it's been like people died with just taking one and we have two other boys in the house and that could make them take them. So they might not want me there anymore 'cause it will cause a lot of trouble in the house"
(Male participant in focus group)

Summary of findings

- Reported drug use was rare among young people in foster care. 47 out of 66 replied as to whether they had used drugs or not. Out of these, 41 (87%) stated they never used drugs
- This might be an accurate reflection of the difference in lifestyles between young people in different placements, or there may have been some under-reporting if respondents were worried about confidentiality and unconvinced by the assurances given in the research
- Only 6 respondents reported trying cannabis at least once. One of the six had also tried ecstasy and solvents. Another had also tried magic mushrooms. None of the respondents had injected drugs
- The findings contrast sharply with the previous survey when drug use, particularly cannabis use was found to be prevalent
- Generally, respondents felt that if foster parents found out they were taking drugs they would be "disappointed" in them and "be upset", and more seriously that they may even want to move them onto another placement

Alcohol Use



Prevalance

Rates of drinking alcohol among the sample were low compared to young people in other care settings as shown in the previous survey. Just over one third (34%) of young people never drank any alcohol, which is a significantly higher proportion than in the previous survey when only 4% stated they never drank alcohol. The level of weekly or more frequent drinking was also far lower. Only five respondents (9%) drank alcohol once a week or more compared to 50% of respondents in the previous survey. This was also a lower rate than found among 12-15 year olds in the Community Schools Survey, which found 16% in this age range who drank alcohol once a week or more.

Unlike the previous survey where 14% stated they were drunk most days, none of the respondents drank alcohol to this extent. Out of those who replied (35 respondents), 54% stated they drank alcohol but did not get drunk. This compares with 16% in the previous survey. Only three stated they were drunk at least once a week (2 females and 1 male). Another three stated they were drunk once or twice a month (2 males and 1 female), and 10 that they were drunk less frequently than monthly.

Other surveys have found that the incidence of drinking and drug-taking tends to increase with age (e.g. SHF, 1997). The findings of this survey support this assertion.

In comparison with the previous study, it was less common for young people to have started drinking alcohol before going into care (16% compared to 63%). A high proportion of respondents (48%) had first tried alcohol while in care, which compares with 29% in the previous survey. It should be remembered that, on average, the young people in the current survey had first come into care at a younger age than those in the previous survey, so they were more likely to have already been in care at the age when they were first presented with the opportunity to try alcohol.

Education and Support

The ways in which young people in foster care talked about the consequences of drinking too much alcohol and how this was dealt with in foster families was significantly different. In residential settings, young people wanted more guidance from staff about 'social drinking' as well as about smoking or taking drugs. When asked in interviews what foster parents would say and do if the young people drank alcohol, they

typically commented that foster parents would "go mental", or "hit the roof", or that they would "be annoyed or angry", and in the respondents' opinion this was the "right thing to do", it was "fair" and "sensible". Typical comments were:

"Well they would smell it off you first of all, so you can never hide it cause when you come in you'd be falling about the place so you can't hide it. So probably get shouted at and I would get grounded"
(Female participant in focus group)

"They'd say you're under age and get me into trouble and ground me and then say don't do it again, stuff like that"
(Male participant in focus group)

One young person stated:

"They tell me that they won't allow that when I'm staying here under their roof"
(14-year-old female)

Invariably, respondents agreed with foster parents' approach and had sometimes experienced problems with birth parents' drinking:

"My birth parents used to drink and I seen what it done to them, big big fights and that's why I don't drink too much, I only drink like at parties and celebration times"
(Male participant in focus group)

Alcohol in itself was not banned but there was a stronger emphasis on the need to drink in moderation and to do so only during social occasions, for instance, two young people commented:

"Only at parties I'm allowed to drink"
(Male participant in focus group)

"I'm allowed to go out at weekends with my pals and I'm allowed to have a drink at the weekends so long as I don't go over the top"
(16 year old female)

Health Services, Information & Advice

Summary of findings

- There were lower rates of drinking among the respondents than in the previous survey: over a third never drank any alcohol at all compared to 4% previously
- Only five respondents (9%) drank as regularly as once a week or more compared to 50% in the previous survey
- Neither was it common for respondents to be drunk regularly: 54% drank but never became drunk
- It was less common for respondents to have started drinking before they came into care (16% compared to 63% in the first survey)
- A high proportion (48%) had first tried alcohol while in care compared to 29% in the previous survey
- They had received guidance and direction from foster carers and this was accepted as "sensible"
- They reported that foster parents would "hit the roof" if they found out about drinking and that there were clear consequences to this action
- Alcohol in itself was not banned but there was an emphasis on drinking only in moderation, and mainly during social occasions

This study sought as the previous one did, to find out which health services young people in foster care had used, what they thought of them, and what ideas they had for making improvements. It is widely acknowledged that the circumstances of being 'in-care' or 'looked-after' by the local authority can frequently result in a lack of continuity of health care and as this was investigated in the previous survey, it was important to explore whether the same or different issues existed for young people in foster care settings.

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. The interviews also explored young people's views of health services and how to improve them and quotations from these interviews are incorporated where appropriate.

GPs/doctor

The vast majority (98%) recalled visiting the doctor or GP at some time, although for nearly a quarter (24%) this had been over a year ago. Most (59%) had seen the doctor or GP in the past 6 months, which was fewer than in the previous survey (83% had seen the doctor in the past 6 months). This was however, similar to Robinson's study (1999), which found 58% of their sample of looked after young people in Edinburgh had seen their doctor in the past six months.

However, fewer respondents (25% compared to 42%) had had a medical check up in the past 6 months, which taken together with the length of time in current placement perhaps reflects the greater stability within this group, as well as reflecting changes in practice with foster care placements and the requirement to attend medical examinations. It did appear that young people in foster care were using primary health care services in a more 'normalised' fashion, that is going to see the doctor predominantly when they were ill rather than for required medical examinations. In the last survey, those living in residential settings were the most likely to have had a medical examination within the past 6 months.

As before, experiences with GPs were somewhat mixed but overall they appeared happier than respondents in the past survey with the way their doctor had dealt with their problem: 82% were either 'very happy' or 'quite happy'. Those who were positive felt they had received the treatment they thought they needed, their problem had been diagnosed, understood and dealt with appropriately, and the GP had been helpful and/or "supportive":

"My doctor specialises in my medical problem"
(17-year-old female)

"The doctor has helped me see sense of health and my life. Thanks!"
(16-year-old female)

"It's a good service and I know they'd help me best"
(15-year-old male)

Nearly a fifth (18%), mainly females, were not so positive about the way their GP dealt with them or their problem at the last visit. Some felt that GPs did not always explain things to them:

"He didn't tell me what's wrong, he just gave me tablets and didn't explain what they were for"
(17-year-old female)

Or going to the doctor had not seemed to them to make any difference:

"They still haven't found out what's wrong with me"
(18-year-old female)

It was said that doctors sometimes didn't listen to young people:

"They were friendly but didn't seem to really listen or understand"
(17-year-old female)

"The last doctor I had never spoke to me and made me feel like a hypochondriac"
(16-year-old female)

Young people had been too embarrassed to discuss some of their problems with the GP:

"I understand they are stuck for time but was scared to ask about health problems in case of embarrassment"
(17-year-old male)

A couple of young people felt the treatment they had been prescribed was inappropriate:

"I told her that I was getting really bad pains in my side after I had taken an overdose on Paracetamol and she gave me more tablets for headaches"
(15-year-old female)

Dental & Oral Services

Young people in foster care used dental and oral services more frequently than those in the previous study. All of the respondents had visited the dentist: the majority (66%) had seen the dentist within the recommended 6 months (compared with 51% in the previous study), 22% between 6 months and a year, and 13% over a year ago. Only one person confessed to not having a toothbrush and 92% said they brushed their teeth daily, a further 5% that they brushed alternate days, and 3% brushed less often. Overall, this is a more positive result than the previous survey.

