"DON'T BE SO FORMAL, I'M NORMAL"

A Research Report on the Mental Health of Looked After Children/Care Leavers in Northern Ireland

SUPPORTED BY: Executive Programme Fund for Children & The Camelot Foundation
AUTHORS: Christine Mullan, Fiona Rollock, Siobhán McAlister & Lelia Fitzsimons
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The views expressed in this report are those of the authors and do not necessarily reflect those of the Eastern Health and Social Services Board or Down and Lisburn Trust.
Foreword

This research is published at a time of huge change in Northern Ireland. As the Review of Public Administration gathers momentum, it becomes increasingly important for the voices of young people in care to be heard by everyone in a position to offer services and support to them and to influence their futures. The new structures being developed provide a real opportunity for those voices to be heard at all levels and VOYPIC will continue to support research into, and the articulation of, key issues for all young people in care. A particularly valuable aspect of this work is that it directly includes the views of young people.

This report follows on from the earlier Literature Review published by VOYPIC’s Caspar Project, and leads into a poster to be developed by the Young People’s Advisory Group. It offers valuable insight, which should be of interest to a wide range of readers, including young people, students and academics, policy-makers, carers, and a range of practitioners and service-providers in the statutory and voluntary sectors.

Following on from the Review of Mental Health & Learning Disability chaired by the late Professor David Bamford, this work aims to inform policy and to add to the growing evidence base in the area of mental health needs of Looked After Children in Northern Ireland. It is vital that all of the needs articulated here are addressed on a regional basis, so that all young people receive the same standard of support, no matter in which part of Northern Ireland they live.

In order to best meet the needs of young people in care, VOYPIC works in partnership with a range of organisations. We are always keen to develop new partnerships which could offer benefits to young people, and would be happy to hear from anyone reading the report who would like to explore opportunities to partner with us.

VOYPIC is pleased to publish this report in conjunction with the Professional Advisory Group.

Joy Allen
Chair
VOYPIC
Preface

Voice of Young People in Care (VOYPIC) is an independent regional voice that seeks to empower and enable children with an experience of care (Looked After Children/Care Leavers) in Northern Ireland to participate fully in decisions affecting their lives. Our aim is to improve their life chances through working in partnership with Looked After Children/Care Leavers, staff, managers, agencies and government. We do this through listening and learning and facilitating change which impacts and influences legislation, policy and practice. One of the Agency’s core aims is to record, collate and catalogue practice experience, training materials, publications and research to assist in developing and promoting good practice.

This research report is the second publication from VOYPIC’s Caspar Project. The Caspar Project is being undertaken by VOYPIC in partnership with the Eastern Health and Social Services Board (EHSSB) and Down and Lisburn Trust (DLT).

The overall aim of the Caspar project is to produce an evidence base which will contribute to the development of a strategy to meet the mental health needs of Looked After Children/Care Leavers across Northern Ireland. We believe that there is a current gap in services that requires a strategic commitment. The outcome sought by the project is:

‘That children and young people who live in care [Looked After Children] and those who have left care [Care Leavers] have improved psychological, emotional and mental health and hence improved life chances’.

The project seeks to contribute to these outcomes through the production and dissemination of the findings of a literature review (Mullan & Fitzsimons, 2006), the current research findings and a young people’s poster.

About the Authors

Christine Mullan: Christine was the Research Officer for the Caspar Project. In October 2006 she commenced a PhD on sharing responsibility for the emotional well-being of young people in care with Queens University Belfast. She previously worked in the field of market research, as a Research Executive with Market and Opinion Research International (MORI) Ireland and formerly with SIGNAL Business Growth Centre (based in Stockholm). She graduated with a BA Honours in Psychology and French from Trinity College Dublin and is registered with the British Psychological Society.

Fiona Rollock: Fiona was the Project Worker for the Caspar Project. Prior to assuming post in 2003 Fiona had previously worked in this area in a voluntary capacity with particular interest and experience in working directly with young people and service users. She graduated with a BSc Honours in Psychology from Queens University Belfast and is completing MSc study in Social Research and Policy with the University of Ulster.

Siobhán McAlister: Siobhán’s role was to consult on and contribute to the writing of the Caspar Report. She is currently working as a Research Associate with the Institute of Child Care Research at Queen’s University, Belfast. Prior to this she was a Research Officer with Youth Action Northern Ireland working on action research concerning the lives and experiences of young women in Northern Ireland and a project examining the training needs and experiences of youth workers and young volunteers in cross border areas of Ireland. Siobhán was previously part of a large multi-disciplinary team examining Children’s Rights in Northern Ireland (NICCY/QUk) and has recently been awarded her PhD which involved an investigation of the lives of young people living in an area of multiple deprivation in Northeast England.
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Lelia Fitzsimons: Lelia was Project Manager for the Caspar Project and is Assistant Director in VOYPIC. She was previously Senior Manager of Social Care at Bryson House assuming overall responsibility for the management of all social care services. In the past, Lelia worked as a Mental Health Social Worker in North & West Community Mental Health Team and as a Family Centre Social Worker at Beersbridge Family Centre. She trained as an approved social worker, worked as a practice teacher for a number of years and is registered with Northern Ireland Social Care Council (NISCC). Lelia graduated with a Masters in Social Work from Queen’s University, Belfast.
Acknowledgments

We are grateful to:

• Firstly, all the young people who took part in the research and who spoke very openly about their lives. Many of these young people also painted a canvas which has been used at various events for which we are thankful.

• The Young People’s Advisory Group who have been instrumental in the design of all stages of the research and ensured that it was always young-people-friendly.

• Members of the Professional Advisory Group.

• The Caspar Management Group.

• Our funders: The Children’s Fund, The Camelot Foundation, the Eastern Health and Social Services Board and Down and Lisburn Trust.

• The Institute of Child Care Research at Queen’s University Belfast and in particular Dr Rosemary Kilpatrick who has provided a key consultative role in the project and was also a member of the Professional Advisory Group.

• Ciaran Acton for his kind help with training in NUD*IST N6 software.

• Those who carried out the liaison role in the EHSSB and the Directors and Programme Managers in the EHSSB Trusts who consented for the research to take place.

• Edel, Sharon, Kerry, Stirling and Jillian for their tireless transcribing of the interviews and focus groups.

• Other colleagues in VOYPIC who helped along the way.

• And a general thanks to all those who helped by participating in the various workshops held or at other stages in the project.
2.Methodology

Methodology
Methodology

The aims of the research described in this report were two-fold. Firstly, to identify the emotional, psychological and mental health needs of Looked After Children and Care Leavers aged 12-25 years old and secondly to review and explore how to develop services which support care experienced young people through the transition to adult life and to document relevant current policy and practice developments in Northern Ireland. In order to achieve these aims the views of (i) young people and (ii) their carers were sought on a range of mental health issues. This section of the report begins by describing the overall management of the research. This is followed by a description of the two strands of the study including an overview in each case of how the sample was generated and accessed, the data collection techniques and data analysis. Examples of the research tools utilised in the study can be found in Appendix 2.

2.1 Management

The research was funded by The Children’s Fund, The Camelot Foundation, the Eastern Health and Social Services Board and Down and Lisburn Trust and conducted by a research team consisting of a research officer and two members of VOYPIC staff who were assigned to help conduct the research alongside the research officer. The research team met on a regular basis to plan the programme of work and discuss any issues or problems that occurred, particularly during the fieldwork period. Additionally, the research officer was supervised and supported by an academic based in the Institute of Child Care Research in Queen’s University, Belfast who also met with the research team as required.

Further support and advice for the research team came from three key groups established at the beginning of the study, these being the Professional Advisory Group, the Management Group and the Young People’s Advisory Group (for membership of the first two groups see Appendix 1). The primary aim of these three groups was to advise on the research design, data collection techniques and dissemination strategies. While each group contributed to all stages of the research the 13 young people who took part in the Young People’s Advisory Group played an absolutely key role particularly in helping to identify research issues and questions that professional researchers may miss or not prioritise. Additionally, the input and advice of this group ensured that the design of innovative and engaging tools of data collection were young-people-centred and was worded in a language that was clear to young people which would help put research participants at ease, thus making the research process less formal. This group also provided input to the draft report and helped develop subsequent dissemination of the research findings (for example, a young people’s poster based on this report).

2.2 Looked After Children and Care Leavers

Of the total population of Looked After Children in Northern Ireland the highest proportion are located in the four Health and Social Services Trusts in the Eastern Health and Social Services Board (EHSSB). Therefore, it was decided that the young people in the study would be drawn from these four Trusts.

The age range of 12-25 years was chosen to allow for an overview of the issues affecting younger and older teenagers as well as those who had left care. Children under 12 years of age were not included
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for a variety of reasons including the fact that the majority of younger children are in foster care and therefore were unlikely to be able to give a perspective on the various types of care provision being examined. The time period for inclusion in the research was being placed on the liaison person’s list between July and August 2006. The inclusion criteria for these two groups was as follows:

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<th>Group Inclusion Criteria</th>
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<tr>
<td>Looked After Children (LAC)</td>
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<tr>
<td>Care Leavers</td>
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</table>

2.2.1 Data collection

Since looked after young people or those who had been in care were the focus of this research it was essential that the methodology for the study recognised the perspective of these young people as a legitimate source of knowledge and that the material was collected in a manner which was respectful and caring of them as individuals. Qualitative methods in the form of carefully constructed depth interviews and mini-focus groups meet such demands and it was agreed that these were the most appropriate data collection tools. The nature of depth interviews allows for an informal, conversational style meeting between the researcher and participant, and there is freedom to allow the participant to explore other relevant areas which may not be covered in the topic guide (interview schedule). This is a particularly good method to use at the initial stage of a research project on such a sensitive topic since it helps ensure that the researchers capture all issues that are important to the target group (rather than the ones they have already identified). Another advantage of depth interviews is that they give young people a chance to put forward their opinions outside of a group context and it has been argued that young people feel more at ease in one to one interviews than group discussions, particularly for sensitive topics such as this (PHIS, 2003a).

Interviews were carried out between August and October 2005 by the three members of the project team and lasted on average one hour. The eventual length of an interview was determined by age, ability to concentrate and how much detail the young person was willing and/or able to provide about their experience. We offered young people the opportunity to carry out the interviews in the place of their choice, and largely, they chose their home, whether it was residential care, or foster care, although several interviews did take place in VOYPIC’s office.

It was decided to follow the depth interviews with mini-focus groups to allow for further discussion of issues that had been raised during the interviews and to ensure that all themes had been adequately explored. Six mini group discussions with between two and four young people were held from 30th November – 15th December 2005. A further two were cancelled as only one young person was able to attend. Each discussion
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group was facilitated by two of the research team and on each occasion there was time at the start for refreshments. The discussion itself lasted approximately one and a half hours and there was usually a break half way through. At the end we also ensured that the young people had some time to wind down and the participants had time to write down some thoughts on the group activity. All focus group participants also contributed to a piece of art work which has since become the image associated with the project. In order to ensure that the environment was as comfortable as possible for the young people these mini focus groups were convened according to age grouping (12-15 yrs and 16-17 yrs for those in care and 18-25 yrs for Care Leavers) with the youngest age group being split according to gender. The topic guide for the focus groups was designed using the findings from the depth interviews and included three vignettes, one for each of the age groups (see Appendix 2). Not only are vignettes a useful means of collecting information from young people but they aid in depersonalising sensitive issues making them less threatening to explore (Barter & Renold, 1999). Within this context then, they helped to ensure that any information disclosed during the focus group discussion was not associated with any one individual in the group.

2.2.2 Generating and accessing the sample

After discussions with key personnel in each of the four Trusts it was agreed that each Trust would appoint a liaison person to work alongside the research team especially in relation to identifying the sample. In the case of the sample of young people the Trust liaison person was responsible for compiling a list of young people who met the required criteria for inclusion in the study and assigning each individual with an id number. At this time any young person that the Trust liaison person felt it would be unadvisable to include in the study was omitted from the list (for example, if it was not felt to be in the best interests of the child).

A total of 665 potential participants (423 Looked After Children and 242 Care Leavers) were identified in this manner. The resultant lists were then passed to the research team who randomly selected (every nth number) 220 Looked After Children and 68 Care Leavers and returned this information to the liaison person in the Trust. The liaison person then sent an information sheet about the research and an opt-in/out letter to these young people (and for the under 16s, their legal guardian and birth parent). Included in this information pack was a request that the opt in/out letter should be returned within three weeks (See appendix 2 for further details of these letters).

After the three week decision period the liaison person passed on the details of those young people aged 16 years and over who had agreed to take part in the research to the research team. In the case of those under 16 years the consent of the legal guardian and birth parent was also sought. Once this information had been received a member of the research team contacted the young person by telephone (and/or legal guardian where necessary) to discuss the project in more detail and asked if they were still interested in taking part in the study. On receiving a positive response the interviews were then arranged at a time and place convenient to the young person and a confirmation letter was sent out. Thus, the research team never had access to the names and addresses of those young people who did not wish to participate in the study.
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2.2.3 Profile of the young people

51 young people eventually took part in the study. This final group of young people comprised of 36 in the Looked After group and 15 in the Care Leavers group. Of the 51 young people we spoke with, 27 were female and 24 were male. The young people lived in various types of care, with around a third in residential care, a third in foster care and a third in aftercare at the time of the interviews. There was a spread of ages with 21 of the young people aged 12-14, 16 aged 15-17 and 14 aged 18+ years. A similar range of young people across the Trusts was also achieved while the actual time they had spent in care varied from person to person, some being in care only a few months, others almost all their lives.

Following the first phase of data collection (i.e. depth interviews) research participants were asked if they would like to participate further in the research by taking part in the second phase of data collection (i.e. mini focus groups). All but two young people were willing to continue and those interested were contacted by telephone to make further arrangements.

2.2.4 Design of topic guides

The topic guide was designed according to key areas outlined in the literature review (Mullan and Fitzsimons, 2006) alongside those issues raised as important by the Young People’s Advisory Group. We approached our research with a broad definition of mental health and therefore structured the interviews from more general concepts of well-being through to asking young people directly about mental health near the end of the interview. We were particularly sensitive around the use of the words ‘mental health’ following recommendations in The SNAP report which stated:

“Mental Health’, a term with negative connotations for young people, does not describe usefully or well the types of difficulties facing young people. It would be better ... to describe the difficulties individually rather than risk the stigmatizing influence of the term ‘mental health’.

(p. 11, PHIS, 2003a)

In light of these issues, in collaboration with the Young People’s Advisory Group a number of projective techniques were designed to help facilitate discussions around mental health issues. These tasks included giving young people a trophy to ask who they would give a support prize to and a crystal ball or a timeline for how they saw their future (see appendix 2). As the research progressed any concerns regarding the topic guide were discussed and revisions which would allow for more open conversation with the young people but which would not detract from the rigour of the research, were made. This included the redrafting of a question on who the young person ‘looked up to’ as it was often misinterpreted with young people answering that they were happy with themselves and did not want to be like anyone else, rather than interpreting it as a question about role-models.

2.2.5 Incentives and benefits

All the young people who took part in the research did so in their own time and in order to thank them for this they received £5 for the depth interviews and £10 for the focus groups (since the latter would involve more time and participants had to travel to the venue). The arrangements around whether or not this money was given directly to the participants were agreed in advance with the foster carer or residential staff member. Each young person was given a thank-you letter at the end of their depth interview with the incentive and young people at the mini-focus groups
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were given a Christmas card with their incentive. Additionally, out of pocket fees such as travel or childcare costs were reimbursed for all participants and those who took part in focus groups received light refreshments.

2.2.6 Data analysis

With consent, interviews and focus groups were recorded digitally and full verbatim transcripts were made. Immediately after each interview, the Caspar team member recorded top of mind thoughts into a matrix. The research team then organized and analysed the qualitative data drawing out the main themes. Analysis took place after each stage of research and informed the next stage. A computer assisted programme (NUD*IST) was used to assist with this process.

2.3 Carers of Looked After Children

Under the umbrella term of carers of these Looked After Children we included foster carers, residential carers, fieldwork staff and birth parents since the perspectives of each of these groups were considered important in helping gain an understanding of the young people’s perceived needs. The inclusion criteria for each of these groups of individuals which were used for the research are presented below.

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<th>Group</th>
<th>Inclusion Criteria</th>
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<td>Foster Carers</td>
<td>Foster carers providing foster care for a child over 12 years and had done so for 6 months or more at the time of the research (includes short-term, long-term, respite and private foster carers).</td>
</tr>
<tr>
<td>Residential Workers</td>
<td>Qualified and unqualified staff working in a residential setting with 6 months experience or more at the time of the research. By residential setting, this meant specifically children’s homes, intensive support units or secure accommodation.</td>
</tr>
<tr>
<td>Field Workers</td>
<td>Those who had statutory responsibility for a Looked After Child with six months experience or more at the time of the research (includes for example those in initial assessment, family and childcare, adolescent, leaving and after care, CAMHS &amp; Looked After Children teams)</td>
</tr>
<tr>
<td>Birth Parents</td>
<td>Lead contact for the birth parents of young people aged 12 years and over who were in care and had been in care for 6 months or more at the time of the research. (Where it was felt that contacting the birth parent would cause distress they were not included in the study).</td>
</tr>
</tbody>
</table>
Methodology

2.3.1 Data collection

Postal questionnaires were chosen as the most suitable method for carrying out the research with the carers given the project scope and timetable. These allow respondents the chance to devote attention, concentration and thoughtfulness to the responses (which is quite difficult in face-to-face interviews). Another advantage of postal questionnaires is that they limit the inconvenience to respondents and in this case, ensured that all those on HSS Trust lists had an opportunity to express their opinion. Further to this, discussions with the Professional Advisory Group and other researchers suggested that involving birth parents in research of this nature is notoriously difficult, especially in face-to-face interviews, thus a postal questionnaire was seen to be the best possible alternative.

The questionnaires had core elements (including a section on protective factors which impacted on young people’s mental health and the degree to which these were met, services accessed and a training and support analysis). These were broadly similar but allowed for areas to be adapted to the experiences of the various groups. Each version was piloted and commented on by the three key groups as well as the Trust liaison people, and several external contacts.