Use of other health services

In the survey of young people leaving care, 46% of respondents had visited a hospital casualty department in the previous 6 months, whereas only 11% of respondents in this survey had. There might be several different reasons for this. One could be that young people in foster care had better relationships with their GPs and primary health care services generally and therefore had less need to access health services via accident and emergency services. Another plausible reason might be related to the low drug and alcohol use particularly compared to the previous survey, which suggested that episodes at hospital casualty department were possibly drug and/or alcohol related.

In terms of other health services, more respondents had their eyes tested regularly, for example, 30% had had their eyes tested within the last 6 months compared to 23% in the last survey. Telephone helplines were rarely used (only 7% of respondents used helplines) and as before, few respondents had visited a drop-in centre for health information or advice (13%). Similarly, contact with the school nurse was infrequent, but given the high proportion of young people over 15 years responding to the survey, this is hardly surprising. However, slightly more had seen the school nurse within the past 6 months (21% compared with 15% in the previous survey).

Barriers to access

The respondents highlighted a number of barriers to accessing health services. The most significant appeared to be that there were staff who did not understand young people's problems, 'boring waiting rooms', information about the service was not easy to understand, there was no choice of male or female staff and young people worried that the service might not be confidential. There were slight differences between the issues raised here and those raised in the previous survey. More young people than in the last survey (23% compared to 13%), highlighted staff who don't understand young people's problems as the main barrier to them accessing services, while fewer were concerned about

there being a choice of male or female staff and the service being confidential (17% compared to 23% and 17% compared to 22%, respectively).

Although many did not perceive themselves as having a need for health services as typically they felt as one person said, "perfectly fine and dandy!", there were some suggestions for improving health services for young people. This mainly involved increasing staffing within hospitals but with staff who understood young people better, improving waiting areas and reducing waiting times and ensuring diagnoses that are more accurate:

"More doctors, more nurses for young people and waiting areas should be more fun. It should be quick"
(15-year-old male)

"Younger staff would make me feel better"
(15-year-old female)

"More activities for young children, teens, teenagers and adults in the waiting rooms"
(16-year-old female)

"If doctors could diagnose the correct thing"
(19-year-old female)

It was suggested that young people needed opportunities to "talk about the things they want to talk about" and "be free to talk about any problems they have". A better health service therefore, needed to listen to young people's concerns more:

"Doctors that actually listen to what your problem is"
(15 year old female)

Information & advice

Throughout the questionnaire in relation to various health related topics, respondents were asked if they had received any information or advice while they were or had been in care. They were also asked if they wanted to receive information about the topic in the future.

Respondents in this survey tended to be better informed and advised on a range of health related topics than those in the previous survey. For instance, between 60% and 80% recalled having information and/or advice on aspects of sexuality (such as safer sex, sexual intercourse or contraceptives); physical health (especially eating healthily and getting fit and exercise); drugs/alcohol/smoking (especially the effects

of drinking alcohol); and mental well being (especially relationships, violence and bullying and self confidence and self esteem). This compares to a range of between 20% and 60% of respondents in the previous survey who recalled receiving such advice.

There was some demand, although not huge, for more information/advice on all health related topics in the future. For some reason, this was generally lower than in the previous survey perhaps given the much higher levels of information and advice already received from foster parents, schools, and others. The highest demand was for help and advice on cooking on a budget, losing weight, getting fit and exercise, being a parent, self confidence and self esteem, and relationships.

Summary of findings

- The vast majority (98%) had visited their doctor or GP although for nearly a quarter (24%) this had been over a year ago. The majority (59%) had seen the doctor or GP in the past 6 months, which compares with 83% of respondents in the last survey
- Fewer respondents (25% compared to 42%) had had a medical check up in the past 6 months, which taken together with the length of time in current placement perhaps reflects the greater stability within this group, as well as reflecting practice within foster families - using primary health care services like other young people in the community
- Experiences with GPs were again somewhat mixed but overall they appeared happy with the way their doctor had dealt with their problem: 82% were either 'very happy' or 'quite happy'. In their experience, GPs understood and dealt with their problems appropriately and had been helpful and supportive in some cases
- Nearly a fifth (18%), mainly females, were not so positive about the way their GP dealt with them or their problem at the last visit. Some felt that GPs did not always explain things to them or going to the doctor had not made any difference. Doctors sometimes didn't listen or young people felt too embarrassed to discuss their problems with the GP and some had received inappropriate treatment

- Young people in foster care used dental and oral services more frequently than other young people in care and leaving care. The majority (66%) had seen the dentist within the recommended 6 months, 22% between 6 months and a year, and 13% over a year ago
- The majority had a toothbrush and 92% brushed their teeth daily, 5% brushed alternate days, and 3% brushed less often
- Respondents were slightly more likely than in the first survey to have had their eyes tested recently, and to have seen the school nurse; and were less likely to have used hospital Casualty Departments, or family planning/contraceptive services
- As in the previous survey few (only 13%) had used drop-in centres and only 7% had used telephone help-lines
- The most common barriers to using health services were that staff did not understand young people's problems, waiting rooms were boring, information about the service was not easy to understand, there was no choice of male or female staff and lack of confidentiality
- Respondents' suggestions for improving health services for young people were for increased staffing levels in hospitals, but with staff who understood young people better; improved waiting areas; reduced waiting times; diagnoses that were more accurate; and young people having opportunities to talk about their concerns
- Respondents were generally better informed and advised on a range of health related topics than in the previous survey. For instance, between 60 and 80% of respondents recalled having received information and/or advice on topics such as sexuality, physical health, drugs/alcohol/smoking, and mental well being
- There was a demand for more information/advice on all health related topics in the future but especially for information and help with cooking on a budget, losing weight, getting fit and exercise, being a parent, self confidence and self esteem, and relationships

The Future

Leaving care

As in the 2001 survey, respondents identified the most pressing need for information and support for young people in care or who had recently left care, as getting help with leaving care or "going into the big bad world on their own", and secondly, with sexual health. They wanted information and advice about how to get a job and accommodation as well as how to manage on a budget, to look after themselves properly and how to live their own life, as well as coping with becoming a parent. Some of their comments included:

"Living on their own, where to go from now, what help there is for them and getting the best out of life"

(17-year-old female)

"How to space out money, be quite detailed about living on their own and the things they need to do"

(16-year-old male)

The findings show the vulnerability of all young people leaving care even of those in foster care who might reasonably be expected to have stronger social support within the community than those living in residential settings. All young people who are moving into independent living want to be able to cope. One respondent reflected on what happens when young people do not get the support they need:

"Most people I see are junkies and most of them came from foster homes. I hate that and am very certain I will make something of myself so I don't end up like them"

(18-year-old female)

A recent study of throughcare and aftercare services in Scotland (Dixon & Stein, 2002) found that a majority of young people (61%) had no planned programme of preparation for leaving care. Many will also experience social isolation and exclusion as they are less likely than their peers to have access to social support, family and community resources and networks, if and when they meet social, health and emotional problems. All of these factors are considered to be particularly detrimental to good health and well-being and highlight the need for adequate throughcare and aftercare support, which is clearly at the heart of young people's own health concerns.

Future aspirations

At the end of the questionnaire respondents were asked to consider what might happen to them in the future by age 22 years. The question was taken from the 11 to 16 Study and was the same as had been used in the first survey questionnaire. There were nine items and respondents were invited to tick all that applied from a choice of:

Be at university or 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 a dad myself; Have a job.

Again while not directly comparable with the 11 to 16 Study given the different age profile of the samples, overall respondents were positive about their future and in many respects they were more optimistic than the previous respondents. For instance 85% thought they would have a job compared to 81% of respondents in the past survey; 89% that they would be in good health compared to 68%; 77% that they would own a car compared to 60%; and 75% compared to 50% that they would be a student at university or college.

Summary of findings

- As in the 2001 survey, respondents identified the most pressing need for information and support for young people in care or who had recently left care, as getting help with leaving care or "going into the big bad world on their own", and secondly, with sexual health
- The findings support the assertion from other research that there is a need to focus on adequate throughcare and aftercare support as this is central to the concerns of young people themselves
- Again, respondents were positive about their future and in many respects were even more optimistic than the previous respondents - 85% thought they would have a job; 89% that they would be in good health; 77% that they would own a car; and 75% that they would be a student at university or college

Foster Carers' Perspectives

In four focus groups, 18 foster carers discussed a range of topics in respect of young people's health needs and issues and their own role in promoting young people's health. The five main topics of discussion were:

- The main health issues and concerns of young people in foster care and comparisons with their own birth children
- How foster carers perceived their role in relation to preventing ill health and promoting the health of young people in foster care and whether they and/or their birth children act as role models
- The perceived obstacles to promoting health and encouraging healthy lifestyles among young people in foster care
- How supported and confident foster carers felt in promoting health and supporting young people's health needs and concerns, and if there was any aspect of health they felt less confident about supporting
- The support foster carers wanted and their perceived need for training and other resources, as well as their ideas about who should provide this support

The themes to emerge from the focus group discussions are discussed below. Where relevant, reference is also made to comments from young people and these are compared with foster carers' views.

Young people's health issues and concerns

Most foster carers when asked did not perceive there to be significant differences between foster children's and their own children's health needs, although it was thought to vary according to the individual and their background. The following was a typical response from a focus group participant:

"I can't think of any differences, I've never had any problems with health. We are registered with our local doctor and if they need anything, we just give them a phone. Usually kids can get seen that day, we never seem to have emergencies unless they drop dead in the morning to go to school!"

(Foster carer)

Having said that, they did point out that many of the children and young people coming into foster care were "chronically neglected" and/or "malnourished", which presented particular health issues. One foster carer described how a child of three was so malnourished that he was wearing clothes for a one and half year old. In short, many of the health issues and concerns foster carers could identify were as a consequence of poor care and neglectful environments that had caused them to come into foster care, for instance:

"I've got this boy and his dad was a heavy drinker when he was born and he's got foetal alcohol syndrome. You can tell with his face and his looks..."

Linked to this issue of neglect was the poor record of dental care among children and young people coming into care. Foster carers highlighted issues around dental care as a major issue particularly at the beginning of many foster care placements. The dentist was frequently the "first port of call", especially for young children:

"Well their dental care, I mean that always needs attention when they come to you. I had one wee boy that needed an awful lot of work done in his mouth, he was a poor wee soul the amount of teeth he needed to get out. It goes back to poor eating"

In respect of young people's specific health issues or concerns, foster carers highlighted two main areas: while not a health issue in itself, it was suggested that young people in foster care were especially diligent about following up health problems and keeping health service appointments; second, foster carers thought the young people tended to exaggerate health problems to get attention.

First they suggested young people were "very health conscious" in the sense that:

"They want to be very clean, they want to take care of their teeth. If they've got the slightest wee cough they want you either to take them to the doctor or get cough medicine. They're really eager for anything to do with their health to be taken care of, that's all aspects, that's to do with nits and you know anything wrong with them, very health conscious"

Some felt that foster children had a "small pain threshold" or sometimes exaggerated or "dramatised" health problems or illnesses to get attention:

"I'm not saying they don't deserve it because they obviously do but I'm saying it triggers off that protective mechanism. So if you have your own child and he complains of having a sore head, then you probably give him a couple of aspirin and say "go and lie down in bed" and that's it, but with foster children, they would dramatise it a lot more"

"I think it's the environment they come out of, so naebody pays them any attention, so this is them trying to get attention: 'I've got a sore stomach, I've got a sore head'. I'd say a lot of children that come in have got health issues, but it's all psychological, it's a cry for attention"

In the words of one foster carer, the greater the insecurity of the children, the greater the magnification of whatever is wrong. However, it was also observed that foster carers might take foster children to the doctor more often than their own children because, as they put it, "it's a big responsibility" with children in care. Having said all that, it was also claimed that young people in care were "very resilient" due to their background and because they had often survived more illness and infections more than other young people.

Health records

Inconsistent practice

It is now considered good practice that every child in care has a health record that should follow the child when they move placements and is intended to contain vital information about the child's health, family history including the nature of any abuse, details of immunisations and so on. Foster carers should receive these health books or 'blue books' (or 'red books') as they are sometimes called when the child or young person is placed with them and this way have a clear understanding of the young person's health needs. In speaking to foster carers, it was discovered that health record books commonly did not arrive with the children or they arrived late, sometimes with little or no information in them:

"Sometimes it's a new book and all that's in it is the child's name and address"

One foster carer said they still had five health books for children who had left some time ago. Despite such experiences, the overall sense from foster carers was that practice was changing for the better and "they're getting their act together." All were agreed on the need for some kind of medical record and thought they were a good idea if used properly, which meant keeping records up-to-date. They thought it would be useful to have a section in the health book detailing dental health history and treatment given that this is such a significant health issue. Overall, it was considered a "good system" but the big flaw was that its use was "not getting monitored". The foster carers were not aware of any compulsion on professionals, parents, residential staff or foster carers etc to complete the records.

Vital information such as when they had last had a tetanus injection or whether they were allergic to penicillin were often blanks that had to be filled in from experience. The name of the GP was missing in some cases, which caused some confusion. This wasn't necessarily the fault of Social Work as it was said they "can only go on what the parents say", and some parents did not keep up-to-date records. While regarded positively however, it was also suggested that to understand what was in the health book, one had to "be a philosopher", which suggests the content and layout of health books needs to be examined.