2.3.2 Generating the sample

In a similar way to the identification of the sample of young people the liaison person in each Trust was also responsible for identifying lists of all foster carers, residential carers, field workers and birth parents caring for children and young people aged 12-25 years. We were interested in all those caring for young people in the chosen age brackets, not simply those working with the young people in our sample. Once identified these carers were informed about the research by the Director of each Trust and at the same time a list of names and addresses of these potential participants was sent to the research team. Each individual on the list was then assigned an id number in order to allow for a degree of anonymity but at the same time permit the team to track return of the questionnaires. An information pack including an explanatory letter, an information sheet, the questionnaire itself and a SAE envelope for its return was then sent out to all names on the list. The progress of returns was tracked and in order to boost response rates two reminder letters were sent to all the carers with the exception of birth parents who only received one reminder. The total population of carers was 644 of whom 25% (158) participated in the research by completing and returning questionnaires. All questionnaires were completed during March-May 2006. Thirteen of these questionnaires were not included in the analysis due either to incomplete responses or not being eligible for inclusion in the study.

2.3.2 Profile of the carers

The following pie chart outlines the overall profile of respondents (see Appendix 3 for full individual profiles). Almost equal proportions of respondents came from each Trust Area (40 responses from NWBT, 36 from SEBT, 36 from UCHT and 31 responses from DLBT). There were three main respondent groups, foster carers (54 responses), field social workers (44 responses) and residential workers (41 responses).
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2.3.4 Focus groups

On the postal questionnaire, foster carers, residential carers and field workers (not birth parents) were asked to signal if they would be willing to participate in a focus group to follow up on the findings. Those that answered ‘yes’ to this question were selected and contacted by telephone. While total numbers were too low to report on this aspect of the research on its own, we felt that the most appropriate use of the findings was to incorporate quotes from the participants to illustrate points behind some of the quantitative findings in the results section.

2.3.5 Data analysis

Data from the questionnaires was coded and entered into SPSS (Statistical Package for the Social Sciences). This allowed for descriptive analysis of the data and the production of graphs and tables as a means of understanding the information contained in the questionnaires.

2.4 Ethical Considerations

The project was reviewed by the Office of Research Ethics Committees in Northern Ireland (ORECNI) which granted a favourable opinion in July 2005. Additional internal ethical approval was also required by one of the participating Trusts. A protocol was agreed with the EHSSB which ensured that the young people had access to additional support following their participation in the research should this be required.

As one would expect of research of a sensitive nature, there were a number of ethical issues or concern which required particular attention in the study. A major concern was ensuring that the young people who participated gave informed consent. To ensure this, participants were provided with a comprehensive information leaflet prior to agreeing to take part in the research in appropriate form and language. Importantly, the information leaflet and consent form (see appendix 2) were very clear on issues such as consent and the right to withdraw. The information leaflet also described the
confidential nature of the interviews and focus groups. The limitations of confidentiality in cases where there was some indication that the young person was at risk of harming, or being harmed themselves, were made clear. In order to ensure that the participants understood the material in the information sheets, especially in relation to confidentiality, they were taken through the material verbally prior to the commencement of the interviews. Additionally, it was explained to the young person that their anonymity would be protected at all times and at no point would their names appear in any write-up or discussion of the research. We offered young people the opportunity to choose a pseudonym but most did not wish to do so. A confidentiality statement for the transcribers was also drawn up in the case that they would know any of the young people in question.

In the case of young people under the age of 16, we needed to ensure that their parents and legal guardians were aware of their potential participation in the research and also had a say in this decision. However, we needed to balance this with ensuring that those young people who wished to take part in the research were able to do so. We took on board the ethics committee’s requirements and, where possible, sought to achieve three-way written consent for those under 16.

Researchers ensured the safety and comfort of the young person and offered an alternative venue if the young person did not feel that the interview should take place at home. When necessary, safe travel for the young person was arranged to and from the venue. An adult was always nearby.

Data protection
At the point of transcription all identifiers were removed from typed interviews/focus groups and original recordings locked in a filing cabinet to which only the research team had access. In order to ensure the anonymity of research participants no real names have been used in the report and details have been omitted where we felt we might run the risk of identifying individuals.
Mental Health & Emotional Well-Being in the context of Young People’s Lives
Background

Considerable differences have consistently been reported between the rates of mental ill-health for children and young people living in care and those living in private households (see for example, McCann et al., 1996; Philips, 1997; Butler & Vostanis, 1998; Dimigen et al., 1999; Williams et al., 2001; Minnis et al., 2001; Royal College of Psychiatrists Research Unit, 2001; Residential Care Health Project (RCHP), 2004; Blower et al., 2004). This difference has been demonstrated on a nationwide scale by the recent ONS studies across England, Scotland and Wales. Among 11-15 year olds, the prevalence of mental disorders within the three countries looked after populations was 49% compared to 11% for those in private households in England; 41% compared with 9% in Scotland and 40% compared with 12% in Wales (Meltzer et al., 2000; 2003; 2004a; 2004b).

Unlike the rest of the UK, Northern Ireland has not benefited from a large-scale prevalence study examining the mental health of the population as a whole, or the looked after population in particular. It seems likely, however, that Looked After Children and Care Leavers in Northern Ireland may be at greater risk of mental ill-health than individuals in other parts of the United Kingdom since this is the case with the general population (O’Reilly & Browne, 2001; NISRA, 2002; McConnell et al., 2002; O’Reilly & Stevenson, 2003; RMHLNDI, 2006). Some reasons for the estimated higher incidence of mental ill-health than individuals in other parts of the United Kingdom since this is the case with the general population (O’Reilly & Browne, 2001; NISRA, 2002; McConnell et al., 2002; O’Reilly & Stevenson, 2003; RMHLNDI, 2006). Some reasons for the estimated higher incidence of mental ill-health in Northern Ireland include the high number of areas of social deprivation (McConnell et al., 2002) and the impact of the conflict (O’Reilly & Stevenson, 2003).

Definitions of mental health can vary widely but for the purposes of the present research the definition chosen is that used by the Mental Health Foundation (1999 p. 6) where it is argued that children who are mentally healthy have the ability to:

- Develop psychologically, emotionally, creatively, intellectually and spiritually;
- Initiate, develop and sustain mutually satisfying personal relationships;
- Use and enjoy solitude;
- Become aware of others and empathise with them;
- Play and learn;
- Develop a sense of right and wrong;
- Resolve (face) problems and setbacks and learn from them.

One of the strengths of this definition lies in the emphasis on the broader concept of well-being rather than an absence of illness, a notion used by the Public Health Institute of Scotland (2003b). Another strength is the presumption that mental health is something shared by us all.

When looking at the mental health of Looked After Children and Care Leavers we have placed importance on understanding their environment (WHO, 2003) as well as their circumstances that are much more adverse than their peers (Coleman, 2005). This is on the assumption that any attempt to explain mental health problems of Looked After Children whilst ignoring the fact that a young person is ‘looked after’ will be limited (Aggleton et al., 2000).

The way young people choose to respond to the challenging situations they face in their lives has received less attention in the literature. Nevertheless, there is some evidence to show a shift from withdrawn, internalising difficulties to more overt out-of-control and aggressive behaviours among Looked After Children referred to residential provision (Street 1999 cited in Kerfoot, 2005). Furthermore, Callaghan et al. (2003) mention a veil of secrecy which...
Mental Health & Emotional Well-Being

some Looked After Children draw around themselves, something which the professionals around them interpreted as a coping strategy, and one which they as professionals felt they had to respond to skilfully and sensitively.

Some evidence suggests that the views of Looked After Children often differ from those of professionals and caregivers regarding whether or not they have mental health needs (e.g. Williams et al., 2001; Mount et al., 2004; White & Stancombe, 2004). Mount et al. (2004) gave several reasons for Looked After Children denying having a mental health problem including preserving self-esteem or considering the ‘symptoms’ as normal in the context of their lives. They believe it is plausible that Looked After Children in their study found it necessary to normalize their behaviour and that their main reference point for ‘normal’ feelings and behaviour was their own experiences fuelled by a desire not to be perceived as different from their peers. Like Callaghan et al. (2003), they note that some Looked After Children are extremely skilled in shutting themselves off and keeping adults at a distance which is another major difficulty in identifying and assessing mental health problems (Mount et al., 2004).

Research across the UK provides a number of pointers regarding what services young people want. Looked After Children have reported that they wish to avail of services which are user-friendly, accessible, flexible and discreet and they welcome being able to access these services without the knowledge of care staff or other professionals (Blower et al., 2004). Accessing services can, however, be a difficult process for young people in care because often they cannot be afforded confidentiality as information has to be shared (Bundle, 2002; Ward et al., 2002; Stanley, 2002). Stanley (2002) found that Looked After Children wanted workers to spend time with them or to be able to talk to someone who had personal experience of similar problems.

While this section essentially sets the context in that it explores young people’s understandings and perceptions of mental health and their experiences of contact with mental health services and professionals, it goes beyond this in focusing upon other experiences and behaviours which may be symptomatic of poor mental health but not defined as such by young people themselves. Many of the points and issues raised in this section will be expanded upon in more detail in the sections which follow which aim to contextualize them more fully in the everyday lives and experiences of Looked After Children. Here, however, we focus upon illustrating the lack of understanding of mental health among young people and how poor emotional well-being can manifest itself in their lives.

The discussions within this and the subsequent two sections are based solely upon the research carried out with the young people. That is, 27 young women and 24 young men in various types of care or aftercare across the various Trusts.

3.2 Definitions and Perceptions of Mental Health

3.2.1 How young people define mental health

Mental/emotional health was generally very poorly understood and even when given help to explain it young people still had difficulty. They found it hard to say what mental health was, saying things like “not right in the head”, “being psycho”, “hearing voices”, “mad” or “crazy” or linked it with learning difficulties. Others appeared to have developed some misunderstandings about mental health, examples included, “you are psychic”, “mental like evil” and “you sit too close to the TV”. Typical of the young people’s uncertainty and lack of understanding was the following description:

“Don’t know it’s like sometimes you have to go into a mental home and they are talking all like crazy and they don’t mean to, your blood pressure or something goes up.” (Young woman, aged 12, foster care)

All of these definitions and understandings, and indeed the majority of those offered by the young people were inherently negative, primarily focusing on poor mental health. Overall, there was a lack of understanding that mental health is a feature of all and that it goes right across a spectrum. That said, a smaller number of young people did have a more general and accurate understanding of the term. These, for example, noted that it was to do with “sadness and happiness”, “how I’m feeling” and “emotions and stuff” or they linked it to the mind or brain.

“I would think maybe my state of mind; you know if I am depressed or if I am stressed out.”
(Young man, aged 18, aftercare)

One young person even connected the term ‘mental health’ with good mental health and an absence of illness:

“Mental health? Means your brain’s working ok, you’ve not got psychological problems coming and challenging your head, you’re not mentally ill, you know schizophrenic or something.”
(Young man, aged 15, residential care)

3.2.2 How young people perceive their own mental health

When asked directly about their own mental health, only a few young people saw themselves as having mental health problems. While none of those interviewed were in-patients at the time, a few mentioned previously being in receipt of mental health in-patient care. One interviewee neither knew much about her diagnosis nor did she accept it:

“You see I was diagnosed for post dramatic stress disorder, but I think they must be wrong, cos I don’t think I’ve got that.”
(Young woman, aged 20, aftercare)

This example clearly illustrates the need for young people to be informed about their mental health in a manner which is understandable and appropriate to them. This includes explaining illness and how it manifests itself in order that confusion and uncertainty which may in fact exacerbate anxiety and mental illness are, as far as possible, minimised.

Indeed this issue regarding informing and including young people in their health care also relates to issues around medication. In the following examples, the young people did not appear to have a full understanding of why medication was being given/taken, what the impact could be expected to be and how they could be excluded from decision-making by
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carers or health care professionals:

“My foster mum, she goes ‘you’re different every other day, will you just be the same’. She got me these tablets, mood swing tablets, one minute I’m happy, one minute I’m sad the next minute I’m really angry, they didn’t work for me…”
(Young woman, aged 15, foster care)

“Dr X, but he’s evil like, nah he’s a nice doctor and all that there but he likes to medicate people, he is a wee bit too quick at that prescription pad of his, I said to him once and then he turned round and said ‘well if you don’t want to try the tablets you don’t have to’, we don’t really have sessions any more, you just go on in and he says ‘well how is it going’ and I’m just like ‘dead on’, a wee bit of small talk for a minute then he will turn round and say ‘right come back and see me in another three weeks’ that’s about it.”
(Young woman, aged 20, aftercare)

This latter example raises another issue that will be returned to throughout the following sections, that poor experiences with professionals early on where they feel there is a lack of trust or understanding can result in young people closing up and not talking.

3.2.3 Feeling down, being unhappy: Issues relating to mental health

In contrast to the relatively low numbers of young people who perceived themselves as having mental health needs, a substantial number of young people reported feeling down or depressed. Thus, while there was a general lack of knowledge regarding the meaning of mental health and the young people were (unsurprisingly) unwilling to ‘label’ themselves as having poor mental health or a mental illness, they were willing to self-

define other related issues and concerns in their lives. Understanding or defining these, however, was often far from straightforward:

“(Pause) All the time, I don’t really, I’m not really a happy person anymore … I don’t know but whatever it is I don’t, I don’t like it. I don’t like being like this, I like, I like my normal self but I can’t be myself anymore cos I don’t know how.”
(Young woman, aged 16, foster care)

Young people also found it much easier to talk about general health and associated this with eating the right food, being clean, exercising, being “fit”, “strong” and “happy” (some of which clearly relate to emotional well-being). Health was also defined by not engaging in unhealthy behaviours such as smoking and drinking, or by not having an illness. Nevertheless, a number of young people stated that they were not healthy on a number of levels such as not eating the right food, not getting enough exercise, smoking and drinking or having low energy levels.

There is a clear contrast here in how the young people discussed general health and mental health. Whereas most definitions and understandings of mental health focused on the negative (i.e. poor mental health), discussions of general health tended to focus on the positives and how one could ensure good health. This may, therefore, not only suggest a lack of understanding of mental health but alongside this a lack of knowledge of ways to ensure good mental health.

It was also not uncommon for young people to purposely try to appear differently to how they were feeling as illustrated in the quote by the following interviewee:
“I always have a smile on my face like but I don’t know, it doesn’t mean to say I’m happy if you know what I mean, then again I don’t want people thinking I’m not happy, cos they would be asking.”
(Young woman, aged 15, residential care)

In many cases there is no clear physical manifestation of poor mental health and there are clear implications with this in terms of identifying and addressing need, particularly if young people are unable or unwilling to talk. Another important issue to emerge from this extract but again which was recurrent throughout the young peoples’ discussions relates to their reluctance to talk. Clearly in this young woman’s case people thinking she was unhappy would draw further attention to her when often these young people already feel under a public gaze. Further to this and as will be expanded upon in section 3.4.2 having to talk about issues essentially meant having to deal with them and there was a reluctance or fear on the part of some to discuss their true feelings for fear that they would upset others, jeopardise placements etc.

3.3 Experiences and Perceptions of Mental Health Services

3.3.1 Mental health services

While most did not presently perceive themselves as having mental health problems, many of the young people reported have seen, at some point, a mental health professional about an aspect of their mental health. This included a range of professionals such as Psychologists, Psychiatrists, Counsellors, those in family centres or those dealing with anger management. Once again there was a degree of confusion about the nature of different professionals they had contact with. This is illustrative of the wide range of professionals they had contact with over their lives and losing track of whom they had told and retold their story to (this will be elaborated in section 3.4.2).

While a number of young people spoke of the stigma surrounding seeing a mental health professional, it was more often the case of feeling that they did not need to do so or did not want to do so which summed up their resistance to this:

“Counselling wasn’t really my cup of tea; I don’t really like talking about that kind of thing.”
(Young woman, aged 15, residential care)

“My temper is bad it doesn’t take much for me, it’s like a wee thin line … I get annoyed all the time … [social worker] wants me to go to anger management. They want me to do counselling, they want me to do this, and they want me to be that … I don’t want to do counselling, I’m only doing it to keep other people happy.”
(Young man, aged 19, aftercare.)

While the above are only two examples of some of the resistance to seeing mental health professionals they illustrate two salient points. In relation to the first extract is an issue which will feature throughout the forthcoming sections, that is, young people not wanting to, or not seeing the need to talk. As previously noted, this may symbolise a lack of willingness to face and deal with difficult issues, but it may also reflect the fact that these young people meet with many professionals and feel a lack of affinity with a number of them, why then would they want to meet with another whom they may feel will be of little benefit to them? This relates to the second point which is clearly illustrated in the second interview extract – attending services not because they want to or feel that they need to, but because they are
told or made to feel that they should. Clearly, being supported in coming to this decision on their own would have many benefits as would discussions with the young person about their support networks and whom they could talk to if they felt they needed or wanted to. If young people feel ‘forced’ into counselling etc. and feel that they have had little say in the decision, their mere attendance may be of limited value. For while they may attend, they may not open-up or talk.

In contrast to this were a small number of instances where young people wanted to see a mental health professional but were unable to due to practical barriers to service uptake. The following example further illustrates another of the impacts of placement moves on young people’s lives (see also section 4.3.1 on ‘pinball living’ in aftercare and 5.5. on ‘I’m not a parcel’ in care) and their emotional well-being. Furthermore it illustrates the need for continual mental health care for those who feel it is necessary and the continuing or prolonged emotional difficulties experienced by young people aftercare:

“I went to see a psychologist when I was younger, I was very young so I was, I was doing some work there about family background, it was for a couple of months, I was able to get some of those feelings out, but not all of it, it would have came in time, all of it would have come out, but circumstances, me moving ... I would like to see someone like that again when I get everything sorted out, cos I am still partly trapped in the past, I want to move forward, but without that, without getting help at the minute I will still be stuck there in the past.”

(Young woman, aged 20, aftercare)

Finally in relation to young peoples’ experiences of mental health services, it is noteworthy that for a significant minority who had accessed inpatient care, that all of their experiences were defined negatively. Again, the following is reflective of the views of others:

“I would say the least useful thing was them putting me into hospital, then them f**king me into long term psychiatric care, it was the worst, being in hospital that just contains the problem it doesn’t solve it”

(Young woman, aged 20, aftercare)

This was the experience of the same young woman who previously spoke of her doctor prescribing tablets that she thought were unnecessary and of being diagnosed with an illness that she did not understand anything about. While this case may be extreme on many fronts it shows the true and potential impact of mental health care and professionals when young people feel excluded from their own care and are not provided with an understanding of the nature of their illness or the reasons for their care.