Stigmatising

Foster parents highlighted a problem with stigma for the young people arising from using the health record book system while in care, as it marked them out as being in care or "shows that I'm in care". They added:

"It stigmatises the children. Our children hate to be labelled as 'in foster care', 'looked after' or whatever. I don't think it keeps their dignity. I know there has to be a record but I think there could be a better way for the sake of the children. There's a lot of them I don't think it bothers them, but some children they don't like the idea of this book"

The issue of stigma did not arise from the young people themselves but this suggests this is an issue worth investigating further. What young people did say was that they would not necessarily want responsibility for holding their health book themselves. All the young people interviewed were aware they had a 'health book', in which was recorded for instance, details of health problems and immunisations. Older teenagers felt they should keep their own health book but younger teenagers (under 16s) were happy for foster carers to keep these safe:

"My foster mum keeps it. I don't think I should keep it, I might lose it and it's important"

(14-year-old female)

Health promoting roles

Role of foster parents in promoting health

Foster carers did perceive themselves as having a role in promoting health in respect of showing young people "a different lifestyle", and providing a "normal pattern of life". They saw it as up to them to model a healthier lifestyle than the young people might have previously known:

"That sums it up really about lifestyle, you know a different lifestyle just to show them and also just routine. They've never known any boundaries, they've never known any routine and just you know whatever is there just eat when you can, when there is food available and just to give them that routine to know that their life has a rhythm so that they can grow as adults, you know into strong adults"

They were entirely "comfortable" with having a role in promoting a healthy lifestyle with young people. Their role was to maintain health "to a high standard as we would our own children". It meant providing basic things such as three meals a day, and promoting a healthy lifestyle. In a family setting as opposed to a residential setting, they believed young people had more 'natural' opportunities for joining in activities such as swimming, cycling and so on and had better access to equipment such as bicycles, a football etc, all of which was borne out by the findings elsewhere in this study:

"But I don't see myself as actively promoting a healthy lifestyle, but just making sure that... there's things to do, get off the couch and do it, and I think that's just the philosophy I have. I don't think that because I'm a foster parent I think 'I must promote this', it's part of our everyday living"

"Well I'm a great one for what we eat, when these children came to me they just liked junk food and now they don't, you know they'll eat salads and they're interested in their health now...I'm quite health conscious regarding food and I've got the children sort of into that role because I tell them that's why their skin is so good"

Second, foster carers took very seriously their role to ensure foster children saw the doctor when necessary, visited the dentist and accessed other health services as appropriate to their needs and to ensure immunisations were up to date. It was a case of:

"It's our responsibility and if there's anything wrong with the child then we have to make sure it is investigated and any necessary treatment carried out"

"You think oh that cough is a wee bit deep, we'll go to the doctors today, just exactly as you would do, you just use your common sense and you just see to things when they're needing seen to and just like that the dentist every six months...so things are just as normal as they should be"

Taking on such a role was commonly thought of as "an obligation", and as all "part of the job" of being a foster carer.

Foster carers as role models

Foster carers definitely saw themselves as acting as role models. Some preferred not to think in terms of being a 'role model' but rather as acting like 'a good parent'. In this sense they argued, "every parent is a role model to their children" and as such they were encouraging "basic things" such as personal hygiene routines - tooth brushing, washing, showering, washing their hands etc, healthy eating and taking exercise.

Some foster carers felt they provided a positive role model by the way they lived their own lives, while others used their own 'bad habits' to point out the error of their ways and ward young people off adopting similar habits:

"Well I smoke and I warn them no to smoke, it's the worst thing I've ever done boys so don't you try it".

These perceptions were borne out by the findings in the rest of this study that respondents tended to eat more healthily, be more physically active and feel more positive about themselves and their lives than those in residential settings. It should therefore come as no surprise that young people often identified their foster families as role models for good health.

Role of birth children

Foster carers' own children, if they were older than the foster children, were said to have played a significant role as powerful role models. For instance:

"I've a boy, he's 23 now but he's grown up with foster children. They did learn from him because our boy is never out of the shower or he's never away from the mirror and things like that. He's got all these deodorants and body sprays he was collecting and he used to say, 'you better get some as well'"

In terms of tackling some of the health issues and concerns of young people in foster care, it was generally felt more likely that foster children would be more likely to listen to other young people than to adults and that birth children therefore potentially played a significant role in relation to young people's health:

"There was a child that came in, wouldn't actually talk to us, just came in and went upstairs to the room, but she talked, and she does talk to my own daughter, she doesn't shut up. She's telling her everything, boyfriends, details, everything, that's only even after four days, it's like a stranger she's telling it to, but it's also somebody her own age as well, to see what she thinks"

"They're more likely to talk to a young person than they are approaching you and I think that works. We find one of ours who's 17, and our daughter is 22 so she would talk to her and she you know helps to make sure everything is right so I think your older ones can set an example"

It was also suggested not all birth children have been happy with the role their parents have taken. As one couple commented:

"To be quite honest, when my own children were at home, and we were fostering, they hated it- they hated us fostering. Especially my daughter, she was the youngest. Health-wise - they never mixed. They would talk to each other but outside they had their own circle of friends"

Building self confidence and self esteem

Building self-confidence and self-esteem were perceived a "a big part" of foster carers' role:

"You have to try and point out their good things to make them see their good things and make them learn to like themselves and other people will like these qualities because a lot of them don't like themselves"

Sometimes their role was to support the young person's decision, even when this differed from their birth parent:

"His mum had said he was to get his inhaler again. And he said 'I don't need it', and his mum said he's to get it - what do you do here, do you say you've got to take it, your mum says you need it. So at the end we left it, he's fourteen, fifteen, it's his choice whether he takes it or not"

Foster carers' feeling confident

Foster carers generally felt confident in their role of promoting health. As one put it "it's just parenting isn't it?" This was a typical response:

"Well I feel confident to the fact that I know how to keep healthy and I try to follow the same example, obviously they don't always do everything exactly as you want them to but I think if you know yourself how to keep healthy and you pass it on, you're doing your best"

Confidence increased over time and they grew to know the young people more and foster children came to trust them more. They were confident about tackling issues such as smoking, as one foster carer comments:

"I have hopefully weaned her off cigarettes, she's in with me a year and she's been smoking since she was seven, her mum gave her cigarettes. So I've worked with her for a year now and I think I've got there with her"

Some though not all were less confident in tackling issues around sex education and worried about teenage girls getting pregnant. Part of the hesitancy was in view of allegations against foster carers in the past. While many stated they were happy to discuss sexual health issues with young people of the same sex as themselves, others, especially males, clearly still felt vulnerable:

"I don't discuss sex. Maybe you would explain the facts of life to a thirteen year old boy, and next year, when he leaves, he says 'He was talking sex to me last year', and carers, we've got to protect ourselves"

Tackling issues around sexual health was considered a normal aspect of bringing up teenagers and should not according to some foster carers be avoided. They also stressed the importance of giving young people support and the space to discuss issues around sex and relationships, and outlined how this had sometimes led to important disclosures about past abuse that could then be dealt with:

"Well when these children came to us they were young and we all sat around the table, and they used to...air their grievances. And one of them says to the other, do you remember when that boy assaulted you? And we find out it was a sexual assault, in a children's home, and that all came out. And I think if we hadn't he might have held it all in to himself, and might have ended up a wee hooligan or something, because they do hold things in"

From the young people's perspective, foster carers tended to be people who they felt comfortable talking to about all their health issues and concerns, although females would tend to approach their foster mum and males their foster dad about personal issues related to sexuality or relationships. This supports the foster carers' views that they tried to encourage young people to be open and discuss health issues. On the whole, young people felt they could trust their foster carers and they were "easy to talk to":

"I can just talk to anybody in the family 'cause we're made to feel ... it's a very sort of open family and naebody really like tries tae make a fool of you or anything if you want to say something"
(Male participant in focus group)

Only one older female said that she didn't find her foster carers very understanding as "they never have time". Young people themselves did not report turning to foster brothers or sisters or their own siblings in preference to foster carers. One 18-year-old female found it easier to talk to her boyfriend about her personal life. Others might choose to talk to friends about "lassie stuff" or personal relationships.

Challenges for foster carers

Lack of psychological services

By far the most common frustration highlighted by foster carers in carrying out their role, was the difficulty they experienced in accessing mental health services for young people. Despite recognized improvements in Glasgow's psychology services, from some foster carers' perspectives, these services were "near enough non-existent" or "atrocious". The complexity of issues and problems of young people in foster care, especially the extent of sexual and physical abuse, acted as a major barrier when promoting health. Foster carers told how they had had to wait lengthy periods for psychology treatment for young people and that sometimes such help was not arranged until after the young person had left their care:

"I'd say in Glasgow of all the children there, loads of them have got psychiatric problems, and getting help for them is very hard, but it's maybe children who have been abused, and through drugs, and seen things they maybe shouldn't see, and we've got to deal with it. We know it's part of our job that we've got to deal with it, but there should be professionals helping the children"

This theme of inadequate psychological services was highlighted often but as the following extracts from one of the focus group discussions illustrates, there were mixed views on the subject:

"I found that it's excellent actually, in fact the mental health is second to none, say a child of your own you would never get to see a psychologist but if the child is in care"

"Oh no, I don't agree with you, I had to fight for over a year for a wee boy"

"I had to by-pass Glasgow and go through my own Panel to get that attended to"

"I had a kid that needed it and he's never got it and he's away from me for almost a year now. I got a kid that came to me from his previous foster carer, I asked for it, it came almost a year after"

"It's usually too late"

Lack of timely and appropriate psychological service support had resulted in some young people being removed from foster care and placed in residential schools:

"We experienced a five year old who had to leave us and go into a residential school because his behaviour was so horrendous, they just didn't have the services there to help the child"

Given the difficult backgrounds of children in foster care, it was not surprising that foster carers worried about the lack of such services and the effect this would have on young people's future development:

"He never got the help, for a kid so badly abused he never got the treatment that he should have got to help him through that and I think he will be an abuser. For almost four years I had him and he still never got the treatment he needed"

Lack of information

A second area of concern identified by foster carers was around the information they received (or rather did not receive), about the young people placed in their care. While some identified not receiving adequate information as a general problem, it was common in respect of emergency placements and in respect of asylum seekers' children who usually had to be placed swiftly:

"I was talking about stand by and emergency because none of them have any information about the kids because they're picking them maybe in the middle of the night so they can only try to tell you in a roundabout way, a rough idea of where they're coming from"

In the recent past, foster carers had mixed experiences of the Social Work Department passing on sufficient information in relation to children with communicable diseases, such as HIV and Hepatitis. This had changed somewhat and while some bemoaned the fact that social workers had "withheld any information and it's so frustrating", others had been given information, although this was not always direct:

"The last three we got we did get a warning before they came about the fact that they had Hepatitis and they just could give you what they know and during the emergency what the stand by would tell you is they're coming from a drugs background. I mean that was a polite way of saying you need to just take extra care because they really don't know"

While it was not suggested that Social Work had necessarily set out deliberately to deceive foster carers, there was at times poor or selective communication. It appeared to them that social workers did not always communicate negative information about a child in case they put foster carers off taking them. And with a stronger emphasis now in Social Work on the notion of capacity rather than with identifying deficits, this unwillingness to highlight negative issues was even greater. However, several stories of poor communication related to past incidents, and some foster carers felt this was now improved.

Foster carers sought a more honest and frank partnership with Social Work and demanded:

"They should give you all the facts about a child that they know about. A lot of them, so you'll take the child in, they don't tell you things"

As well as identifying problems with communication with Social Work, there were frustrations with other professionals' communication for example, GPs or doctors and their attitude towards confidentiality:

"The first time I took them up for the medical, even the doctors wasn't really very nice to the fact that she wasn't going to tell me any information. Now I explained to her that these children were with us long term and I did know a bit about the background. And she says 'No, no, it's highly confidential, I won't be discussing anything about their background with you'. And I says, 'I'm not asking you to, I've already been told as much as they know'"

Foster carers interpreted this as professionals (e.g. social workers, doctors) "not trusting us". What was called for was...

"Common sense from the worker you're talking to instead of treating you as if you're the enemy"

Other factors undermining healthy living

A third way that foster carers' efforts to promote healthy living could be undermined was by the young person's birth parents (during home visits), as well as by peers at school:

"Sometimes they come back with a big bag or sweeties from contact with mum"

"His mum and his grandparents and all his uncles are all alcoholics, and I take him to see his mum every month, and they see all this. The other two decided last month that they weren't going back, but the older boy still wants to go back, and when he goes back, she buys him drugs and she buys him drink"

Concerning the pressures exerted by peers, one foster carer commented about the four children they looked after:

"It's two packed lunches and two that eat in the chippie. That one you can't stop 'cause that's what their friends do so you're going to go along with that."

Support for foster carers

Foster carers had received a range of supports to enable them to promote the health of young people, which included training courses and accessing other resources such as a video and CD library and other information. On the whole the Social Work Families for Children Team provided this support, but some foster carers also accessed information and advice from primary care health services and NHS help lines and the Internet.

Training courses

Foster carers had attended various training courses organised by Families for Children or purchased from specialist agencies including courses on sexual health, epilepsy, ADHD and drugs. There had not been on any training course on general aspects of health and the foster carers' role. In respect of the training provided, it was commented that:

"Social Work do try to train you the best they can"

Although there was a felt need to learn through experience about how to deal with certain situations, all of the courses had been useful. After attending the course on drugs, one foster carer was better prepared for a situation she was presented with:

"I had a little girl who came to me from a home at week-ends and I realised then that that's what I was smelling off her clothes, it was hash. I kept saying to her 'what is that K, you're jacket keeps smelling', I knew she smoked because she smoked in the home. She said 'well I don't know, it's just fags, just fags', until I realised what it was and then that was it so she was told no more hash, I can smell it now"

Of the workshops on sexual health one foster carer stated:

"I thought it was very good, very informative and really good"

Comments on the training received so far were positive and speakers from America and the foster carer led discussions through the Carers Support Group had been well received.

Accessing other resources

Not all foster carers were aware of how to access information about health issues and concerns, although many said they would access information through the Internet and others were aware of a video and CD library and book resources offered through Social Work. The Department was thought to offer "a lot". One carer commented:

"Give credit where credit's due. There's a lot of things they've done, lots of good things, the access to the libraries and games you get, PCs"

Knowing about such resources did not guarantee they would use them however. While they did know about the lending library, videos and computer CDs available through Families for Children, they were honest in saying they did not use such resources unless needing very specific information. One person said:

"They've got a collection of CDs for the computer. I'm no sure how to work them but I know they come out in a lot of various subjects"

Some said they would turn to doctors and primary health care services for information if they needed it. There was a 24 hour healthline available for Glasgow and some had accessed health information through this. The main support for foster carers was from their Link Worker in Social Work. As one foster carer said, "that's what they're there for" and another that:

"If there's something specific you needed I would assume that I would make a phone call to my Link Worker and if he didn't know where to find it, he would know how to go about it if I didn't know myself"

Another indicated that they only contacted their Link Worker as a last resort:

"If I phone he panics, he knows if I phone him there's a problem!"

For general information and advice especially at the beginning of a placement, foster carers would often turn first to the Families for Children Team, but they also wanted support from other foster carers:

"Listening to how other carers maybe have coped with problems you think Oh I could try that and it might work and it might not but we get ideas from each other"

Some of the focus group participants were involved in the Carers Support Group, and this was suggested a useful forum.

Better support

In terms of improving the support foster carers received to help them work better with young people and to promote their health, four main suggestions were made:

- Ensure foster carers are better informed about individual young people placed with them and about the resources available to support young people
- Support opportunities for foster carers to meet and share experiences - mutual support
- Provide additional training to foster carers on health topics
- Improve systems of communication and ways of following up and reviewing young people's needs in foster care

Better information

Foster carers felt they would benefit from receiving better information from social workers and wanted "honest, above ground" information even if that meant they would think twice about agreeing to a young person being placed with them. This was not only for their benefit but for the young person:

"Just a bit of common sense that you're there to help the child and the more information you've got the better it is for the child"

They also felt they would benefit from having more information about what's available in terms of resources for young people such as mental health services, as well as what training and other resources were available to support them.