3.3.2 ‘Emptying the pit’:
Understanding and meeting young people’s mental health needs

Despite varying experiences of mental health services and professionals the young people, particularly through focus group discussions, provided a number of recommendations about how young people could better look after their own emotional well-being and how others could better understand it. This included, young people having someone to talk to, feeling that they could ask for help and having more accessible information on mental health issues. The need for talking, and the difficulty for young people in doing so was clearly realised by one young woman:
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“If you have bad mental health, most times you can’t talk about what is wrong and then it’s getting on top of you and you’re filling up a pit. And, it needs emptied, if the pit’s full you’re going to be upset you’re going to be more fragile, you’re going to be on edge, if you even get to empty a quarter, your mental health will be more healthy than if it was full”. (Young woman, aged 20, after care)

Thus, whilst talking could be difficult, it was understood that to have someone to talk to (not necessarily an outside professional) was essential because, if nothing else, it aided in unloading some of the issues in their heads. Related to this, young people identified that often the people best placed to help a young person were those they knew well:

“Well most people don’t understand, don’t realise they have a mental breakdown until it actually happens, so people around you can realise it before they do, like in Children’s Homes staff all round they will help you with it, if you live outside with family and friends they can help you with it.” (Focus Group, mixed gender, aged 15-17 years)

There is a clear suggestion and perhaps expectation here that those closest to young people act as their support. For this to happen, however, it is necessary that these are trained and supported in carrying out basic mental health assessments and in how to deal with issues rather than feeling a need to ‘refer on’, when this, in many cases, is not what young people desire.

Considering some of the more negative experiences of the young people can also provide valuable information on how services might be changed to better meet their needs. A number of young people, for example, talked of feelings of discomfort and within one group, the following suggestion was made:

“Cos it frightens you so it does, cos it’s like it’s very formal and all and you go into a wee room and you just feel real uncomfortable but if you are in somewhere that you were comfortable, like your own room or something, then you know that’s where you feel comfortable so you’re gonna be able to talk to them best.” (Focus Group, female 12-14 years)

While there may be some difficulties in implementing this particular suggestion, a number of young people stressed the need for a comfortable location as well as discretion. Young-person-friendly or neutral environments may go some way to making young people feel less uncomfortable and more willing to talk.

3.4 Young Peoples’ Lives in Context: Responding to Challenging Situations

Despite the information that young people gave in response to direct questions around mental health, perhaps it is more useful and indeed revealing to look at their lives in context. Mental health can be an abstract concept but, put in the context of everyday life experiences, particularly in relation to how young people respond to challenging situations, tells us much about the emotional well-being of this group. Here we look at the young peoples’ responses to difficult situations and where possible include young peoples’ reflections on the way they dealt with these.

A range of ways of dealing with difficult feelings and situations were described by the young people. These were on a continuum from positive means of coping through to negative coping strategies, about many of which the young people found difficulty in talking to us.
3.4.1 Healthy ways of coping with stress and distress

At the positive end of the continuum a large proportion of young people described activities such as listening to music, going for a walk or watching TV. Some younger participants also noted the value of going outside to play.

“There’s no point in getting upset about something like ... The best way is just ... you know like focus on art or, or draw, or going on and messing about like playing.”
(Young woman, aged 17, foster care)

“I don’t know, I just like going up and lying in my room with all the lights off and just trying to relax and just let them listen to my music or something.”
(Young woman, aged 14, residential care)

These examples, among others, can be seen as strategies the young people employed in order to take their mind off issues of worry or concern. While some (as will be discussed shortly) actively sought not to think or talk about issues of concern, others felt that time and space to reflect could be a useful strategy. This is an important issue, particularly for those in residential care who talked about the lack of opportunities for privacy and time to themselves. One young woman told us how time and space to reflect had enabled her to learn what to do in the future:

“Yea, sometimes cos like you’re just lying there thinking about it all and then you’re like, I don’t know, just whenever I’m doing that I’m just lying and like you get inspiration and try to work at it from a different point of view. Then like when you shout at people, talk to them instead. Then like, whenever it happens again you know what to do in the future.”
(Young woman, aged 14, residential care)

3.4.2 Talking or not

A striking feature of these young peoples’ accounts was the prevalence of those who stated that they did not or would not talk to anybody about things that worried them. Some felt they did not need to; others wanted to resolve issues for themselves while some simply preferred not to talk. While some did note that there were people they felt they could talk to and get support from, some chose not to speak to professionals within the care system about their experiences and dissatisfaction with care, opting instead to confide in other professionals:

“I just talk to myself in here. If I have really bad problems I wouldn’t say to anyone, I don’t feel like saying ... I usually talk to my teacher, Mrs X, she understands ... and everything and sometimes I do have bad problems but I usually just keep them to myself so I do.”
(Young woman, aged 15, foster care)

“If you don’t have that label that you’re a social worker, then I’d find it easier to talk to you.”
(Young woman, aged 19, aftercare)

The important issue, therefore, was not necessarily who these young people talked to but more so that they had someone to talk to. That said, some, actively chose not to talk and even though the young women in the first extract noted that she did have a teacher that she felt she could talk to, she followed this by still stating that she would, nonetheless, more often keep things to herself. Others explicitly stated that they had simply learned to hold things in and a few noted that it was not by accident that they came across as coping well:
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“Everyone says that I am like a wee turtle and when everything goes wrong I just put my head in my shell.” (Focus group, mixed gender, aged 15-17 years)

Of those that did talk, however, examples of those most often referred to were friends, social workers, residential staff, mothers and foster carers. Often a young person’s choice of who they talked to came down to privacy and trust and the identified benefits of talking included releasing something and getting a perspective from others. While the issue of support from others will be returned to in section 5.2, here it is important to consider why such a high number of these young people reported that they did not talk about problems or concerns. Firstly, talking can be difficult and upsetting, a form of facing and expressing issues which are distressing. Not talking may then be viewed as a short-term method of coping (putting my head in my shell) and a form of self-preservation when talking may appear to simply add to the upset:

“I don’t want to talk about anything [sigh] cos when you do talk you just cry anyway [big sigh].”
(Young man, aged 15, residential care)

Not talking about it, however, could be just as distressing as the same young man said of how he often felt:

“I just want to go and cry and cry and cry.”

Beyond this, however, these young people for a number of years may not have talked about their emotions and concerns, and to suddenly expect them to feel comfortable and able to share and vocalise them is perhaps somewhat unrealistic. Furthermore, and will be expanded upon throughout the coming sections, many aspects of the care system may not be conducive to young people opening up and sharing their concerns and worries. Multiple placements, difficulties in maintaining friendships and changes in social workers can make it difficult to build relationships, and young people may fear that talking about their distress may expose them as vulnerable or difficult and thus jeopardise the stability of placements or lead to further professionals entering their lives or them being more heavily monitored. Young people mentioned meeting lots of professionals in their lives and having to speak openly about many issues. For some this sheer volume of professionals meant it was difficult to differentiate between them. Some examples of what seemed to work well was having professionals who understood young people, who took the time to build up trust and did not cover ‘old ground’ each time:

“Well I didn’t respond to it very well, when I was first introduced to them like, I wasn’t even kind your name, but you know everything about me, oh aye right, dead on. I just found that dead hard to comprehend, I just thought it wasn’t right, but after a while, my major social workers ehmm the ones that have been with me a long time like X and Y, they were brilliant I swear to God absolutely fantastic!”
(Young woman, aged 20, aftercare)

“They’re there to help you and that’s about it. You can’t very well tell them to clear off cos they don’t do it, they stay. So you might as well just let them come and help you. Yeah, cos the quicker you work along with them, the quicker they bog off.”
(Young woman, aged 15, residential care)

In this context and in the context of these young peoples’ lives and experiences before care and their experiences of the care system, it is perhaps not surprising that so many prefer not to talk.
3.4.3 Alcohol, solvent and drug use

More negative ways of coping included alcohol, solvent and drug use. While any number of interview extracts could have been used to illustrate involvement in these behaviours, the following illustrate a number of key points. Firstly, the nature and extent of some young peoples’ drug/alcohol use; secondly, how drug/alcohol use could lead to other risk-taking behaviours such as involvement in crime and absconding from care and finally, drug/alcohol use as a form of escape from the realities of their lives:

“I’d go out; I end up running away for about a month and getting drunk, cos I used to be able to never say no to people and that’s why I ended up getting myself into situations and I used to run away … I took E’s and dope and all … big lumps of speed but it was actually crack cocaine with heroin in it … I was never sober, I got really skinny because I wasn’t eating.”
(Young woman, aged 16, residential care)

“I went through a patch where I was sniffing every single day, nail varnish, oh aye, collection 2000, then I went off sniffing for about a year and then I went back on it, only this time I started on WD40, cos it was closer, the garage up the road done it. So I would have went in and nicked two tins of it every couple of days…”
(Young woman, aged 20, aftercare)

“I don’t know my head just went nah, I turned to the sniffing so I did, nail polish, I was big into it, like I was doing it every day so I was … do a wee glue bag then my head was in cloud nine then … I had a wee place to go on my own just outside my head … it just reached to a certain point where I said this is getting me nowhere like, after so many months of doing it, I just said to myself this isn’t going to help, your problems are still there once you’re back to normal.”
(Young man, aged 18, aftercare)

In this latter example, the young man clearly states how solvent use was a means of coping, of providing him with a temporary escape from having to think about and deal with the issues in his life. Further to this, an issue to emerge here and which is returned to in section 4.2.8 is that some of these young people could be exposed to a higher risk of drug/alcohol use due to the nature of their placements. Those in residential care for example, often talked about the high prevalence of drug use among their peers; one demonstrating how certain drugs had, to a certain extent, become normalised:

“Blow [cannabis], I’m addicted to it, everyone in here I say smokes blow, well not every single person but it would be about seven out of ten, about seven out of ten would smoke blow. It gives you a good feeling, it helps you relax, you’re just sitting there and it’s, it’s just a good feeling.”
(Young man, aged 15, residential care)

3.4.4 Self-harm and suicidal thoughts

One of the most extreme forms of ‘coping’ or responding to difficult situations and circumstances was self-harm and in a small number of cases, suicide attempts. While a sizeable number of interviewees described their coping-motivated self-harm, some who had telling scars did not talk about this in the interview. This would suggest that the prevalence of self-harming behaviour among these young people was greater than we uncovered here. Some described their reasons for self-harming and the emotional release they experienced through it in a very vivid way.
In the following extract the young person clearly outlines how self-harming was a way of making her emotional pain visible and the sense of freedom it provided her with. Interestingly we can see parallels in this young person’s description of the short-term nature of the freedom, the addictive nature of self-harming and the realisation that it was short-lived with those who previously described their use of alcohol, drugs and solvents:

“One of my mates she was doing it all the time and I think that’s when I first started, I don’t really think it crossed my mind before that, but at first I just tried it just to see how it would make me feel and all that there and then I discovered that it did help. What I didn’t realise was it didn’t help long-term and by that stage, by the time I realised that, I was at it all the time. Well if you are feeling something up in your head, right, you can’t rationalise it till you see it, it’s like it’s not real until you can see it so basically when you cut yourself you can see the blood, you can see when you are hurting, so you are saying yeah I can rationalise that now it’s there. I think it lasted until the adrenaline rush wore off and then once it wore off you felt worse it’s just a cycle cos you will keep on doing it, cos you just want that wee half an hour or an hour or whatever of just it’s not even feeling a bit better it’s just like feeling problem free, it’s like nothing else matters.”

(Young woman, aged 20, aftercare)

This young woman, among others, noted feeling a short-term release but annoyance with herself afterwards, perhaps only increasing her distress. Furthermore, she also stated that this behaviour had been learned from a friend in a residential unit. In another case a young woman noted how it was a behaviour which was learned from her mother:

“Well I used to body harm but I don’t anymore, cut myself and take overdoses and all ... I got annoyed afterward for doing it so I just don’t do it anymore ... it relieved the pain and all I had ... I used to see my mum doing it when I was little.”

(Young woman, aged 16, residential care)

Learned behaviour can be difficult to break especially when young people grow up in an environment where self-harming might be understood from a young age as a learned response to stress or a form of coping. For some young people then, this may have been a coping mechanism they had adopted before coming into care. For others, however, it was something they had learned whilst in care. While this may appear as a small point, it is an important one for those working with and trying to understand and support these young people.

There were invariably many triggers to young people’s self-harming, for some as previously illustrated it became learned through others as a response or means of coping, but for others, there was a clear, identifiable point when anger, grief or hurt had become so intense that self-harm or suicide attempts became the only response that some young person could find:

“My granny passed away about two years ago … and I just couldn’t cope so I just used to slice the f**k out of my wrists. Me and my granny were like that there …. I loved her with all my heart like and then she passed away like and I just took it bad, I wanted to kill myself, so I tried and tried and tried and then just stopped and … I couldn’t take it so then I started self-harming myself and I just got to a point that my arms were that f**ked I just couldn’t cut no more and just really didn’t give a f**k like I just couldn’t care what was happening in my life … just cut myself and I just used to throw myself on the bed and throw my arms out and hope I didn’t
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wake up. Whenever I used to work I used
to wake up the next morning f**k,
couldn’t even move my arms were f**ked
just all these big cuts and all and I was
living in that hostel at the time and your
woman kept saying, ‘what are you doing
to yourself, you’re f**king stupid!’”
(Young man, aged 18, aftercare)

Not only does this quote illustrate the
despair that this young man was feeling
but also the lack of support he had around
him. Self-harm remains a little understood
area and somewhat taboo and the
professional reaction to it in this young
person’s account is very worrying
suggesting a need for greater training of
professionals. That said, this was not the
experience of all and some found good
support and sensitivity among professionals in
their lives. One young woman, however,
IMPLIED that self-harm was an effective last
resort in order for her social worker to listen
to her.

“The social worker asked what
happened, what’s wrong with you and
why did you do it and you can talk then
cos before that no-one wants to talk to
you or listen to you.”
(Young woman, aged 19, aftercare)

Again it is worrying that some young
people felt that they had to go to such
extremes to make their emotional pain so
physically visible in order to receive help or
support. That said, it is also important to
remember that many of those we spoke to
talked of how effectively they could hide
their distress to appear that they were
coping. It can, therefore, be difficult for
social workers and other professionals to
gauge true feelings (although this does not
appear to be the case for this particular
young woman).

A few young people mentioned suicide in
the same context as self-harm. A small
number spoke of their suicidal thoughts or
the impact of suicide/suicide attempts of
others on them. The following three quotes
illustrate the worrying nature of three
young people’s stories. In the first instance
this is due to frequency, in the second due
to her fear of reoccurrence and the third
due to the extremity and prevalence:

“Four overdoses I think, five or six I don’t
know, morphine tablets, I don’t know I just
black out. Don’t know what they did, I
still don’t know to this day cos I don’t talk
about it … I don’t know, anything I could
find went in my mouth so it did, cos I was
just really, really depressed.” (Young
woman, aged 15, residential care).

“I’ll just have enough [of bullying] some
day and I’ll start all this again … Cutting
and hanging and you know threatening
and all but I don’t want to do it no more
cos I’ve done so well.” (Young woman,
aged 13, residential care)

“I know a lot of people who have been in
care that have killed themselves cos they
think it is the best thing to do cos they
don’t have to stick it anymore … about 3,
that might not seems like loads but it is to
me. It’s the way the staff treat them”.
(Young woman, aged 15, residential care)

While these accounts in themselves are
worrying and hard-hitting, the fact that the
first young woman continues not to talk
about her suicide attempts, and thus
perhaps also the reasons leading to them,
may suggest that the depression she
speaks of may lead to this response again.
More evidently the second young woman
is still coping with serious bullying which she
fears, despite all her efforts, may also lead
to a similar response. Finally, knowing three
young people who have committed
suicide is, as the young woman suggests, a
high number and we do not know how she
or others affected by this have been
supported. While it may be uncomfortable and somewhat irresponsible to talk of learned behaviour in relation to suicide, the recent rise in suicide rates among young men in particular areas of Belfast and discussions of 'copycat suicide' may suggest that this is something that we have to at least consider and contend with.

As a final point, several young people made reference to anger manifested by hitting out, destroying things and punching walls. Young people directly mentioned that their feelings about being in care could have a negative effect on their behaviour:

"I have to admit being in care right just changes your life and about how you think about life and you know what’s happening, most people you meet in care are a wee bit angry but they don’t want to show it so they take it out on other people that they don’t mean to."
(Focus group, female, 15-17 years)

As has been evidenced through many of the accounts within this section to date, young people make various behavioural responses to emotional pain. Drug and/or alcohol use, self-harm or suicide attempts, acting out or hitting out are clearly, in these young people’s experience, sometimes the only known response to the emotional turmoil they often feel inside. Their behaviour, responses, coping mechanisms etc. need to be understood within the context of their lives; that is the emotional pain which often stems from their lives before care and is often added to because of the actual care experience.

3.5 Adjusting to the Environment of Care

Here we offer a brief overview of particular factors impacting on emotional well-being while in care, thus providing a backdrop to more detailed discussions in the forthcoming sections. This section also provides some level of understanding of the responses young people make to difficult and challenging situations as discussed in section 3.4.

Recognising the distinction between a family home environment and a residential care setting, some young people mentioned the specific survival tactics they felt were necessary when living in residential care:

"You still have to get a wee bit wilder when you come in here [residential care], cos you kind of meet different kids, so you have to wise up you know, you have to use your brain ... Cos if you act the way you act at home, you know making a noise at home, but you see you can’t do that in here, you just get trodden on by some of the kids that come in, so you have to wise up ... you got to show them don’t mess with me, sort of thing."
(Young man, aged 15, residential care)

This clearly relates to many young people’s discussions of how they felt that their behaviour had changed as a result of their care experiences, how they had learned to adapt and in some ways became ‘harder’ and lost part of their childhood.

A few chose to behave in certain ways because it attracted attention which could then be used as an opportunity to voice their feelings:

"Say you are in a residential unit and one of the staff have put you in a bad mood and you just want to drink to make them worry about you, you don’t know what the dangers you are putting yourself into."
(Focus Group, female, 12-14 years)

Challenging behaviour in some instances
then can be viewed as a means of getting attention from staff, as we saw in the earlier example of a young women who resorted to self-harm as a means of getting the attention of her social worker. In an environment living with a number of other young people ‘acting out’ may be seen as a tactic employed to gain some individual attention and care.

Some young people reflected that they came to a placement (usually foster) with behaviours from their home environment that could be interpreted as ‘challenging’:

“[Foster Care] was better cos it was, it wasn’t arguing all the time, it wasn’t, but I was like, arguing with the foster parent, a lot so I was ... Cos I was used to sticking up for myself with my mummy and all ... And I was like, arguing with her and she was like ‘don’t take that tone with me’ and I was like, ‘I’ll take whatever tone I want with you’, and then, we shouldn’t have to do it but I used to do it because of my mummy and I thought it was the right thing to do, when it actually wasn’t the right thing to do.”

(Young woman, aged 13, foster care)

“They didn’t like us because we were ‘un-fosterable’ and my brother cried a lot and I misbehaved quite a lot and that was due to my upbringing by my real parents so, I couldn’t help it.”

(Young woman, aged 19, aftercare)

“Just me I was really cheeky and really aggressive. It wasn’t that I was physically aggressive I was more hurtful with my words but I wouldn’t do things and they just wanted the perfect wee child ... and I wasn’t ... Because, you know, I was cursing from I was 1 ? you know, I could say full sentences all curse words you know and I would stand in corners and shouting at people and all. It’s really odd like but it’s just the way it is.”

(Young woman, aged 20, aftercare)

Clearly challenging behaviours need to be understood in the context of these young peoples’ lives. They had lived in and adapted to their home environments in ways that served to protect or preserve them and enabled them to get by. Foster care and residential care brought new cultures with new rules, boundaries and regulations within which these young people were not used to living and working. To be removed from one culture and placed into an essentially unnatural environment which was often different in every way was extremely difficult. There is a need for a clearer understanding of the nature of pre-care experiences and the difficulties of the transition into care. More work at the early stages of entering care around the pre-care experience and preparation for the care experience is essential.

Being in care and the actual care experience was also cited as a factor impacting on feelings of depression and a reason why young people sometimes responded in challenging ways (see also section 4.2.6):

“You just feel like no-body wants you ... I don’t know if it’s because, children don’t feel like they’re cared for and they go off the rails a bit but I went off the rails a bit.”

(Young woman, aged 19, aftercare)

When young people do not want to talk and instead ‘act out’ in challenging ways it can be forgotten that these feelings of rejection and being unloved are often at the root of these behaviours.

In contrast to challenging behaviours some young people noted that through time they had learned to be well-behaved and there was a clear link between behaving well and being kept in a placement:
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“Cos if she starts fighting with her foster carer at the end of the day if she keeps going on the foster carer will just go to her social worker ‘look she is going to have to leave, you know I can’t, she’s not getting on with me you know I can’t control her’.”

(Focus Group, female 12-14 years)

“Do everything right and don’t fall out with your carers, and ... Like, if they ask you to do something, just do it, it doesn’t matter how long it takes or what it is. Or...just do whatever, just look after yourself and, look after them and they’ll look after you.”

(Young man, aged 15, foster care)

Behaving well, however, may not always symbolise a young person being settled, having come to terms with their pre-care experiences or aspects of care. These young people clearly illustrate that being well-behaved benefited them in terms of placement stability and their behaviour may in some cases be a result of fear of further rejection. In the latter case, the young man notes the lengths he would go to (which many young people in birth families perhaps do not have to) in order to ensure that he remained in his placement and did not present himself as causing any trouble to his carers. This once again may relate to the issue of young people not talking (see section 3.4.2), because young people may fear that talking about their worries or concerns may make carers feel that they are difficult and perhaps jeopardise their placements, hence leading to further rejection.

There were of course many more factors which could be seen as impacting on the young people’s emotional well-being and the various responses they made which are not discussed here; these will be dealt with in more detail in section 4. The aim here, however, has simply been to set some of the emotional and behavioural responses of these young people in a general context of their care and pre-care experiences at this early stage of the discussion.

3.6 A Sense of ‘Normality’?

As a final point here we want to again briefly allude to a recurring theme in the young people’s discussions and again which will be returned to throughout, that is the theme of what was ‘normal’ in their lives, and the ‘normality’ they strove for or felt they were missing as a consequence of being or having been in care.

While we cannot ignore the fact that young people are looked after, a sense of adopting a ‘normal’ way of life was mentioned on numerous occasions by young people. This was put across in two different ways. The first was that some young people’s lives are so situated in systems that they had become habituated to care and saw it as ‘normal’. For example, in the focus groups, many of the young people said that all young people do ‘normal’ teenage things:

“Well once you actually tell them what care is and what goes on in the backgrounds of care, there is nothing they can do or say about it because it is like a normal house just you are not with your mum and dad but you are with other young people, you are with staff cos they help you out and all.”

(Focus group, mixed gender, aged 15-17 years)

The second however, involves young people who see their circumstances as strange and would prefer their lives to be more ‘normal’ by reducing aspects which differentiate them from their peers. This could simply mean living in a more homely environment or being allowed to socialise
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by not having to go through police checks in order to have a sleepover:

“It doesn’t feel like a home, it is just a house you live in, it’s not a home.”
(Young man, aged 15, residential care)

“All the time my mates are out having good craic and all enjoying themselves and all while I’m stuck here looking at about 80 walls or something. What do you do whenever you come in here you’re not even allowed to be a child, you’re not allowed to be a young person and do what all your other mates are doing and socialise with your friends because whenever you’re here you’re under their roof, you’re under whatever they say you do. They own you more or less, and it really annoys me.”
(Young woman, aged 14, residential care)

These latter quotes illustrate the unnatural circumstances of living in care and the various ways in which young people feel different. Care, as will be further illustrated in section 4 is not a natural situation and young peoples’ responses to the care environment, the various aspects of it and their experiences while in it clearly impact upon their feelings of well-being.

3.7 Conclusion

While not necessarily relating difficult or challenging times, feelings or experiences to mental health, the young people in this research described a variety of ways to deal with the difficult situations they faced. These could be seen as adaptive or not. What emerges from the research is a picture of young people with various needs which are not unlike the differing levels of need put forward in the Four Tiered CAMHS model ranging from a high level of risk to lower levels of risk (NHS HAS, 1995). Some engaged in quite extreme external behaviours while others seemed to internalise their behaviour. There are also serious implications that young people use health risk behaviours to cope and that some of these can be learned in care (and in particular residential care). While health risk behaviours are also used by young people outside of care there do seem to be significantly higher numbers in care who do this. It is also worrying to find that so many young people said that they did not talk about their feelings and had cultivated a way of presenting well. One must ask if this tendency not to talk, or engage with help offered to them is a result of a lack of engagement with a system which is essentially pitched wide of them and which they often feel they have little control over. As this section has shown, there is also a need to view the behaviors young people display in the context of their lives and while these behaviors can be frustrating for carers or workers, it is important that systems do not make such behaviors pathological.

Overall, this section has demonstrated in a number of ways that a tightly defined definition of mental health may not always provide us with a full understanding of the emotional needs or well-being of these young people. This has clear implications for these young people in terms of ensuring their own emotional well-being, but also for those closest to them in terms of identifying their needs. Not only does the term ‘mental health’ have a predominantly negative meaning to young people, but to wider society more generally. The stigma attached to mental health and mental health services, the language used by some of the professionals with whom these young people came into contact and the adult nature of mental health settings, are clear barriers to young people accessing or finding value in mental health services.

While accessing the right professional
at the right time and in the right manner/setting is clearly important, this research reveals that in its haste to ‘refer on’ that the system may in fact be missing the potential value of key relationships in young peoples’ lives. Resources, therefore, could be directed towards in-skilling those professionals or key people in young peoples’ lives who they define as supportive (e.g. social workers, key workers, aftercare workers, foster carers). While this might involve training these key people as informal counsellors (e.g. equipping them to do basic mental assessments) it does not necessarily mean that all workers need to think psychotherapeutically. An approach of this nature would not only be in line with young peoples’ wishes and desires to have fewer professionals involved in their lives but would also be building upon those positive experiences and relationships which young people already have (this is discussed further in section 5). Such an approach would, of course, necessitate new ways of facilitating and supporting young people in meeting their mental health needs. Full consideration needs to be given to young peoples’ wishes to deal with things privately. If we are to expect young people to find support in key people in their lives and be able to open up and talk to them, this will entail granting greater freedom and decision-making powers for professionals in that they feel they can keep information confidential. It is also worth considering the extension and promotion of child/youth services which already exist to support young people’s emotional needs such as Contact Youth, how we might address the notion of stigma and the meaning of mental health held by young people and ways of providing more young-people-friendly settings (e.g. Blower et al., 2004).
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There are many factors that may place some Looked After Children or Care Leavers at greater risk of developing mental health difficulties than their peers not living in care. These factors have sometimes been described as the three “Ps” (i.e., predisposing, precipitating and perpetuating factors) and were identified by the Clinical Psychology Speciality Advisory Committee (2002) as follows:

- Predisposing factors may include genetic influences, low IQ, developmental delay, communication difficulties;
- Precipitating factors may include overt family conflict, family breakdown, inconsistent parenting and so on; and
- Perpetuating factors involve socio-economic disadvantage, hopelessness, and living in conflict.

In relation to the family and parenting (one of the identified precipitating factors), steps can be taken prior to a young person coming into care to assist with parenting through early intervention and preventative initiatives. In Northern Ireland however, the level of investment in early intervention is much less than in England and Wales. Additionally, the link between deprivation and referrals to family and child-care teams was highlighted in a recent study in Northern Ireland which analysed referral data at ward level from 1998-2000 (Winter & Connolly, 2005). While the authors acknowledged that more research was needed in this area in the UK in general, they stated that if they knew the multiple deprivation score for a particular ward, they would be able to predict the number of childcare concern referrals with 91.4 per cent accuracy. In other words, deprivation is likely to increase the chances of referral to Social Services.

Leaving care also brings with it a number of risk factors and one which is often cited is the negative outcomes in terms of educational attainment and economic activity levels (Mooney & McDowell, 2006).

Taking these various factors and research findings as our starting point, this section focuses on what we or the young people themselves reported as vulnerable points in their lives. By this we mean, times or events in their lives which caused distress or put them in positions of risk and may impact upon their mental health. Here we focus upon vulnerabilities in relation to three main areas: before coming into care, while living in care and in life aftercare. Other events or experiences where clear vulnerabilities were evident relate to their current and future outlooks and expectations, bereavements and
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experiences with the Criminal Justice System.

The aim of this section is to give an overview of the views and experiences of the young people in relation to each of these themes and to discuss the potential impact on their mental health. Also, where possible the aim is to highlight areas where intervention had or may have had a positive impact. While both positive and negative experiences of care were discussed by the young people, the aim here is to examine vulnerable points, situations and circumstances which may impact negatively on young people’s mental health in order that these might be targeted in policy and practice. This inevitably results in a disproportionate focus on the more difficult or negative aspects of life before care, in care and aftercare.

4.1 Life before care

While young people were not, for various reasons, asked directly about their lives prior to care or reasons for coming into care, this was an issue which inevitably arose out of questions on how things had been for them ‘before now’ and general discussions about their lives in full. While not dwelling on this issue in detail here, we found common and re-current themes emerging in relation to their family situations. These included a high frequency of family quarrels and fighting, physical violence within the home, a lack of food (and neglect) and parental drug and alcohol abuse. These were often difficult experiences and memories to convey and a number of young people felt that they could not talk about this period of their life. Others, however, noted a sense of a ‘lost childhood’ relating to living in these circumstances and often taking on primary caring responsibilities for siblings as a result. The memories that a number of young people were left with were vivid and could be said to continue to impact upon their mental health. The following interview extracts are illustrative of this:

“I had to grow up very quickly... I can remember a lot... I can remember the fighting; I remember every single solitary thing, but, because of that there, that hindered me.”
(Young woman, aged 20, aftercare)

“I don’t know I’m trying to think of other things, I can think of loads of things but I don’t want to say ‘cos they are too private.”
(Young man, aged 19, aftercare).

Not all young people had such negative memories of their life before care, a number were fairly non-committal describing it in various ways as ‘fine’ or ‘ok’, while others talked of the love they had experienced or the positive experience of living for a time with extended family. Indeed, it was the feeling of love that one young woman, among others, experienced which over-rode the more difficult times:

“See to be honest with you things weren’t absolutely fantastic, but sure no one’s life is sure very ‘fantastic’. And like, I didn’t get everything I wanted but then again I don’t think anyone really does but there was love, there was a lot of love” (Young woman, aged 14, residential care).

In light of the varying reasons for young people entering care it is little surprise that experiences of life before care were diverse. A minority had lived in care most of their lives and had no real memory of their lives pre-care and those who reported issues which had made them vulnerable in their family homes were similar to those reported in other research.
4.2 Living in Care

A number of issues relating to points of difficulty and vulnerability while in care emerged from the young people’s accounts. These ranged from the initial experience of entering care, to actual care experiences and their understanding and voices within various aspects of care proceedings. Key themes running through the various issues discussed here are uncertainty, misinformation or a lack of information, distress and self-blame. It is important to provide real accounts and experiences in order that we can consider ways in which these issues might be eased.

4.2.1 Information, misinformation and uncertainty

Unsurprisingly, many young people noted the entrance into care as difficult; the key issues to emerge were the transition into a new way of life, new surroundings and new people and missing their families:

“What was difficult, getting used to not seeing your mum walking through the hallway or something and not being about downstairs.”
(Young man, aged 12, residential care).

Many spoke of this as a time of sadness, unhappiness and uncertainty. Self-blame was evident in numerous accounts; this was despite the recognition that the situation they had moved into was in many ways a positive one:

“I thought what have I done? How come I’m going away from my mum? Mmh hmm, I think that that’s what most kids think when they’ve been took, is why they have been taken away. Everything was different from home, a clean warm bed, a home, a family, food, everything and love as well.”
(Young woman, aged 20, aftercare).

Many spoke of this as a time of sadness, unhappiness and uncertainty. Self-blame was evident in numerous accounts; this was despite the recognition that the situation they had moved into was in many ways a positive one:

Uncertainty about why they were coming into care clearly related to their confusion, sadness and feelings of self blame, and many noted never understanding the abrupt change in circumstances and being given no real information about what was happening. The following extracts are illustrative of the way some young people talked of being placed into care by parents/social workers without knowing where they were going, why or for how long:

“She [her mum] never told me where we were going, I thought we were going to the park and we ended up here and she never came back for me. I ended up upstairs crying my eyes out.”
(Young woman, aged 15, foster care).

“[Social worker] came into the house and gave us twenty minutes to get our stuff and go, she told us we were going up to X but sure I didn’t know where X was, I didn’t even know it was a place.”
(Young man, aged 13, foster care).

While these were not the experiences of all, they highlight the importance of clearly explaining the process of moving into care to young people in a manner which is understandable to them. Feelings of anger or resentment towards one social worker because of feeling “tricked” into care (young woman, aged 16, residential care), can make it difficult for other professionals to build trust and work with them in the future. While this may not fully prepare young people for the sudden and drastic change of circumstances, a smaller number of young people who felt that they had some degree of understanding of the process explained to them noted that it had at least aided in reducing the confusion and uncertainty about the process.

Related to this, many young people...
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reported being given information at the initial stage of entering care which they had clung to until finding out much later that it was inaccurate. This most often related to having no idea how long they were going to be in their placement although a number had the impression that they were going home in a specific period of time. While there was some suggestion that they had been given inaccurate information in the early stages of entering care it was difficult to decipher if this was the reality of the situation or was a result of miscommunication. That said, for many this involved longer than expected care placements (in their opinion). The following experience was not untypical:

“They explained it a wee bit….all they were really telling me was I was going to stay here for a week and then a week passed and then I was still here and it was going on for two weeks. Then two weeks passed like then it was three months, and then three months passed and then there was another three months. So they weren’t telling me nothing, they were just telling me how long I was going to stay here … And like every 3 months I was getting my hopes up to going back home and then they were like, ‘no you’re staying here for another three months’ ... So like, they never gave me a clear picture of what was going to happen. [And what do you think would have been better?] Like, setting me down, like telling me what’s going to happen in those three months and what I could do to get home quicker” (Young woman, aged 14, residential care).

A lack of clear information, as in this case, had led many to have unrealistic expectations about expected length of time in care. As this young woman suggests, sitting down with her and talking through what could realistically be expected within the forthcoming months could aid in hopes not being built up and let down. Beyond this, however, feelings of self-blame in terms of believing that delays are in some way the fault of the individual young person (“what I could have done to get home quicker”) could be reconciled by clearly and honestly communicating the process and the difficulties involved.

A lack of certainty and feelings of confusion were also discussed in relation to care placements, particularly when young people were having positive experiences and unaware of how long they could expect these to last. Indeed a small number of young people discussed the impact of uncertainty on their feelings of well-being and their behaviour:

“I don’t know I just got a bit annoyed, I just kept getting told I’ll have a home soon, you’ll have a home soon and they never had a home for like the two years, I was supposed to be there for a weekend and I went a wee bit crazy.”

(Young woman, aged 19, aftercare).

Through time and experience, unrealistic expectations, having hopes built up and being let down time and time again had led some to give up on having hopes and a positive outlook and essentially being disillusioned about a positive outcome:

“There’s no point in feeling hopeful you just take life the way it is. Cos you may be hopeful you get this and you get that and then, hang about maybe a week or maybe a month and maybe a year down the line you don’t get it”

(Young woman, aged 19, aftercare).

Uncertainty was also mentioned in other areas of young people’s lives such as placement breakdown, the future, returning home, where they were going to live in aftercare and their reasons for being
in care. As illustrated through a variety of the young people’s experiences, uncertainly, misinformation or a lack of information could lead to unrealistic expectations, increased distress when the reality of the situation was revealed or understood and a lack of trust of professionals.

4.2.2 Family contact

Despite the complexities of young people’s relationships with their families, maintaining contact was extremely important to them. Many aspects of family contact, however, led to distress from the way in which it was organised, the location, number of visits and/or the inconsistencies in it. Some had particular difficulties in coming to terms with the infrequency of contact framing this as an entitlement or a right, the importance of which they felt was not fully understood by professionals:

“I think everybody is entitled to see their family everyday ’cos I’m used to seeing my brother and my sister and my daddy every day. But now they cut it down, to what, two hours a week which is rubbish, you know what I mean like? It’s nothing off [social worker’s] back she doesn’t have to go through what we’re going through ... family is everything, ’cos at the end of the day you’re always going to go back to your family no matter what, it doesn’t matter who comes along and ah, they don’t understand that.” (Young woman, aged 14, residential care).