Mutual support

Opportunities to meet with other foster carers were highly valued and might be extended. Those involved in the Carers Support Group who took part in the research felt this was a beneficial forum:

"An ideal opportunity to exchange experiences. That is the biggest help you can get in terms of support by listening to somebody that's been through it"

More training

Foster carers in this research felt they would welcome further training opportunities on both general and specific health related topics. For instance, they wanted training on behavioural problems and sexual health issues. They also wanted further training on what one called "counselling skills", but rather than counselling qualifications they described this as:

"Just how to ask questions, how to get them (young people) to open up, how to react, pointers. Part of the job is being able to talk to them you're doing that all the time"

There was a call also for First Aid training.

Improve systems of communication & review

By improving systems of communication and review was meant more active involvement of social workers so that they became aware of problems earlier. Also, a more efficient system of reviews was thought to have implications for meeting young people's health needs:

"If the reviews are supposed to be done, then they should be done. Then I think if there was more of that, then it would be a good preventative measure for a lot of things, like identifying the needs of the child, there'd be things flagged up more often. I think that's a major area that has to be looked at, and I think a lot of other good things would follow on from that"

Summary of findings

Health issues and concerns

- While not perceiving significant differences between their own and foster children's health issues and concerns, foster carers highlighted health problems caused by neglectful environments
- Children coming into foster care often suffered from poor dental care and malnutrition as well as congenital health conditions such as foetal alcohol syndrome or disability
- While not a health issue as such, it was suggested that young people in foster care were "very health conscious" or diligent about following up health problems and keeping health service appointments

Attitudes of foster children to health

- It was suggested young people in foster care tended to have a "smaller pain threshold" and tended to "dramatise" health problems to get attention
- However, they were also perceived by foster carers as being especially resilient given that they had lived through more illness and poor conditions than other young people

Health record books

- Health record books did not always arrive with the young person and sometimes they contained minimal information
- Foster carers thought the health book should contain a section on dental health given this is a major issue for young people in care
- While health books were considered a 'good system', the "big flaw" identified by foster carers was that its use was not being monitored
- However, in order to understand the health book it was suggested one had to "be a philosopher", which suggested the content and layout might be usefully reviewed if it is to be more helpful to foster carers
- Foster carers highlighted a problem that young people were stigmatised through using the health book system when other young people do not use this

The role of foster carers in relation to foster children's health

- Foster carers perceived themselves to have a positive role in promoting the health of foster children and they were entirely comfortable with this role. It was all "part of the job" of being a foster carer
- They saw their role as providing a "different lifestyle", a "normal pattern of life" and encouraging young people to access appropriate health services
- Foster carers were positive role models by the example of how they lived and they also used the example of their own 'bad habits' e.g. if a smoker, to ward young people off adopting similar habits
- Birth children were role models if they were older than foster children and young people sometimes turned to the birth children for advice about health issues and concerns
- Building self-confidence and self-esteem were considered as a "big part" of what foster parents do
- Generally, foster parents were confident in their role of promoting health except around sexual health as this had become a fraught area after allegations had been made against foster carers
- Young people themselves were comfortable discussing most issues with their foster parents

External resources for health

The main problems identified by foster carers were with accessing timely psychological services; not being given sufficient information before a young person was placed with them; and their efforts to introduce healthy lifestyles being undermined by birth families and the young person's peer group

- Foster carers had received training and were aware of the resources available to them through Families for Children Team, as well as primary healthcare and others, although they did not make much use of them
- Foster carers identified four main supports that would help them do their job better: receiving better information about young people and resources; further opportunities for mutual support; training courses on for example sexual health; and an improvement in systems of communication and review

Synopsis of findings

Perceptions of health

- 97% felt they were "quite healthy" or "very healthy"; 94% felt they were "quite fit" or "very fit"
- Young people generally had a positive and holistic sense of 'health' as being "in top form both physically and mentally"
- Role models for 'good health' included famous people but also mentioned were foster family members, which was often contrasted with the lifestyle of their natural family
- Living in foster care was suggested by young people as good for their health
- 33% identified specific health problems, typically physical health problems, such as asthma or chronic health problems. Over 90% were getting the help they needed

Mental Health & Well-being

- Levels of depressive symptoms were lower than the previous survey - 21% compared to 28% had scores of 21.7 or more
- More females (30%) than males (4%) appeared to be at risk for diagnosis of depressive illness
- The average scores for self-esteem were high - 71% had a score of 20 or more on the Rosenberg scale compared to 25% last survey
- Fewer females scored 20 or more on the Rosenberg scale - 62% compared to 86% of males
- 35% stated that they had thought of deliberately self-harming. Less (20%) stated they had actually self-harmed compared to 45% in the last survey
- Rates of reported self-harm were higher among females, 29% compared to 5% of male respondents had self-harmed. As found in the previous survey, those who deliberately self-harmed were more likely to score high on the depression scale (46%) and to have low self-esteem (55%)

Diet and Nutrition

- Respondents generally ate healthily and foster families were seen as proactively promoting healthy eating habits
- Young people in foster care reported having better access to help and support to eat healthily than those in the last survey; but fewer had help with how to cook on a budget, and they rarely did food shopping - only 14% compared to 32% in the previous survey

Physical Activity

- They tended to be physically active - only 11% compared to 34% of the previous sample never took part in any exercise or sports

- All stated they had become more active while in foster care and that foster parents actively encouraged them to be more physically active
- As before, the primary reasons for not taking part in physical activities were the cost of taking part, individuals' lack of motivation, and not having anyone to go with them

Sexual Health & Relationships

- 75% of young people had had no contact with sexual health or contraceptive services
- 41% of respondents did not know where the nearest young people's sexual health or contraception service was
- 18% of young people 'often worried' about getting pregnant or getting their girlfriend pregnant and another 44% worried about this 'sometimes'
- young people reported being unprepared for 'leaving care' in relation to sexual health and relationships
- Foster carers expressed particular issues and needs in relation to being better supported in matters relating to sexual health

Smoking

- Just 10 or 16% of respondents were smokers compared to 75% of respondents in the previous survey, and overall proportions of males and of females who smoked was similar (14% of males and 17% of females)
- Further, nine out of the ten smokers wanted help to cut down or stop smoking
- Fewer foster parents than natural parents were reported to be smokers, and respondents did not like foster parents to smoke, especially if they were non-smokers themselves
- In relation to their own smoking, they said foster parents did not stop them from smoking but they did point out the health risks involved and encouraged them to stop

Drug taking

- Reported drug use was rare. 47 out of 66 replied as to whether they had used drugs or not. Out of these, 41 (87%) stated they never used drugs
- There may have been some under-reporting if respondents were worried about confidentiality and unconvinced by the assurances given in the research
- Generally, respondents felt that if foster parents found out they were taking drugs they would be "disappointed" in them and "be upset", and may want to move them

Alcohol Use

- Rates of drinking were low especially if compared with the previous survey: over a third never drank any alcohol compared to just 4% previously, and 54% drank but never became drunk
- It was less common for respondents to have started drinking before they came into care (16% compared to 63% in the first survey)
- Foster parents had provided guidance and direction and would "hit the roof" if they found out about excessive drinking. Furthermore, there would be 'consequences'