Others did not like the way contact with their family took place. This most often related to the presence of others such as staff and the location of contact visits. In particular it was felt that if contact took place in the house of a member of the extended family, that it gave young people an outlet in which to see other family members and feel more relaxed:

“[feeling that contact in granny’s house is more relaxed than in a foster home] say a foster home or foster placement that they are in, the foster parents would be walking around and you would feel dead nervous and uncomfortable and stuff about talking to people.” (Focus Group, female, aged 12-14).

Despite wishing to maintain contact with their families, it was often a difficult process which prompted the return of difficult memories. On other occasions the inconsistency of visits was distressing when young people expected parents to turn up but were constantly let down. While little may be done to resolve these difficulties a full awareness of the conflicting emotions young people experience due to family contact, or a lack of it, is important in relation to understanding young people’s mental health and the various factors which can impact negatively upon it. Consideration could also be given to potential work with the family, particularly since they often return to the family.

4.2.3 LAC Reviews, policies and procedures

In the main young people were critical of many of the policies, procedures and rules which governed their lives in a way that they say did not happen to those living in “normal families”. The one procedure where almost all of the young people were unanimous in their criticism was LAC Reviews. These were something which young people did not feel that they could participate in and their lasting impression was the volume and relevance of people talking about them in a predominantly negative way:

“Hated them, every LAC review I had there wasn’t one person apart from the people from the home, that had nice
things to say about me, that’s why I don’t like them. Ever see the start of LAC reviews. Just everyone’s got all bad things to say about you ... Everyone sitting around me talking about me like and I had to sit there. My first LAC review that I was in, I sat there and I felt as if I was f***ing boiling a kettle on the top of my head, I just wanted to get up and kick everyone in the face like.”
(Young man, aged 18, aftercare).

“I didn’t like them one bit, they were always quite daunting ‘cos there is always loads of people there, like a senior practitioner, senior social worker and all that and the foster family and just you there, it’s like all eyes preying on you, in the hot seat, it should be more relaxing for them.”
(Young woman, aged 20, aftercare).

Many young people talked of the tension and discomfort they felt during this process. Rather than them understanding it as a review of the care process as related to them, they experienced it as a review of them as a person in which they had little or no part. While they could be there, the situation and the power imbalance meant that the young person essentially did not have a voice. While a small number of young people reported that they did continue to attend LAC reviews on occasions, primarily as a means of finding out what was said about them, many, because of the aforementioned experiences, had stopped attending. This is a worrying finding as these reviews are an opportunity for young people to be included more fully in the care process and to have their voice represented by themselves in their own terms. Yet the findings here would suggest that LAC reviews simply do not provide a forum for this in light of the imbalance of power and the way in which the young people experience them. Indeed we cannot take young people’s attendance as being synonymous with representation and their voices being included. Further to this, the impact of what they experience as a wholly negative personal indictment of them by a number of people in positions of power can have a negative impact on their feeling of self-worth and hence their mental well-being.

With regards to other policies and procedures, the young people also displayed a high level of annoyance with the delay in having PECs checks carried out before visiting friends’ houses. Many mentioned the rigidity around these such as the speed of getting the PECs checks through or the difficulty of timing around weekends, evenings or social workers’ holidays. While there was some level of awareness of the reasons for this process, time delays led to uncertainty about whether their requests would be met on time, last minute plans could not be made and the young people were once again reminded of their feelings of difference:

“The one thing I hated the very, very most was if I wanted to stay at my friend’s house, I had to phone the social worker and ask them, then they’d do a police check, to make sure it’s ok for me to stay at my friend’s house ... which is understandable because they’re legally in charge of me. It’s not like a normal childhood, when you have to ask your mum, and ask these people and they’ve to do all this, you’re scared your friends think you’re a freak.”
(Young woman, aged 19, aftercare).

This feeling of ‘difference’ was also discussed in relation to other rules which surrounded their care experiences. While this was discussed by a number of young people, one young woman in particular felt that the rules and regulations which surrounded her life were stifling her
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independence and her youth:
“Here you can’t go out every day. I don’t see why ‘cos I’m used to going out every day and then just ‘cos you come in here it’s as if you’re not allowed to be young anymore you have to ask permission, or else you get a sanction or you abscond or something like that, you know what I mean? I think it’s all rubbish.” (Young woman, aged 14, residential care)

4.2.4 ‘People don’t realise what care means’:
Stigma and peer perceptions of care

Young people were not only reminded of their feelings of difference because of the policies and procedures which impacted on their lives but a significant number had experienced name calling and differential treatment outside the care setting too. This most often related to their experiences in schools and with their peers and was often a consequence of society’s misconceptions of living in care and the stigma attached to it. Making new friends could be difficult because of misconceptions:

“Sometimes it takes a while to make new friends ‘cos once you tell them you are in care they think the worst of you, you know what I mean, when I first met all my mates they all thought I was a bad wee s*** like ‘cos I lived in care” (Focus group, mixed gender, aged 15-17 years).

Furthermore, having to explain the reality of living in care to others continued to highlight a sense of difference. Some also experienced differential treatment and name calling because of being in care. While the response to particularly hurtful comments about their families not loving them or them not living in a real family had led some to react by fighting back, others found that they had no means of defending themselves emotionally from such experiences:

“You’d say to somebody that you would trust, well, that I’m in foster care and then they go and say it to somebody else and then somebody else, like, someone really nasty like would, like if you got into an argument with them, then they’d go, ‘well at least I’m not in foster care’ ... it just drains you so it does, it’s just like well, you can’t say anything back so you can’t ‘cos, they’ve got a mum or a dad and you’ve got foster parents, so you can’t say anything back.” (Young woman, aged 13, foster care).

It is clear that there is need for understanding and learning regarding care. While this might be best achieved through the likes of PSE in schools, broader learning is also needed.

4.2.5 Privacy of personal information

The privacy of information was important to young people yet this is often difficult to achieve given that these young people tend to lead very exposed lives and a lot of public information is held about them. Yet they, more so than other young people, were more aware of confidentiality procedures and the limitations of confidentiality (as was evidenced at the start of interviews when discussing these in a research context). As a result they had a keen understanding of the importance of confidentiality and some had felt that problems had arisen due to the process of confidentiality not being adhered to and thus trust being breached:

“I swear to God see those hostel staff they say ‘You can talk to us, you can trust us’, No! ... I get up the next morning and there’s different staff on, obviously ‘cos it’s different shifts and all that, started talking to me about all the stuff that I was talking to her about, see after that I have just..."
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kept my mouth shut now. ‘Are you all right today?’ ‘Yeap fine’ ‘Are you sure?’ ‘Yeap fine’. Just give me my key and I’m away.” (Young man, aged 19, aftercare).

“They [social workers] have made promises to me and then they have lied, we were having a confidential talk about [nature of conversation] and she said ‘now you do understand that this is all confidential it won’t go nowhere it’s just me and you’. I said ‘yeah’. But she lied and [everyone] found out about it.” (Young woman, aged 13, foster care).

The fact that trust had, in young people’s opinions, been breached, is a worrying finding and these illustrative examples demonstrate the detrimental effect in terms of the likelihood of young people opening up again. Trust is very important in building up relationships and for young people sharing their thoughts, and they were very selective in whom they chose to confide. It only follows, therefore, that professionals should be equally attentive to this. Indeed the young people felt that the sharing of information needed to be more explicit regarding what the person was passing on and why. Further to this, the research suggests that young people were often told to give similar information on various occasions to various professionals, the use and diffusion of this information needs to be more fully examined.

4.2.6 General feelings about being in care

With regards to their general feelings surrounding being in care, some stated that living in care was ‘fine’, ‘all right’, ‘nothing to be ashamed of’ or mentioned that they had become used to it. Many young people’s comments about living in care were, however, negative. They used words like ‘hate’, ‘depressing’, ‘mad’, ‘strange’, and linked care to feeling sad or unhappy, being bored or feeling different. Feelings around being in care centred for many on being away from their families or far from home:

“I never knew what care was like ‘til I came in and it just ruined my life … I have [family members] who need my help. Whereas I feel I should be there than just laying about this here dump ... I hate it. I get everything I want and all that but material stuff don’t mean anything to me, it’s love I want you know what I mean?” (Young woman, aged 14, residential care).

On a more positive note a small number of young people mentioned that they would not be the people they were if they had not been in care. Several interviewees when reflecting on their experiences had a preference for living in care noting that they had been encouraged to do things they would otherwise not have done such as going to school, social and leisure activities and having friends as well as someone to talk to. Others experienced relief at getting away from the family home and the life they had there, noting the opportunities and support that care had afforded them:

“Care, I loved it. I loved, like see when I was in the children’s home and all like, see compared to my house the children’s home was f**king parties. It was powerful, getting took out and doing activities and all, just all the nice things you get to do in it.” (Young man, aged 18, aftercare).

“It’s good fun; it’s a better life ... than my life was with my parents ... ‘cos you’re looked after ... like being talked to, if I needed someone to talk to, they will always be there.” (Young woman, aged 12, foster care).
It’s helped a lot because, you can get a lot of support that I needed. Because when I was young I really didn’t get that much support ... I wasn’t really brought up right, so, that’s why I’m getting more and more better, feeling better than I was when I was younger. Cos like sometimes them memories bite back on you but I’m like, oh, don’t worry about it cos I’m happy.”

(Young woman, aged 17, foster care).

A small number in foster care already felt they were in their ideal placement and that foster homes, more so than residential care, had the potential to have a more ‘normalising’ effect.  

4.2.7 Views and experiences of foster care

While the aforementioned themes and issues relate to vulnerable points and potential risks to good mental health across all types of care, issues were raised directly in relation to foster care and residential care.  With regards to foster care a number of young people mentioned the difficulty of feeling ‘at home’ in foster care because the reality was that they were not living at ‘home’ with their parents.  Making a distinction between their family life and home life some felt unattached to foster families which impacted upon the degree to which they felt comfortable opening up to them.  As one young woman told us:

“... they’re [her foster family] not like related to you so you can’t talk to them, they have got nothing to do with you except you live there, they give you food, they give you a bed to sleep, they give you shelter over your head so you can’t exactly go in to someone that you have been living with for like a couple of months and tell them all your deepest darkest secrets like because at the end of the day they are not related to you, they have got nothing like no blood relation at all to you.”

(Focus group, female, aged 15-17).

Furthermore, a significant number; while noting varying positive aspects of foster care discussed how they sometimes did not feel that they fully belonged.  Intermittently they were reminded that they were ‘different’ and not really part of the family.  ‘Family occasions’ and periods of respite care were most often cited as the main cause of these feelings and those who would have liked to feel part of the foster family articulated their feelings of ‘hurt’ or sense of being ‘removed’ at key family times such as holidays or when they had to go into respite care:  

“I just didn’t feel that they even cared if I was there or not ... I kind of liked it at the start but then summertime came and they were just like, ‘Well we’re going on holidays and holidays are family times you know so, you’re going to go stay with the [respite carer]’.  I was like ‘Thanks’ .... It was just hurtful you know at Christmas time, Easter time, summer time, it’s a family time you’re not part of that, you can go with someone else, I just got so sick of being there, I don’t know, [pause] I don’t know if it’s because, children don’t feel like they’re cared for and they go off the rails a bit but I went off the rails a bit”

(Young woman, aged 19, aftercare).

Respite care and being ‘removed’ at key times could, inadvertently, lead young people to feel unsettled and uncared for.  This young woman did note that she had initially enjoyed her foster placement but that periods of respite unsettled her and led to her reassessing her initial feelings.  While her experiences may not have been illustrative of all, a significant number who had foster care experiences did note, despite the best efforts of their foster families, that they did, on occasion, feel a sense of not fully belonging or being in some way different to other family members:
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“At Christmas [foster carer] sees all her kids … and sometimes you feel like an outsider … but then you feel like, well, you know, you feel like but she tries to involve you, sometimes you feel like you have to step back a wee bit you know, sometimes you feel a wee bit out of it, but that’s only sometimes so it is” (Young woman, aged 13, foster care).

Finally, there was some mention of the issue of identity. Some young people, for example, preferred to use their foster carers’ names while others called them ‘mum’ or ‘dad’. This was a personal and individual choice but it was clear that among a number of the sample there was a real desire to feel part of a family and a positive self-identity and value that went with that:

“I’ve been in children’s homes mostly in my life; I’ve never been with a family. And they make you feel like, oh like this is lovely and this is like, oh sometimes I call [foster mum] mum, and sometimes I call [foster dad] dad … Um, it’s just a bit difficult ‘cos I haven’t heard mum and dad like you just, ‘cos like so many years I just haven’t had a mum and dad … . And it feels so nice, it, just like brings back memories.” (Young woman, aged 17, foster care).

“Most of my friends see me out with my foster mum, and think it was my real mum, and I let them think that and [foster mum] lets her mates think that I am her daughter and that so it’s just like having my own family really ‘cos I’ve been living here for nearly 10 years” (Young woman, aged 13, foster care).

Conflict with other young people was mentioned, including in some cases,
bullying. Some young people spoke of poor relations and conflict with residential staff particularly around the use of restraints and sanctions. Conflict and discontent can clearly lead young people to self-destructive behaviours particularly when they do not know or have the means to resolve tensions. Likewise there was mention of staff being unable to control situations due to low staff numbers which put both staff and young people at risk:

“No man, it’s not a good place [Children’s Home] for anybody to go in....there was two staff on the sleep over and you see when things got serious, they couldn't stop, two staff couldn’t stop nine kids, so it was crazy, there was no control.”
(Young man, aged 15, residential care).

Other issues included boredom and a lack of stimulation in residential care. Private space was also mentioned as being particularly hard to achieve in the residential setting, especially when young people felt that they needed some ‘mental space’. A few young people also noticed on reflection that they had been institutionalised by this group-living and the following interview extract is illustrative of the difficulties this can create in the transition to independent living:

“It wasn’t so much living on my own and all that there it was more the fact that, I mean a good part of my life I was living with loads of other people and it was just like going from that ‘til just me, it’s just strange.”
(Young woman, aged 20, aftercare).

4.3 Life after Care

4.3.1 ‘Pinball Living’:
Post-care moves and vulnerabilities

It was confusing to piece together young people’s aftercare history since this was often characterised by a variety of placements and numerous moves through hostels, B&Bs, living on the streets, supported accommodation, moving back to the family home and renting their own accommodation. One young man defined this instability and frequency of change as ‘pinball living’ and it clearly took its toll on young people overtime:

“Just having like a stable place to live and not this pinball living. ‘cos I was living from hostel to B&B and just all over the show and it just melted my head and just I couldn’t take it.”
(Young man, aged 18, aftercare)

Some of the young people entered these environments even before they were the standard age to leave care. The options available to young people at the time could be particularly vulnerable environments such as hostels which exposed them to a range of older adults with various issues such as drug and alcohol problems. Further to this, early moves could lack preparation and adequate support, again increasing the young person’s vulnerability:

“Well in my own flat with no support or nothing for 6 months but I have been in places like [aftercare accommodation] and all since I was 15.”
(Young man, aged 18, aftercare)

Other young people returned to the family environment and they could then be vulnerable in the future either because no work has been done on the complexity of their relationship with their birth family or
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because they are re-entering into the situation which prompted their entrance into care.

Despite the vulnerabilities, however, there was a keen desire among many of those nearing care-leaving-age to move into aftercare as soon as possible.

4.3.2 Anticipations, expectations and realities of aftercare

The prospect of leaving care was a source of both anticipation and apprehension. Some who were nearing care-leaving-age were anxious to get out of care and looking forward to having their own place, sometimes for no other reason than to get out of care:

“I’m 16 [in three months] ... I’m excited, I can’t wait [to leave care] this week or next week she [social worker] is going to be taking me around all the hostels, you know to start me off.”
(Young man, aged 15, residential care).

“I wanna leave, I’m ready to leave, I wish I could just have a wee flat of my own somewhere, but they won’t let me; too young”
(Young man, aged 15, residential care).

In some respects it might be suggested that the deep-rooted desire to leave care as early as possible meant that some young people were not fully prepared for the drastic change in circumstances where they would be alone, responsible for themselves in most respects and limited in their finances. Others, however, had more awareness of the potentially difficult realities of life after care but felt prepared nonetheless because of the skills they had been learning:

“Scared, ‘cos it’s a big bad world out there, there’s bills and all to pay, feed myself and keep myself up in cigarettes and all, it will be really hard. I feel I’m quite prepared ‘cos I get £40 a week and £12 of it feeds me and £7 goes to rent a week so I’ll be all right; you can feed yourself for £12 a week, ‘cos I’ve learnt how to budget in here, I do social skills.”
(Young woman, aged 16, residential care).

While learning budgeting and other social skills is vitally important the thought and reality of living on £40 a week can be very different. Some of those previously in residential care noted that they had everything that they wanted and the experience of living on, never mind managing, a small budget is very different to what they were previously used to. Further difficulties noted by those who had made the transition were a lack of preparation regarding financial matters, filling in forms for benefits, cooking and cleaning:

“It’s a bit strange ‘cos as soon as I left X and went into Y it was a wee bit too soon to be going. I wasn’t really used to independent living ... There’s no staff about, there’s no dinner time for you, no dinner sat on the table or nobody to take you out for a spin in the car. More or less you have to take control, keep track of your own stuff ... I’m not really sure like, sort of getting everything done for me like, you never really had to do much, dinner was made for you, I had my own room, I more or less [had] everything I wanted in there.”
(Young man, aged 18, aftercare).

Furthermore, those in aftercare noted having more freedom and control (one of the most frequently cited positive aspects of aftercare), but this can be limited in other ways in aftercare, particularly financially. Indeed some of those who had made the transition to aftercare, despite their anticipation, had found that they were simply not as prepared as they had thought:
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“I’m eager to go out try it, but I’m not completely a 100% ready, I’ve already been out there once and it didn’t work out, so I came back in. So they are going to try me again, they said they will [do] a trial run, to see what it is like, then if I’m not really successful and if I’m not ready to move out... But this time I’ll have support out there, ‘cos last time I didn’t have support.”

(Young woman, aged 20, aftercare).

Key to this young woman’s account is the issue of support and the difficulties she experienced as a lack of it first time round. She now has an experiential understanding of the difficulties she is likely to face in aftercare (perhaps unlike some of those yet to experience it at all), despite her eagerness to make the move she is prepared to wait until she feels fully prepared and supported. She was also given this possibility to remain in care longer until she was ready which was not always the case for other young people. Some hope on this matter can be found in the new Leaving and After Care Legislation.

Again, despite some of the difficulties which may place young people in positions of risk, many positive aspects to aftercare were discussed by those currently in that position. These included no longer having to live with the stigma of ‘being in care’, having a sense of control over their own lives and personal freedom:

“I can do what other young people do now, I can go out. I have got me own flat now, I can walk in and out when I want, I can do whatever I want. I can’t exactly do whatever I want, I can do whatever I want to a certain extent and hmm, just, more happier.”

(Young woman, aged 19, aftercare)

As has been clear throughout, different young people require different levels of support at various points in their lives. It is important that more young people are supported in making a successful and smooth transition to ‘independent living’.

4.4 Bereavement

Close and recent bereavements featured in a number of the young peoples’ lives. While these were not usually associated with their entrance into care the impact of them happening while young people were in care and often experiencing other difficulties clearly impacted upon their mental health. The following are only two examples of the experiences young people shared with us regarding bereavement:

“I found it really hard when my granda died, really really hard, I felt all alone cos I was really close to him and it really did muck my head up a bit and I did crack up loads of times.”

(Focus group, mixed gender, aged 15-17 years)

“My granny passed away and I just couldn’t cope so I just used to slice the f*** out of my wrists, me and my granny were like that there, I was her china doll and she was my granny.”

(Young man, aged 18, aftercare).

The impact of losing someone close for a young person in care can be devastating and the pain associated with this can manifest itself in anger or in self-blame (perhaps due to limited contact with them before their death) and self-destructive behaviour. It is vital that young people have adequate support and that their behaviour is understood within the context of the events in their lives. From this research, while we had a little information on the support available to young people when they experienced the death of someone close, the lack of discussion of
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this, however, may suggest that it was limited. While expert and outside support is essential, it is also important that staff are well-trained and supported in issues surrounding bereavement.

4.5 Care and the Justice System

As previously noted young people spoke about how they felt varying situations within their care experiences had impacted upon their behaviour particularly in relation to alcohol, drugs and violence. Only five young people in the sample, however, had direct experience of the Juvenile Justice System, all of whom were in residential care at the time of interview. While this may suggest a relationship between residential care and crime it is important to remember that firstly, many young people will commit crime which goes undetected or unreported, and secondly, that this research was not designed in such a way as to examine causal relationships. Having said that, some previous research has suggested that there is a higher level of reported crime among those in residential care than those in foster care or the family home (see McMaster, 2004).

With regards to involvement in crime two young people felt that they had been ‘bullied’ into this by their (older) peers due to their age or perceived vulnerability (e.g. learning disability). On a more general level others felt that their care experiences had placed them at more risk of involvement in crime and/or anti-social behaviour. While the following interview extract is not typical (in terms of the nature and extent of offending), the way in which the young man discusses the influence of peers on his behaviour was not uncommon:

“It’s all bad influences around ... Since I moved into care, I started taking drugs

and all, started doing criminal things ... ‘cos of the people I run about with ... And if I wasn’t in here, I’d be out having a wee part time job and all. Being in here depresses me so much. I used to be a 34 waist. I am a 26 waist now ... See that wee c**t out there, the first time I met him, he said X has 6 charges, Y had 56 charges or some s***e like that. And I had to listen to that for days ... Now I only had about 10 or something, he probably has about 68 or something.”

(Young man, aged 15, residential care).

In this example the young man himself makes a direct link between being in care, being in trouble and being depressed. While the care experience in itself has been seen in various ways to lead young people to feel depressed, this is intensified in this young man’s case as he also has criminal convictions and is surrounded by those he feels put more pressure on him. Peer pressure and young people’s desire to ‘fit in’ is as much an issue for those outside of care as it is for those in it, yet care experiences may increase this pressure due to the concentration of young people in residential care placements and difficulties in adapting to new surroundings and new people.

Also, related to the issue of crime a few young people talked about having been ‘picked up’ by the police who had suspected them of committing a crime or causing trouble. The stereotype of young people in care and their relationship with crime is one that still very much remains and these young people felt discriminated against by the police due to their living circumstances. Many noted, however, that these stereotypes were more wide-held in society and had felt demeaned or discriminated against because of the general perception that children in care are children in trouble (or troublesome children):
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“I’m actually happier that I’m in aftercare than I was in care, there is more or sorry less of a stigma, ‘cos you see most people they think that in care are the joy riders or people who have took drugs I have never touched drugs in my life and I have never stolen a car I have never been in a fight, you know, and I’m tarred with the same brush.” (Young woman, aged 20, aftercare).

4.6 Young People’s Attitudes to the Future

As a final point in this section we want to briefly give attention to the young people’s attitudes and aspirations towards the future. We do so because we feel that this not only highlights current vulnerabilities but also the possible vulnerable situations they may be placed in or be at risk of in their future lives. This information, therefore, may be useful in guiding interventions and practices which may reduce these risks.

While data was collected on the young people’s employment and lifestyle aspirations and general feelings about the future, here we offer a general overview. Needless to say, the young people’s future outlook varied depending on their age and life experiences to date. Younger members of the sample were sometimes more ‘hopeful’ and had a more positive outlook, while older members of the sample were often less hopeful. This was particularly true with regards to their feelings around employment with many of those aged around 16-18 yrs finding great difficulty in finding jobs:

“I need to get a job like, I’m trying my best to get a job, I’m never out of that jobcentre, I’m down trying to get a job near enough every day I’m down looking, ‘have you any more jobs there?’ and your woman phones me if she has anything for me. I’ve tried A, B, C, I tried D and E. I tried day shifts and night shifts, I’ve tried everywhere, just no luck finding a job like, I try my best. I was doing everything right like, I’m going down on Monday and do this, it’s like interview techniques and just all stuff to try and help you get a job and all.” (Young man, aged 18, aftercare)

What emerges from the findings is that there are a number of barriers for young people regarding employment including lack of qualifications, lack of employment history and part-time jobs as well as a lack of preparation for interviews and for some criminal activity. This is set against young people’s job aspirations for the future. A substantial proportion would like to pursue social work, youth work, child-care or similar professions and also popular were trades like builders or mechanics, chefs or waiters. The experiences and frustrations at being unable to find a job had led some to feel that despite their hopes they were unlikely to find satisfactory employment in the future and could be left with little option but the dole.

Regarding young people’s lifestyle aspirations, the main finding is that they had very typical desires for the future - a job, a house, a family and a car. Within these accounts, the issue of ‘normality’ again arose frequently, again suggesting that young people in care felt different (for many of the aforementioned reasons) and looked forward to a future when this difference was no longer a feature of their lives:

“Umm, I just want to be normal, and have a normal life” (Young woman, aged 13, foster care).
4.7 Conclusions

This section has focused on the risks and vulnerabilities in these young peoples’ experiences of life before care, in care and aftercare. Through the young peoples’ accounts there are a number of areas where alternatives, future work or policy change should be considered. These fall into four identifiable areas: the separation from the birth family, the transition into care, experiences while in care and after care experiences. Indeed, while a small number of young people did note that care provided them with a better life than they would have had at home, there was a large number of young people who pointed out a number of risks present in their lives which were directly due to being in the care situation. Furthermore, while previous research shows that we can underestimate the huge sense of loss young people experience when their family breaks down, or when they are separated from their families (Berridge, 2005), this research suggests some of the social and psychological effects of this loss. It also reveals that young people were often discriminated against or isolated because of their care experience (see also Stanley, 2002) and that there is a need for adequate assessment of what young people are moving into when they move into care (i.e. out of risk into different risk).

In light of the young people’s strong sense of attachment to their families, the impact of separation from the family and often an ultimate desire to return to the family home, this research indicates the need to find ways of making family homes mentally healthy. Further, it highlights a need to establish the effect of care on mental health controlling for other factors such as circumstances coming into care, family history and socio-economic background. In this vein, preventative work emerges as a priority area when thinking about the mental health of young people in care and a budgetary commitment would be necessary. As Mc Sherry et al. (2004) points out, parents may be amenable to maintaining the family unit and a large number of the young people in this research desired this also. Education could be an obvious way of introducing preventative and proactive work with young people both through a formal and infomral approach. There is also a need to understand, in more detail, the actions taken to reduce the likelihood of young people coming into care and this may require work being done at a community level particularly given research findings which show a link between deprivation and care (Winter & Connolly, 2005).

A further way of easing the difficulties related to family separation might be to centralise the service provided to enhance contact. This would include appropriate professionals and supports, some training provision to assess contact, awarding the young person real power regarding their contact arrangements and finally therapeutic input to improve contact through various models (for example, family group conferencing, family therapy, behaviour modification, attachment work). All of these, of course, bring specific resource implications. Coupled with a mixture of these methods, it would seem necessary to have some form of ongoing assessment which verifies if the contact is working in the best interest of the young person. It is worth noting that while it is important for many young people to see their family, it may be equally important not to build up expectations too high.

With regards to the transition into care greater clarity, information and honesty is required in order to reduce the degree of uncertainty and confusion at a potentially traumatic time in these young peoples’ experiences of life before care, in care and aftercare.
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Clear and honest information could also help create more open relationships and aid in communication at an early stage of these young people’s care experiences – relationships of the nature that young people here undoubtedly valued. As will be discussed in section 6, suggestions were made in the adult questionnaires that more use could be made of life-story work as a means of openness of dialogue. Linked to this is the confidentiality that young people expect and workers sometimes do not provide for one reason or another. Young people value workers keeping their information confidential and safe, yet workers are not always allowed to manage the risk and feel unable to hold information for the sake of confidentiality. This is often the result of a system which is structured in such a way that it does not encourage or support trained professionals to use their own professional judgement in matters concerning keeping the confidence of young people. From this research we know that privacy is linked to young people’s openness to talking, which in turn can be positive for their emotional well-being. As such, this is an area which clearly warrants some attention.

Related to this is the disorientation young people experience through being in care. From what these young people have told us, the care experience is not a natural experience, young people are sometimes removed from a familiar (albeit often detrimental) situation in which they know and understand the rules and cultures to new families/homes each with their own rules and cultures. There is a clear lack of preparation or understanding of this and a regional booklet explaining care, types of placements, reasons for admission, professional roles and responsibilities, etc. may be a step towards this. New ways of easing the transition into and out of care need to be found. Some discussion on the means of conveying information to young people whether it is in verbal or written form or a mixture of both is needed. While verbal information can be forgotten or misunderstood, written information can be reviewed and shared to ensure better clarity.

Alongside a need for more work around the transition into care, there is a need for more direct work on pre-care trauma and providing information on life history through the likes of a guardian report or life-story work. While life-story work is useful, it needs to be considered alongside many interventions such as emotional literacy, resilience-type projects or mental health interventions. Beyond these initial measures, a degree of flexibility is needed to make new decisions around what a child needs including the voice of the young person and those involved in their care. Adjustment work around being in care also needs to be a key component of the Looked After Children service and the potential for multi-professional consultation should be recognised.

With regards to the actual care experience, the young people in this research outlined the many ways in which the system and the policies and procedures within it reinforced a sense of ‘difference’. This research, along with other recent local research (NICCY, 2006), has highlighted some potential areas of improvements for LAC Reviews and PECs checks including for example focusing less on negative aspects in LAC Reviews and improving the process of going through PECs checks. Undoubtedly, there is a tension between safeguarding children and young people and making the care experience more ‘normal’ but this research does suggest that a greater balance needs to be found. This raises issues around the ‘Corporate parent’ and questions the absolute necessity of all these policies and procedures particularly
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since they impact negatively on young people’s mental health, send the message that young people feel they have no voice, diminish their sense of control over their lives and ultimately create an unreal experience while in care followed by an abrupt cessation of protection when a young person leaves care. Corporate parents need to be responsible in the same way birth parents are. While attending to and studying the risks and negatives attached to corporate parenting is a sensitive issue, this seems to be urgently needed in order to better understand these and ultimately reduce their influence on the care offered to young people.

The continued experience of bullying and stigma associated with being in care is also noteworthy and another way in which the care experience can have a negative impact on young people. A public information campaign may be useful to look at what care is and the various reasons why children may be in care in order to dispel myths about children as trouble, residential care as ‘prison-like’ and to aid in reducing stigma. As will be seen in the next section, schools could play a specific role in creating a more realistic public perception of care. Through citizenship education or PSE, schools could explore the different home lives of children and young people to help develop an understanding of care and explore this further in sessions they already run with regard to bullying.

One might suggest that in the lives of some of the young people we spoke to, there was a cycle or build-up of difficulties which continued to impact upon their mental well-being after care. So, for example, pre-care trauma had not been directly or adequately dealt with, the care experience may have been difficult, confusing, constricting or unstable and these issues did not, by themselves merely disappear once the young person moved into aftercare. While there are many policies and procedures to safeguard young people in care, these all but disappear when they move into aftercare. Young people in aftercare do not benefit from the same safety net as their peers leaving home and while the new legislative changes do make it necessary to provide numerous supports in aftercare, there is much confusion and young people may be ‘falling through the net’ at this stage, unaware of what they are entitled to. In fact, recent OC3 statistics show that HSS Trusts had lost contact with over a quarter (28%) of young people who have left care (Mooney & McDowell, 2006). Concerned with the confusion around leaving care, VOYPIC recently set up an Advocacy Surgery which informs young people about their entitlements under the new Leaving and Aftercare legislation. As well as aftercare support, however, it is also clear that young people need to be well prepared for leaving care and need realistic preparation during their whole time in care not just fast, unrealistic cramming shortly beforehand just to ensure the leaving procedure has been completed. Indeed, a more natural transition needs to be enhanced and some movement to reduce ‘pinball living’.

Finally, regarding young peoples' attitudes to the future, more can be done to support young people in their career path, in particular to help them meet their goals and to enhance links with education, training providers and employers. Expectations and encouragement for young peoples' futures can be low and this does seem to be an area where work can be done, which links to the DHSSPS responsibility of being ambitious for young peoples' futures.
Protective Factors
When looking at young people’s lives in the context of challenging and risky situations, it has been noted that some young people do better than might be expected and do not, in fact, become more vulnerable, or more at risk. Research, explanation and understanding of this observation has revolved around the concept of resilience. At its most simple, resilience is defined as “doing better than expected when bad things happen” (p. 105, Gilligan, 2005a). Within resilience theory it is recognised that a number of factors may act in a protective manner in that they aid to “modify, ameliorate, or alter a person’s response to some environmental hazard that predisposes to a maladaptive outcome” (p. 600, Rutter, 1985).

The present study drew on a model of resilience developed by Daniel, Wassel & Gilligan (1999). A thread running through each of the six domains within their model of resilience is their shift in focus away from problems towards strengths, a fundamental principle in the resilience-based approach. This section likewise switches the focus from vulnerable points in the previous section to protective factors in young people’s lives. The findings echo previous concerns which young people have been consistently voicing to VOYPIC as witnessed in a review of 18 consultation projects carried out by VOYPIC between 2002-2005 (McAuley & Bunting, 2006). In this section we examine several factors which protect young people’s mental health on an everyday basis including their family and social relationships, support, education and training, interests and activities and stability.

Previous research has found the value for young people in encouraging and facilitating contact with family and wider support networks (McAuley, 1996; Houston et al., 2000; McAuley, 2006) and that young people often return to their parents for a period of time after care (Mc Sherry et al., 2004). Despite this, and the fact that research has shown that a ‘sizeable’ percentage of parents would be amenable to a programme of support geared towards maintaining the integrity of the family unit (ibid.) continuous work with the family is not commonplace although some developments have been made (Robinson & Whitney,1999). Research has also shown that other relationships outside of the parental relationship are important to young people such as those with siblings and the extended family (Gilligan, 2005a), yet these are neither promoted by frontline workers nor by the planning and review process (Horgan & Sinclair, 1997). More recent research in Northern Ireland has also pointed to the value young people find in relationships with social workers when the young person feels that they are valued and respected (Mc Auley, 2006).

Education and work progression also emerge from the literature as having a positive influence on young people’s emotional well-being. The Residential Care Health Project (RCHP, 2004) suggests this is because education ‘normalizes’ young people’s disrupted lives, reduces unstructured leisure time (and therefore time available for risk behaviours), provides exposure to a wider peer group, access to health screening, preventative measures and health promotion and a chance to get out of the cycle of deprivation and disadvantage (p. 19, RCHP, 2004). A further benefit is that education ensures future employment which in turn protects both adults and teenagers from mental health problems (Koprowska & Stein, 2000). Indeed, childhood industry may also have an important pay-off for young people ensuring they are active on a range of levels including part-time work, household chores, school achievement and extracurricular activities (Gilligan, 2005b).
Despite this, much research reveals concerns about the educational reality for young people in care. These include low educational attendance rates (Mental Health Foundation, 2004; RCHP, 2004), frequent changes of school (Fletcher-Campbell et al., 2003; McAuley, 2006), schooling being frequently missed and truanting tolerated (Martin & Jackson, 2002), a focus more on attendance than on what is happening in school (McLaughlin, 2002), a lack of basic necessities such as a quiet place to do homework (Martin & Jackson, 2002; Harker et al., 2004) as well as difficulties with reading, mathematics and spelling (Meltzer et al., 2003). On the other hand, factors which seem to enhance the educational progress of Looked After Children include the availability of support and encouragement for educational progress as well as the acknowledgement of young people’s achievements (Martin & Jackson, 2002; McLaughlin, 2002; Harker et al., 2004; McAuley, 2006). One promising advance is the Guidance on the Education of Children and Young People in Public Care (DfEE & DH, 2000) which aims to raise standards of expectation. In Northern Ireland, the LACE (Looked After Children in Education) project highlighted that in order to assist in their supportive role social workers and carers needed to know more about future courses and careers and that teachers needed to be trained in understanding what life is like for a young person living in care (McLaughlin, 2002).

A third protective factor which recurs in the literature is encouraging and facilitating the development of interests or hobbies. This is an area young people seem particularly interested in and one in which they gain a sense of achievement (McLaughlin, 2002; RCHP, 2004). Service providers and carers can support young people in their hobbies and interests in a number of ways. The caregiver can for example help in practical ways; the social worker can help in securing resources and the mentor in providing personal attention and encouragement (Gilligan, 1999). Furthermore, the social worker plays a key role in prioritising the encouragement of interests and talents and ensuring this is on the agenda for the caregiver as well as the care review and planning process (Ibid). Freedom, support and finance for participation in outside hobbies and interests were noted by Martin & Jackson (2002) in their study of high achievers as providing the key to ‘normalization’ in Looked After Children’s day-to-day lives.