Views of health services, information & advice

- The vast majority (98%) had visited their doctor or GP, the majority (59%) within the previous 6 months, compared with 83% of respondents in the last survey
- Fewer (25% compared to 42%) had had a medical check up in the past 6 months, which perhaps reflects greater stability as well as reflecting changes in practice
- Experiences with GPs were again somewhat mixed but overall 82% were either 'very happy' or 'quite happy' with the way their doctor had dealt with their problem. The other 18%, mainly females, were not positive about GPs because they did not listen, did not explain things properly, had not made any difference or gave inappropriate treatment. Some young people were too embarrassed to discuss their problems
- Young people in foster care used dental and oral services more frequently than other young people in care and leaving care
- They were slightly more likely to have had their eyes tested recently, and to have seen the school nurse; and less likely to have used Casualty Departments, or family planning/contraceptive services
- Barriers to using health services were that staff did not understand young people's problems, waiting rooms were boring, information about the service was not easy to understand, there was no choice of male or female staff and lack of confidentiality
- Suggested improvements were increased levels of staffing; staff who understand young people; improved waiting areas; reduced waiting times; better accuracy of diagnosis; and better opportunities for young people to share their concerns

The Future

- As in the previous survey, the most pressing need for information and support was getting help with leaving care and with sexual health

- Respondents were generally better informed and advised on a range of health related topics than in the previous survey and they wanted more information/advice on all health related topics in the future
- The findings support the call for adequate throughcare and aftercare support because this was central to young people's concerns
- Respondents were positive about their future and in many respects were even more optimistic than the previous respondents

Foster Carers' Perceptions

- While they perceived little difference between their own and foster children's health issues and concerns, they highlighted health problems arising from previous neglect
- They suggested foster children were "very health conscious", were keen to follow up health problems, and tended to have a "smaller pain threshold"
- Health record books did not always arrive with the young person and sometimes contained minimal information. While a 'good system', the "big flaw" was that its use was not being monitored. Having to use a health book could be stigmatising
- Foster carers perceived themselves to have a positive role in promoting the health of foster children and they were entirely comfortable with this role. Generally, they were confident in this role except around sexual health. Building self-confidence and self-esteem was a "big part" of what foster parents do
- Foster carers were both positive and negative role models for young people. 'Natural' children were also role models; if they were older, foster children sometimes turned to them for advice about health issues and concerns
- Main problems were accessing psychological services; not having sufficient information before a placement; and their efforts to introduce healthy lifestyles being undermined by natural families and young people's peers
- Foster carers had received training and were aware of the resources available to them through Families for Children Team, as well as primary healthcare and others, although they admitted to not making much use of these resources
- Four main supports would help them do their job better: receiving better information; having further opportunities for mutual support; access to training courses; and improving systems of communication and review

Discussion & Conclusions

This study set out to explore health needs and issues from the perspectives of young people in foster care settings and foster carers. As such, it complements a previous study commissioned by *the big step*, which looked at the health needs and issues of young people leaving care in Glasgow. It has examined the contribution foster carers perceive they make to promoting healthy lifestyles and preventing ill health. A number of key themes emerged from this study and these are now discussed briefly below.

One of the most prominent themes is the comparisons and contrasts between the young people in this study, who are in foster care settings, and those in the previous study, who were in a variety of residential settings. The overall picture is striking. The sample of young people in foster care report themselves as being happier, healthier, eating better, exercising more, smoking and drinking less, and being far less likely to use drugs than their counterparts in residential care. Specific aspects of these contrasts are brought up in the following discussion, in addition to key points arising from the present study in its own right.

A more positive view of 'health'

The overall picture painted from the research findings is extremely positive both in terms of the health status and lifestyles of young people in foster care, and the support young people were receiving from foster families to acquire healthy living habits. There is always the possibility of course that the 38% of young people who responded to the survey were generally happier and more secure young people than the 62% who did not respond, though there is no particular evidence to suggest this, and indeed those who responded tended to have been in their current foster homes for less time than those who did not. Girls were more likely to respond than boys, which will have affected the results to some extent. Because girls were more likely to have signs of depression and low self-esteem this would tend to bias some of the results in a negative, rather than positive, direction; though it may be that in some other respects the bias would work the other way. That a tiny minority were unhappy in foster care settings should not be forgotten, and their dissatisfaction is worthy of investigation as it contrasts so sharply with the rest of the picture.

Young people's perceptions of the meaning of 'health' encompassed mental and emotional health as well as physical health, and there was a greater awareness among respondents of the relevance of good mental health to overall health. Young people specifically stated that living in foster care was good for their health while the opposite had been true for respondents in the last survey.

Positive role models for health were located among members of the foster family as well as them identifying with famous people such as David Beckham. Among the respondents to this survey, there was a strong identification with the notion of

'good health' and what it meant. This would suggest they would find it easier to believe they could attain positive health than the young people in the last survey.

Mental health issues

It was encouraging that respondents reported such high levels of self-esteem especially as foster carers perceived one of their main jobs as helping to increase young people's self confidence and self esteem. Again, though, this finding must be interpreted in the light of possible bias in the response.

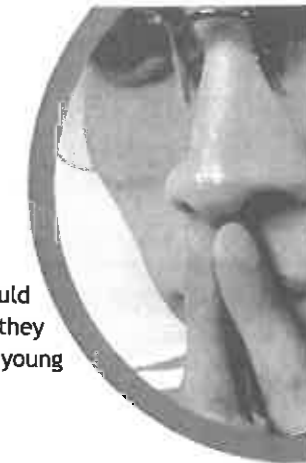
While levels of depressive symptoms as measured by the self-report scale were slightly lower than the last survey, they were slightly higher than prevalence rates reported in other studies of teenage populations. This seems to fit with what foster carers said about young people's health issues in particular that many young people came into care from difficult environments, and some had suffered physical and/or sexual abuse. That so many, both males and females, were having trouble sleeping and said they worried too much about things suggests this was still a troubled group of young people requiring skilled support.

Gender differences

Again, the survey pointed out some important differences between the sexes. More females than males were motivated to complete the health survey, which suggests they might be more health conscious overall. On the negative side, females scored lower than males on the self-esteem scale, which was also the case in the first survey. More females than males were showing symptoms of depression on the depression scale, and more had deliberately self-harmed than males. Self-harm was a behaviour that was linked with both low self-esteem and high scores on the depression scale. Females were also less likely than males to engage in intensive physical activities on a regular basis and slightly more likely to smoke. In short, it would seem that females would more often internalise problems and were less likely to seek external outlets such as sports as a coping mechanism, all of which might have implications for their future mental health.

Healthier lifestyles

The findings reflect the success of foster care settings compared to residential care in actively supporting healthy lifestyles, bearing in mind the caveat above about the potential bias introduced by the response rate and who responded to the survey. The success of foster care was evidenced by different results between the two surveys in respect of, for example, diet and nutrition and levels of physical activity. In terms of risk behaviours, far fewer respondents were smokers, drug taking was rare and rates of drinking alcohol were lower. This compared to alarming rates of smoking, drug taking and drinking reported in the previous survey: rates that were even high when compared to other



national and local research. Foster carers considered it appropriate they take an interventionist role in promoting healthy lifestyles and discouraging certain risk behaviours, and the young people surveyed clearly benefited from this approach.