Finally, ensuring placement choice, stability and continuity of care (a secure base) is a key protective factor. Stable and secure placements have been linked to good general health (Meltzer et al., 2003), relationship skills, educational attainment, and employment status (Koprowska & Stein, 2000). Placement choice, however, has been a major challenge in Northern Ireland for some time (McAuley, 2000).

Having offered a brief overview of the literature, research and discussion of the notion of resilience and the nature and potential impact of protective factors, the remainder of this section focuses on those factors which acted in a protective way in the lives of some of the young people we spoke with. Through this discussion and the young people’s accounts we consider the potential impact of some of these factors on the young people’s mental health and where possible highlight areas where intervention had or may have had a positive impact.
5.1 Family and Social Relationships

5.1.1 Birth family and extended family

A key feature of most young peoples' accounts was the network of relationships in their lives and the varying degrees of value they placed on these. As noted in section 4.2.2, birth family links remained important to young people despite the difficult nature of some of these relationships. There were varying levels of contact with parents but most had some degree of contact. Mothers were often cited as most important as were grandmothers and aunts. Although young people did not mention fathers as often as they did mothers, this may be a reflection of the family backgrounds many had come from (i.e. lone mother households). A significant number of young people felt it important to maintain family relationships while in care because they ultimately believed/hoped to return to their family after care. Lack of contact, some felt, could make maintaining this relationship difficult and did little to ensure that young people's well-being and future desires were being taken into account:

“I'm going to stick with them... family don't break apart we're just together, we're just every family is special, so we're special and we are very close and there ain't nothing going to come between us”

(Young woman, aged 14, residential care)

While family contact could cause some distress, as outlined in section 4.2.2, seeing their 'real family' was often what young people cited as the thing which made them happy. Despite positive care placements, for some these could never replace the 'real family' or the desire, in the case of a significant number, to return to the family home:

“I'd just like to be with my mum and

everybody. I'm happy here and all that but I'm not saying it's awful here, I'm happy as well so I am but then if I was with my mum, two brothers and my granny and everybody, hmm, I would be like happier because you know like what being close with your mum and all and then she could ... just go see your auntie and everything.”

(Young woman, aged 12, foster care)

Clearly there is a balance to be struck between protecting young people from harm and distress through building up their expectations regarding returning home and parents not turning up to contact visits. It may be the case that contact with parents is complex and the answer could be to offer some therapeutic support to the family and be mindful that with time and support family relationships can and do change and have a more positive impact on young people. This is evidenced through the following young woman’s experience:

“Right now I'm quite happy because I only normally get to see my mummy like twice every month or whatever, but this month I was able to sleep over at my mummies and there was about the three weeks with my daddy and that so I am quite happy ... before normally I never got to see my daddy at all and I used to see my mummy like every Sunday but not always, she wouldn't always turn up for them, but now we are sticking to the weekly schedule.”

(Young woman, aged 13, foster care)

Maintaining contact with other family members, particularly siblings was also of great importance to these young people. Indeed many expressed a desire to see brothers and sisters more often and noted a number of factors which made maintaining contact difficult. This included, siblings being placed separately, one or
Protective Factors

other being adopted, the distance to travel to visit siblings and poor relationships with the carers of siblings. Relationships with siblings before entering care could be particularly close, especially in instances where these young people had taken on primary care for younger siblings or where older siblings had taken on much of the caring responsibilities for them. The sometimes sudden removal of these close relationships could be difficult to deal with:

“It hurts ... well if you’re getting took away from your brothers and sisters and you have lived whenever you were born and you have played with them and they have looked after you and they took you places and stuff you would just miss all of it.”

(Focus Group, female, aged 12-14)

A number of young people noted how being placed in different placements some distance from one another had resulted in them steadily losing contact, some foretold that this may lead to the point where they essentially would not know each other anymore:

“You will not be as close anymore and you wouldn’t really know each other. Like if you only kept in touch on the phone and met once a week, in a couple of years time you are going to be different people, you’re not really going to know them any more.”

(Focus Group, female, 12-14 years)

As well as the more practical difficulties of maintaining contact were emotional difficulties. Some of these young peoples’ siblings had remained in the family home and maintaining contact with them invariably meant that they would have to have contact with parents which some were not ready for:

“I used to see my wee sister all of the time cos she would have been up at my daddy’s house, or else I’d be down at my mummy’s house. But then that sort of stopped, because, whenever I wasn’t talking to my mummy or my daddy, I never seen my wee sister.”

(Young woman, aged 14, residential care)

“So, [pause] the only time I get to see them is if like, I arrange to see them. But I don’t really arrange to see them cos I don’t go down to my mummy’s.”

(Young woman, aged 16, foster care)

Often the best option is to place siblings together, but this was only the case for a small minority of those in our sample. The value of it, however, was clear:

“We’re [pause] really close, we’ve been with each other all our lives, so we have, we’ve never been split up, so we’ve never.”

(Young woman, aged 13, foster care)

Where this is not possible there is a need to ensure that efforts are made to ensure that relationships with siblings can be maintained. This can aid young people in maintaining direct contact with their ‘real family’ and particularly in those relationships which they often viewed as healthy and strong. Being placed in care should not instantly or gradually mean a complete breakdown of the entire family unit and the positive and supportive relationships within it.

Likewise, contact with extended family was felt to be important. Young people clearly indicated that their extended family was important in their lives including aunts and uncles, grandparents or nieces or nephews with some having spent periods with their extended family before coming into care. The nature and strength of these relationships, however, did not seem to be reflected in contact arrangements. As noted in section 4.2.2, a
few were unhappy with supervised contact arrangements whereas others felt that they had the opportunity for little or no contact with extended family. Taken overall, many of these young people felt entirely cut off from their families because of being in care yet no matter what their circumstances, most made continual reference to their ‘real family’ and classed this as important throughout their lives.

5.1.2 Friendships and intimate relationships

Friends were very important to young people although some stated that they did not have close friends, or at least very few friends. Young people often made their friends in care as well as through school and from their local area or friendships were linked to ‘hanging out’ or doing some shared activity. Some in after care had been helped particularly by friends they had known over a long course of time:

“The only person I talk to is my best friend X cos she takes me seriously, cos she understands what I have been going through cos I have known her since I started in care, we’ve grew up together and we have always been there for each other. We’ve been best friends since”  
(Focus group, female, 15-17 years)

A number mentioned boyfriends or girlfriends and a minority were engaged:

“My girl, if anything happens to me I just sit and talk to my girl and tell her what a s***y day I’ve had or what a good day I’ve had and all this here and all, and she’ll just sit and talk away to me and all, that there way just get things off your chest or else if you let them build up you’re just going to explode like cos that’s what happened to me.”  
(Young man, aged 18, aftercare)

Friendships or intimate relationships, therefore, were clearly important in providing someone young people felt they could trust and confide in. This is important in light of discussions in section 3.4.2 about many young people being unwilling to talk, here, however, we see that if they have someone they feel they can talk to they can share and alleviate some of their worries and concerns in a more healthy or less risky way. Despite the value of friendships, however, it is again important to note that these young people discussed the various difficulties they faced in establishing and maintaining friendships due to various aspects of the care experience. This included procedures and regulations such as PEC checks which labelled young people in care as different and meant they sometimes could not enjoy the same freedoms as their peers, the stigma attached to being in care and their peers lack of understanding of this (see section 4.2.4):

“I’ve just lost a load of friends. Most people think that when you are going into care that you are a bad wee s**t but you’re not really, you’re only going into care because of problems and stuff and everybody thinks that you’re bad and that you’ve done certain things. People don’t realise what ‘care’ means.”  
(Young woman, aged 15, residential care)

Another major difficulty was the fact that young people had moved around a lot which affected friendships and they sometimes found it hard to build up new friendships. One reason was the strain due to geographical separation because the actual logistics of maintaining the relationship could be quite difficult. Some found new ways of keeping in contact such as through notes, letters or telephone, while others found that they had to start afresh:
Protective Factors

“Moving meant that it was just going to be hard cos I had to make new friends and I’m not very good at making new friends. Just going up to someone and going ‘here, do you want to be my mate?’ Well what are you meant to say?”

(Young man, aged 13, foster care)

This young person’s account is also revealing in that it may also demonstrate some young people’s lack of confidence. It may, therefore, be worthwhile considering local opportunities for programmes of personal and social development of the type offered by many youth organisations which these young people could become part of as a means of building confidence, encouraging social skills and as a means of meeting new friends (see also section 5.4).

In sum, while friendships are an important means of ensuring good emotional well-being various barriers stand in young people’s way of establishing and maintaining these. Clearly relaxation of some of the policies and procedures governing those in care and a greater stability in placement would go some way to removing these barriers.

5.2 Support

To assist young people in answering this section, we asked them to state who they would give a prize to for support. Although young people usually cited their birth family, and particularly their mothers as being most important in their lives there was a discrepancy between who was most important and who was most supportive. Usually the support prize went to foster carers, key workers, co-workers, aftercare workers, teachers, siblings or friends. Young people felt the prize should go to someone who had solidly and consistently helped them. A stable influence on their life came through as a strong protective factor for them. It was noted that this person could notice things and help young people by asking about certain things or talk to them about things and could, thus be preventative. The following are a few examples of the young peoples’ responses and reasons for whom they gave the ‘support prize’ to:

“They [foster carers] brought me up, they are the ones who reared me, that’s the way I see it, I know it might not have been their fault with my mum and dad but they are the ones who cared for me.”

(Young man, aged 19, aftercare)

“Cos the first time I said to her [social worker] about being depressed she made me go to the doctors, but I didn’t go like … Cos she’s the first person I’ve ever told and she’s gonna do something, and I never really told anyone before.”

(Young man, aged 15, residential care)

Some of the young people really struggled to think of a person they would give the ‘support prize’ to. When asked about whom in their lives was most deserving of a ‘support prize’ several young people identified themselves as most deserving of it:

“Being the most supportive to me? Ehmm probably me … Yeah but you see I learnt like to support myself, I don’t know what it is, it’s like once you become 18 you don’t want to depend on your parents anymore to support you and you want to support yourself, so it’s like that there when you go into a children’s home, you don’t know any of the staff, you aren’t really depending on them ones, I don’t know you just learn to support yourself.”

(Young woman, aged 19, aftercare).
A number of people who support young people will be discussed in a little more detail including social workers, foster carers, residential workers and aftercare workers.

5.2.1 Foster carers

Foster carers, in particular foster mothers were mentioned as a first point of contact for the young person to talk to and in a number of cases young people would give them the prize for supporting them. Young people felt that it was important to be suited to their foster family (and vice versa). Some mentioned feeling lucky that they had found the placement they were in and a few regarded their foster carers as parents:

“I just feel lucky that they chose me and that I’ve had a permanent foster home, cos I know, so many children don’t have permanent foster homes ... and they have to stay in one of the homes.”
(Young woman, aged 19, aftercare).

“[give them support prize] Cos they’ve brought in a stranger, like a wee girl that they’ve never seen before in their life ... into their house out of a children’s home, like that’s, I don’t, I don’t think I’d be able to do it if I was [a foster carer].”
(Young woman, aged 17, foster care).

Clearly foster carers can act as a positive influence on young peoples’ lives in terms of the support they offer in relation to their care, understanding, being approachable and indeed in their encouragement of young people. This is illustrated in the following case study which highlights the potential for positive foster carer and young people relations to act as a turning point in young peoples’ lives.

### ILLUSTRATIVE CASE:

**THE POSITIVE INFLUENCE OF A FOSTER CARER AS A TURNING POINT**

This young woman was 19 years old at the time of interview, in aftercare and attending university. She had entered the care system at an early age and experienced a number of foster placements which had broken down as well as difficulties with her behaviour in school. Generally, she recalled a sense of feeling unwanted in the previous placements (and by her birth family) and notes that she went ‘off the rails’ a bit because of this. As a teenager, she entered a foster care placement which she identified as acting as a key turning point in her life where she had developed a strong relationship with her foster mum in particular. She also changed school around this time and saw the whole experience as a ‘fresh start’.

This young woman noted that the change in her attitude, outlook and experience was gradual and came about as a result of her foster mother’s understanding. To begin with she admitted that she could be perceived as quite difficult but that her foster mother took the time to talk to her, understand how she felt, compromise on contentious issues and meet her half way. This she noted had led to a positive relationship which had been built upon over time to the point where she felt she could talk to her foster mother about anything and always get her support. Of their relationship and any problems or difficulties she faced, she told us: “anytime you have a problem, even if you don’t like what she says to you, you know that’s going to fix what the problem is.”

This young woman also held her foster mother directly responsible for her educational achievements and aspirations...
and her current position of being in higher education. Prior to entering this placement she had not given much thought to her future or care for her education, but upon her foster mother taking an interest, guiding and supporting her she began to work towards her GCSEs and gained good grades.

She now speaks of being happy with her life in general and identifies with her foster family as her family although she is still working through her feelings towards her birth family. The experience of having reached her goal of attending university has given her a sense of achievement and she is proud that she has done this. And, while the road has not been easy (e.g. finances) she still has the support of her foster mum and visits her regularly.

Without aiming to detract from the positive nature of this finding it should nonetheless be noted that despite how good a foster placement was, many young people still maintained that they wanted to be with their birth family.

5.2.2 Residential workers

Those in key worker and co-worker roles were also particularly well liked by young people and could also act as a means of support. The key to a good relationship with such a worker revolved around the worker knowing the young person well, being open and friendly and being able and willing to listen. Of good relationships with key workers some of the young people stated the following:

“Like there’s one person I talk to and that’s [my key worker], she’s sound I really like her. So yeah, I talk to her but most things I keep to myself.”

(Young woman, aged 14, residential care)

Again it is interesting to note from the latter of these extracts that despite feeling there was one person she could talk to, this young woman, like many others, still chose to keep many things to herself, and essentially not talk. Again we must consider other factors in these young peoples’ lives which may act as barriers to them talking about problems and concerns, as it appears in the case of some to not always be because they feel they do not have anyone they can talk to.

Again, despite the value of positive and supportive relationships with residential staff, a significant minority of young people did mention tensions between themselves and staff with relationships becoming fractious and aggressive. One suggested that staff take a more relaxed, personable and less professional approach:

“[Staff] are too focused on work too, they are acting too work, too sensible, too mature, you don’t have to act too mature all the time you what I mean, just chill out and have some fun.”

(Young man, aged 15, residential care).

5.2.3 Social workers

Young people had very mixed impressions of social workers. The social worker was generally seen as having a substantial role in their lives and if it worked well, the young person saw the social worker as someone to talk to and someone who understood:

“She’s nice ... takes me to Mc Donald’s and stuff ... She comes out once every three weeks or something ... we get on well, I talk to her and stuff, I like her.”

(Young woman, aged 19, aftercare)
“When you have been with a social worker for so long you get attached to them and you don’t want to get another social worker.”
(Focus Group, female, 12-14 years).

Others did not fully see the relevance of social workers in their lives and the fact that they associated social workers with their removal from the family home often affected perceptions and relationships:

“I’m sure that other young people like need to be took away from their homes for certain reasons but I understand it’s a hard job like they’re probably underpaid and overworked something like that but yea I understand where they’re coming from it’s just I don’t see why they had to bring me into it, you know.”
(Young woman, aged 14, residential care).

If a positive relationship did not develop, the young person mentioned a degree of distrust of the social worker or sense that they were interfering. This was compounded by the fact that they associated social workers with asking questions, taking notes and not listening to them. As a result, many young people admitted that they would not open up to the social worker. Honesty, clarity of information and communication between the social worker and young person was seen as vital. Some felt they told things they should not or promised things and did not follow through:

“[Social workers] make promises that they can’t keep ... every time they come out to see you ... Like who you are going to live with and what’s going to happen in the future.”
(Focus group, female, 12-14 years).

“There’s something about my social worker I don’t know ... cos everything comes back to you, so it does ... It’s like ‘why this?’, ‘why that?’ ... and you’re just like ‘who told you all that?’”
(Young woman, aged 13, foster care)

It is clear that there is great potential for social workers to act as a means of support for young people and from the more negative experiences discussed above lessons can be learned for the future. These revolve around social workers being honest and clear about what they can and cannot do and in clearly explaining the need to ask questions, the reasons for them and how information will be handled.

Another factor which clearly impacted upon young peoples’ relationships with social workers was the stability of social workers within their lives. The majority of young people in this research experienced numerous changes of social worker, some even losing count. This was a crucial barrier to forming relationships since young people tired of repeated changes which could ultimately make them less inclined to ‘engage’ with subsequent social workers:

“Loads (of social workers), 8 maybe, I don’t like it, you get to know one for a short while and then you just don’t bother knowing cos you know that they are going to change again ... [present social worker] well I think she is ok, but she is probably going to leave soon as well, I can just tell”.
(Young woman, aged 13, foster care)

“I have lost count, I don’t know, after you have built up a relationship with a certain social worker she tells you ‘oh I have got another job’, then you are thinking to yourself someone else is taking over here and your trust level just dies down a wee bit, it just feels a wee bit strange so it does.”
(Young man, aged 18, aftercare)

What could help, however, was that new social workers could be sensitive to the
Protective Factors

repetition in young people’s lives, particularly around re-asking questions as recommended by the following young person:

“Chopping and changing every other year, get fed up with it. Just getting to know them, then they go, ‘goodbye’, then somebody else comes in then they go, ‘goodbye’ and you know it gets kind of boring after a while. I don’t like it, they keep asking the same questions over and over again, and they have got my file, they can look it up but they take me out and go ‘blah blah blah’ like with just the same answer over and over again, it’s just kind of annoying all of the time. But [current social worker] she looked at my file before she came out to meet me so she didn’t ask the same questions as everybody else. I got to answer different ones, new ones, and she just said it in a nice way and I’ve liked her ever since.”

(Young woman, aged 15, foster care)

Obviously changes in social workers can be disrupting for young people and create difficulties in establishing and maintaining relationships. As this young woman notes, however, first impressions are important and despite sometimes negative views towards social workers there is clearly the opportunity for these to be reassessed and changed over time.

5.2.4 Aftercare workers

Aftercare workers were perceived in generally a more positive light than social workers. Their approach was seen as different from field social workers as was their perceived role. Indeed social workers and aftercare workers begin from different starting points in young peoples’ lives which is likely to impact on perceptions towards them and relationships with them. Of the numerous positive accounts of aftercare workers, the following are illustrative:

“She is brilliant her, she is brilliant ... She is not, she is a social worker but you don’t think it ... I don’t know it’s wild cos she is so, it’s like she is your mate or something.”