A higher proportion of young people in foster care said they had first tried alcohol while in care than had said so in the previous study, but since they had generally started in care at a younger age this is not surprising. It appears that under the direction and guidance of foster carers this introduction to alcohol was in a controlled fashion. Alcohol for instance was not banned in foster homes, but foster carers encouraged moderate or 'social drinking' and actively disapproved of drunkenness. Young people in the first survey predominantly living in residential settings had wanted adults to take more of an interest in such matters. The results of this survey would seem to support the more direct approach taken by foster carers.

Different use of health services

The responses showed young people in foster care to have a more 'normalised' pattern in terms of their use of health services. The formal medical examination played a less significant role for them than for those in residential care. Foster carers were pro-active in ensuring that young people accessed appropriate health services as and when necessary and that dental and oral health care was attended to. They perceived this to be the role of "any good parent". Again, what the young people said in the survey could be linked to foster carers' comments and the way they described taking an active interest in young people's health.

Overall, young people in foster care seemed well informed and had better access to advice on a range of health care topics. They did not use hospital casualty or accident & emergency departments nearly so much as the respondents in the first survey. This was perhaps further evidence that the links with primary healthcare settings of young people in care were stronger when living in family settings than in residential care.

The future

Once again, the most pressing need for information and support identified by the young people themselves was for help with leaving care as well as with sexual health. They wanted information about budgeting, relationships and how to be a parent, among other things. The findings support the assertion from other research of the need for good throughcare and aftercare services to ensure a positive transition to independent living. It shows that despite all the other positive findings, young people in foster care also feel vulnerable when considering the prospect of independence.

The survey found young people in foster care had even higher expectations of the future than those in other settings, which again provides a challenge for professionals. 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 self advocates working to improve the health and quality of life of young people in this situation.

Supporting young people in foster care

The research highlighted a number of areas for improvement from young people's and foster carers' perspectives. There was room for improving young people's health records as practice was inconsistent, some young people were placed in foster care without health records, or the records were poorly completed. This clearly hampered foster carers' efforts at times. In theory, the system of health records was a good one, but in practice there did not appear to be any monitoring to ensure it was happening as it should.

The perception of foster carers of their positive and 'natural' role in promoting health among foster children was borne out by the findings in the rest of the survey: a role in which they felt entirely comfortable. However, they were hampered in this by inadequate access to psychological services and felt vulnerable when tackling sexual health matters. This could be strengthened through further training and resources and by ensuring timely support from psychology services when dealing with young people experiencing mental distress. Not receiving sufficient information about young people to be placed in foster care was another problem foster carers identified as an obstacle.

Overall, young people in foster care reported a better health status and had adopted healthier lifestyles than those in other in-care settings. There is a possibility that the 38% of young people who responded were untypically healthy, compared with those in foster care who did not respond, but there is no evidence to support this. If the findings are indeed representative of the views of all young people in foster care, they reflect well on the interest and positive regard paid by foster carers to young people's health and the opportunities afforded to young people when staying in ordinary family settings. In certain respects, the survey comments more about the challenges of residential care in promoting young people's health than it says about foster care. Comparison and contrast of the two surveys further serves to highlight many of the concerns raised by the previous survey.

Julie Ridely

Scottish Health Feedback

June 2003

Recommendations

1. The findings of this research are disseminated widely, especially among young people and opportunities created for young people and foster carers to discuss the issues the study raises.
2. The study should be considered alongside the findings of *the big step* (2001) 'the health of young people in care and leaving care in Glasgow' research (Scottish Health Feedback).
3. Ongoing opportunities should be created for supporting 'Throughcare & Aftercare' interventions, which address young people's vulnerabilities, anxieties and needs when considering and moving to independent living and which support young people in realising their high hopes and aspirations for the future.
4. A review of young people's 'health records' should be conducted to identify ways of improving health record systems and monitoring which ensures consistent practice that meets the needs of young people and foster carers in relation to health information.
5. Consideration should be given to building on existing support mechanisms for foster carers in relation to: receiving better information about young people and resources; further opportunities for mutual support; training on specific issues such as sexual health; and an improvement in systems of communication and review.
6. Opportunities should be created to provide foster carers with the necessary guidance, support and information in relation to 'sexual health, sexuality and relationships' that enable foster carers to develop confidence, knowledge and skills in supporting young people. This would include work in relation to sexual health policy, training, information and resources.
7. Improved links between mental health and psychological services and foster care should be developed which better support the needs of young people. This would include the development of appropriate mental health training, information and resources for foster carers.
8. Young people in foster care are still relatively disadvantaged in terms of their health status and access to services in comparison to young people of a similar age who have had no care experience. Therefore, opportunities for ongoing health improvement, which build on existing good practice within foster care, should continue to be explored and developed which meet the needs of foster carers in supporting and responding to young people's health needs and issues.



References

Biehal W, and others, (1992), "Prepared for Living? A survey of young people leaving care of three local authorities", London: National Children's Bureau.

Currie C E, Todd J, Smith R, (1999), "Health Behaviours of Scottish Schoolchildren: Technical Report 1: Smoking, Drinking and Drug Use in the 1990s".

Dixon, J, Stein, M, (2002), "Still A Bairn? Throughcare and Aftercare Services in Scotland", Edinburgh: Scottish Executive

Greater Glasgow Health Board Health Promotion Department, (1995), "Drugs and Alcohol: A Prevalence Study among 16-19 year olds in Greater Glasgow", Glasgow: GGHB.

Kandel D B, Davies M, (1982), "Epidemiology of Depressive Mood in Adolescents. An Empirical Study", Arch General Psychiatry, Vol 39, October 1982, pp 1205-1212.

Market Research UK Group, (1998) "Findings from Research with Residential Care Workers (Young People and Health)", Glasgow: Market Research Scotland Ltd.

Miller P M, Plant M (1996), "Drinking, smoking and illicit drug use among 15 and 16 year olds in the United Kingdom", British Medical Journal, 313: pp394-397.

Patel-Kanwel H, Lenderyou G, (1999), "Let's talk about sex and relationships: a policy and practice framework for working with children and young people in public care", Sex Education Forum, London: National Children's Bureau.

Ridley J, McCluskey S, (2003) "Exploring the Perceptions of Young People in Care and Care Leavers of their Health Needs" Scottish Journal of Residential Childcare Vol. 2 No. 1 Feb/March.

Robinson P, Auckland K, Crawford H, Nevison C, (1999), "'Care Sick?' The physical and mental health needs of a sample of young people in local authority residential care", Edinburgh: Young People's Unit, Royal Edinburgh Hospital.

Scottish Health Feedback, (2001) "A study of the health needs of young people with experience of being in care in Glasgow", Glasgow, *the big step*.

Scottish Health Feedback, (1997), "Survey to identify the needs of those at risk from drug/alcohol abuse in the Borders", for Scottish Borders, Drug Action Team.

Sweeting H, West P, (2000), "Teenage Health: The West of Scotland 11 to 16 Study", Glasgow: MRC Social and Public Health Sciences Unit, University of Glasgow.

Teenage Pregnancy Unit, (2002), "Guidance for field social workers, residential social workers and foster carers on providing information and referring young people to contraceptive and sexual health services", Quality Protects.

West P, Sweeting H, (1996), "Background, Rationale and Design of the West of Scotland 11 to 16 Study", Working Paper No 52, Glasgow: Glasgow University Medical Sociology Unit.

Young R, Sweeting H, West P, (2000), "The West of Scotland 11 to 16 Study. Basic frequencies of the 15 year old (S4) sweep.", MRC Social & Public Health Sciences Unit Working Paper No 2, Glasgow: Medical Research Council.

Notes