(Young man, aged 19, aftercare)

“Aftercare workers come out and see you after you have left care, social workers would still see you when you are in care, so they would, an aftercare worker doesn’t have the right to go into anybody’s home and take their children.”

(Young woman, aged 19, aftercare)

GOING THE EXTRA MILE:

THE VALUE OF AFTERCARE WORKERS

Some specific workers were mentioned as doing really good work and ‘going the extra mile’ for young people offering them help and support in getting accommodation and crèche places for those with children. The time and effort dedicated by some workers was what stood out to young people and some felt that if it was not for the continual support they gave, they may not have managed so well in their transition to aftercare:

“... since I’ve been out of the house, been told to leave the house she has helped me so much. She got me into hhm, a hostel and she has actually put in loads and loads of letters for me to get my own place, so she has really helped me really, really helped me. So I’ve actually really thanked her and appreciate what she has done for me ... She has helped me quite a lot, she has helped me with debt problems she has helped me with housing, she has helped me money-wise, she has given me money when I need it and things like that.”

(Young woman, aged 19, aftercare).

5.3 Education, Training and Work
Young people were involved in various forms of education and training, these included: mainstream schools, special schools, EOTAS (Education Other Than At School), onsite tutoring, further education, higher education and training schemes. A small number of young people were also involved in paid employment at the time of interview.

5.3.1 Positive school experiences

With regards to school, experiences were mixed. Positive experiences or aspects of school included seeing friends, taking part in activities, getting support and encouragement from teachers or carers and a sense of achievement. Some spoke specifically of their sense of achievement in doing well in exams or specific subjects while others spoke of the enjoyment they gained from out of/after school activities. Some young people noted that the support, encouragement and guidance they were given in care regarding their education had impacted upon their attendance and that essentially attendance could be improved through encouragement:

"Just whenever I came in here [children’s home], just like, they talked to me and says I should go to school it would be worthwhile in a couple of years, so then I just decided to go and then ... I have just been starting to attend ... [at home] I just couldn't be bothered like ... no one was forcing me to go. So I'd say 'I don't want to go to school', and my daddy was like, 'just stay off then'."

(Young woman, aged 14, residential care)

GOOD PRACTICE EXAMPLE:

SCHOOL SUPPORT

While perhaps in the minority a small number of young people discussed the level of support they had received in their schools. These not only highlight the value of the work being done in some schools but they act as good practice examples and illustrate what can be achieved through creating a supportive, caring and understanding environment.

One young person described how her school exceeded her expectations in terms of the support they provided her:

"Teachers in my school are brilliant like, they really are, they're real sports. You know when I lived down in X, you would have thought the school would have thrown you out, like you were out of the district, but they just pushed, like I mucked about and didn't come in and didn't want to get up out of bed and they were still there like, so they were they were brilliant so they were."

(Young woman, aged 15, foster care)

Another young person described a support programme for young people in foster care that was delivered by her school:

"I know of two wee girls in my year group who are in care and they mostly just go through what I go through with their parents and that ... cos there’s a project in school where at lunch time and all the kids from foster care or whatever would go, the higher sixth girls would take that at lunch time and our, year head, she would organise it all the time ... It's really helpful, so it is, cos when you're here and you don't really know anyone else who is in foster care and you think that sometimes that maybe you're all alone and think that you are the only one, cos..."
Protective Factors

5.3.2 Negative school experiences

Negative experiences of school included aspects such as starting over again when changing school (due to placement change), bullying, isolation, being seen as different to their peers, exclusions and expulsions and/or difficulty in gaining qualifications. A few young people were nervous about going back to school (they were off on summer holidays at the time of fieldwork) and several under 16’s were not in education at all. Some reported school as being something which made them ‘unhappy’, ‘depressed’, ‘bored’ or that they ‘hated’.

As placement breakdown or coming into care is often associated with a change in school, experiences can be confusing and these young people’s education was often disrupted. The levels of disruption and the impact on educational development were extreme for some, as is illustrated below:

“I went to other schools before, I went to A and then there was B and then C primary, you see C primary I started there first but and then B I got moved cos I was moving house, and then A I got kept back a year in A, you see cos in B I was in Primary 7 so I am supposed to be in 4th year now but it’s just the way it landed, you know but I was kept back... They just thought I was really, really slow and stuff, you see cos I couldn’t read properly and all whenever I was in B, you know they weren’t giving me enough support you know in spelling and all. I couldn’t spell or nothing so that’s why like, but now I’m doing really, really well.”

(Young woman, 13, residential care)

“Your school work gets all messed up and stuff and it takes you a couple of months to get settled in, cos you make friends first and you are not really focused on your school work, you’re trying to make friends and after you make friends you start to focus on it.”

(Focus Group, female, 12-14 years)

As can be seen from the good practice example, young people did receive support in their school, but, as was noted by others this was certainly not the case across the board. The LACE (Looked After Children in Education) initiative, which is specifically designed to help improve the educational outcomes for children and young people in care, identified similar problems (McLaughlin, 2002). On the basis of this report a training manual which was aimed at demystifying care and providing teachers and other professionals with a greater understanding of the care experience was produced. Building on such initiatives current LACE plans include the further development of multi-agency pilot projects which are designed to facilitate inter-disciplinary practice and thus further enhance Looked After Children and young people’s educational experiences. Approaches such as LACE can make a significant contribution to helping Looked After Children and young people achieve to the best of their ability in a secure and supportive environment. They could also help reduce the stigma attached to care and attack head on associated issues such as bullying of which a sizeable number of young people in this sample had experienced in school:

“I’ve hurt everyone in second and third
5.3.3 Returning to Education

Poor or negative school experiences and low levels of attainment act as further barriers to young people returning to education or remaining in post-compulsory education. That said, education was not rejected by these young people despite their experiences and in aftercare some young people realised they wanted to go back to education, often in an attempt to gain further qualifications as a means of increasing their opportunities in the labour market:

“I’d like to go back to school and get a few GCSE’s and all, cos I’ve only got an NVQ in mechanics, one in IT, and what else? You know I got kicked out … think it was just the end of 3rd year, when I was going to do my Key Stage 3, and I had to go [into respite care] … just go back to Tech or something like that there just something to give me a bit more education behind me.”

(Young man, aged 18, aftercare)

“I sat all last summer and said right I’m going to go back to Tech, I told myself everyday that I was going back to Tech and I didn’t, so this year came about and I said right I’m definitely going to Tech this year and so I’m just forcing myself to do it, I don’t want to be going from job to job to job you see them people working in their forties working in [supermarket], one of my mates used to work there and he was saying about this guy getting fired and he is in his 40s and he has a wife and kids and all, he was near in tears cos he doesn’t know where the money is going to come from. See I was saying, I don’t want that. I want a job. I should have GCSEs.”

(Young man, aged 19, aftercare)

While these are positive statements and desires, these young people are often returning to education with few educational qualifications and are, thus, starting at a different and often disadvantaged level than many of their
Protective Factors

peers. Greater support in the early stages of their education careers, therefore, may help in alleviating some of the barriers and difficulties they face in post-16 education.

5.3.4 Training, Employment and Work

It was noteworthy that very few young people were in paid employment at the time of data collection. Those working were usually on work placements through training schemes and others were in part-time employment. That said, most had aspirations towards paid employment and there was a clear work ethic. Indeed those with work experience generally offered positive accounts of these:

“You feel happy when they turn round and say could you tell the Chef or whatever the meal was lovely, and all. I feel more happy I feel more; I actually have more confidence in myself.”
(Young woman, aged 19, aftercare)

“Work’s going fine, like I was in the kitchen for a couple of weeks, I have been in the restaurant three weeks now and it’s getting, I’m coping really well with that, and I can remember how to make the coffees, how to make roll ups. I’m learning everything.”
(Young man, aged 19, aftercare)

While the issue of income levels was not asked about it is somewhat telling that it did not emerge as an issue in these young peoples’ accounts of their training and work experiences. What we can tell from these young peoples’ accounts (and those of others in the sample) is the importance of work at a social and psychological level. That is, it provided a time structure, regular activity, social contacts, involvement in a collective purpose, status and personal identity (see Jahoda, 1982). For both of the young people in the above extracts work either through paid employment or through training placements had also provided self confidence.

For these young people there is clearly a desire for work and ultimately paid employment, yet few appeared to be in positions of paid employment. In light of this, it is worth considering at least in the short-term making greater use of youth sector training schemes and voluntary work as both of these routes have been shown to provide the same ‘social psychological categories of experience’ as paid employment (e.g. MacDonald, 1996; McAlister, 2006).

5.4 Leisure Activities and Interests

Young people were involved in a range of activities in their leisure time ranging from those which were more structured and regulated such as horse riding, sports, holidays, group outings and church groups, to those which were fairly unstructured such as ‘hanging about’ with friends, drinking, sleepovers and playing computer games. In many cases activities and interests were seen as fun (particularly for those with specific interests), a way of socialising and sometimes linked to a sense of achievement. Many talked very openly about what they were interested in and were largely positive about them. Many activities outside the residential or foster setting, however, were valued in terms of a means of getting out of the house:

“I don’t even know why I go in [snooker club], I was in a wild bad mood and I just went over for an hour. I don’t know it just chills you out, well me anyway.”
(Young man, aged 19, aftercare)

“Yeah, I do [activity] ... I come first all the time ... I just love being in lead. [Pause] I love knowing that I’m on top.”
(Young woman, aged 16, foster care)
Leisure space, time and activity is not only valuable for good emotional health (Iwasaki & Schneider, 2003) but in some of these young peoples’ lives it provided a sense of achievement that they did not gain through formal education. Involvement in organised sports and youth provision also has the potential to offer these young people valuable social and personal skills as well as a means of socialisation.

At another level, for young people in care, leisure activities were very much linked to them wanting to do ‘normal teenage things’:

“Let us out everyday with normal people...”
(Young woman, aged 14, residential care)

The availability of particular leisure activities appeared to be linked to placement type. In residential care for example snooker and pool, football and computer games were more often pursued, yet boredom in children’s homes was also mentioned on several occasions. This may suggest that these activities are not necessarily meeting the needs of the young people and/or that they prefer activities outside the care setting. The availability of activities in foster care was more varied and there were more social opportunities. When placements broke down, however, young people were not always able to pursue the same activity at the next placement. A few who had had children had limited access to babysitters and this, along with time restraints meant they often had little leisure time and few opportunities for involvement in leisure activities.

Some young people mentioned ‘schemes’ which helped the pursuit of activities or interests. These included an aftercare scheme which gave out cinema vouchers, a training scheme which gave out free driving theory lessons, an activity calendar in Children’s Homes or getting a surprise ticket to see a favourite band.

5.5 ‘I’m not a Parcel’: Placement Stability, Choice and Continuity

The majority of young people had led very unsettled lives and had experienced a number of placement moves. Some had spent a period in care when they were younger or experienced frequent moves prior to coming into care. This instability did not cease when young people left care and ‘pinball living’ (see section 4.3.1) could continue to be a feature in their lives.

“I went to another foster placement, which was A, I only stayed with them for two weeks cos they were respite carers. And then I went to B, other foster parents, I stayed with them ones for eight months. Am, who else was there? C and then there was D, no, sorry there was E... she was respite like ... And, then there was F, I knew her for about four or five months but that didn’t last long either. And, then I was back with G there for a couple of months and then I was in here, so I have been moved about an awful lot.”
(Young woman, aged 13, residential care)

Placement change, even if not to the extent of this young woman’s experience, can be confusing and unsettling. Every family, be it a foster, respite or residential family has its own culture and unwritten rules within which the young person has to learn and live (see section 3.5). This can be distressing for young people and in the aforementioned case this young woman appeared to have little opportunity to settle anywhere.

Almost none of the young people had been given a choice as to their placement type although one young woman in
aftercare spoke of putting an ad in a paper to find a suitable foster carer. Regarding this young people discussed lack of satisfaction with placements and ways in which more choice could be given to them:

“The foster children should get to pick the family, they should choose, they should get to see some families, three or four families, they should get to choose what one they want to pick ... Like to buy or not to buy programme, you see three houses and then ... Yeah you should get to see three families that want to take, then you should be able to go away and think about it and write down your ideas and go back and see that family.”

(Young woman, aged 13, foster care)

“They are not really concerned about what the personality is and what you’re like as long as you are well behaved? If you’re well behaved and you have like an outgoing personality and you are very excitable and all and they put you in a place with people that are laid back and are kind of boring ... you won’t really get on with the people in your placement well half the people I know that are in a placement don’t like where they are.”

(Focus group, female, 15-17 years)

While some of these young people’s suggestions about choosing foster carers may be unfeasible they raise an important point about young people having a lack of choice and the decision being wholly in the hands of adult carers. In order to establish and maintain placements it can be seen here, and was also illustrated in section 3.5, that young people adapted parts of themselves and became adept at hiding their true feelings in order not to jeopardise potential or current placements. The end result, however, could be young people being unhappy in their placement and a breakdown in placement due to a mismatch of carer and young person.

A substantial proportion talked about the uncertainty they experienced as a consequence of their highly unsettled lives including; getting to know new people, discontinuity of friendships, moving school, missing previous placements, the hassle of moving, leaving the area they were from and the abruptness with which they could move. The following quotes are illustrative of the young peoples’ views, feelings and experiences of placement changes:

“Moving place, different people around, different family to get to know or different home or to find your way around, its c**p.”

(Young woman, aged 14, secure care)

“It’s really, really upsetting for people, for kids in care like when they are put in a placement like a foster placement or children’s home and they have been living there like, then ehmm they have been living there for ages they get told they are moving out and you just don’t want to move out cos, cos you are attached to people. I know what it feels like to be moved about cos I have been moved about from place to place to place to place ... I must have been in like ten foster placements.”

(Focus group, female, 15-17 years)

“It does kind of p*** me off cos I’m not a parcel and to me in the past seven years it’s as if people have been shifting me from place to place like I’m a parcel, but I’m actually a human, people just don’t realise that it does get to them and it does actually affect the way kids behave.”

(Young woman, aged 15, residential care)

This last quote is particularly powerful and worrying because it clearly illustrates (in the words of young people themselves) how they can come to feel dehumanised by
Protective Factors

the process of placement change. A parcel represents an inanimate object, it has no feeling and it is the giver and receiver rather than the parcel itself which has decision-making powers.

On a more positive note and in contrast to the discussion thus far some believed their life at the time to be favourable when stability had been achieved or restored. This also indicated, however, that those young people recognised stability as a need which had not been met by the services they had received. Stability was a departure from the typical experience of Looked After Children and had been achieved for some young adults only after they left care. Yet the advantages of stability were clear in terms of emotional well-being and the other opportunities it could open for young people:

“Yeah it was stable cos I was getting all of my education, I was slow learning when I came into foster care and I got a lot of help with that there when I was in foster care so, I probably wouldn’t be where I am today if I wasn’t there with them.”
(Young man, aged 18, aftercare)

Further to this, a minority were quite happy in their placement at the time, even noting they were in their ideal placement:

“Yeah, this is the best foster home I’ve been in ...”
(Young woman, aged 13, foster care)

“I have lots in common with (foster carer’s) family and I’m glad I’m in X now cos this is my hometown and my brother just basically lives around the corner.”
(Young woman, aged 13, foster care)

“I love it here ... you have your bad days and good days, so, [pause] it’s not all perfect, you know what I mean, it is nice, like, it’s lovely here like, I love it, it’s, it’s, it’s a lovely and it’s a lovely family.”
(Young woman, aged 17, foster care)

The following young man appreciated the stability he had experienced and in light of the experiences of others he knew, he felt that he was in the minority and, therefore, lucky to have achieved it:

“It was good, my foster placement was good, I did get lucky there, it wasn’t one of those ones where you move about from children’s home here to children’s home there. So it’s different from most people ... thinking back on it now, if I had of got moved about all the time, it would be different now, so it’s good.”
(Young man, aged 19, aftercare)

This stability continues to be an important protective factor in aftercare as has already been shown in section 4.3.1 regarding pinball living.

5.6 Conclusions

The DHSSPS (2004b) states that when Social Services take on responsibility for a child they need to provide stability and protect young people from harm. Stated otherwise, this is a commitment to provide young people with protective factors to help them deal with the difficulties they face in their lives. It follows that if young people in care have even more environmental stressors and fewer basic protective factors than their peers that they are doubly disadvantaged.

From previous research and from what young people told us, we know that a number of factors can act in a protective way and that this can impact in various positive ways on young peoples’ lives. This included: good relationships with and support from family carers and other professionals; continuity of social worker...
and care placement; supportive school environments; leisure activities outside the care environment; work and friendships and stability. In many cases, however, there were a number of barriers to maintaining these factors over time.

This research found that relationships were an important element of young peoples’ lives in terms of those with friends, partners, birth family and extended family. Yet it emerged that these relationships need to be managed and turbulent relationships built upon. No matter what had happened in pre-care many young people spoke of their ‘real’ family and classed this as important throughout their lives. Since we know from McAuley (2006) that Looked After Children gain from well established positive relationships with their birth family, and our research would suggest the same, there is a need for more work in maintaining and establishing positive family relationships particularly since many young people return to their birth families after care. The present systems regarding relationships with siblings and extended family could also be improved and do not seem to have moved on dramatically almost ten years since Horgan and Sinclair’s (1997) review. There is clear potential to build upon and maintain those family relationships which were positive and supportive in young peoples’ lives before they entered care and to ensure that entering care does not inevitably mean that these are completely removed.

Other important relationships in young peoples’ lives which could act as protective and supportive were friendships, yet due to the nature of the care experience (in terms of placement and school change and policies and procedures around police checks), these too could be difficult to establish and maintain. On a wider level, young people mentioned those in their wider support network who had helped them and could identify some individuals they liked which generally came down to the young person experiencing ‘genuine caring’. This involvement in caring relationships with others has a positive impact on young people’s emotional well-being (Mullan and Fitzsimons, 2006) and should not be overlooked. That said, young people could feel there were too many adults in their lives (see also James, 2002) and the present research suggests a sense of confusion regarding the particular roles of different professionals. There was great potential for current relationships with professionals to act as support mechanisms but these relationships could change quite abruptly due to staff turnover and placement changes. Placement stability and retention of staff are clearly part of the issue, but alongside this positive relationships with key professionals in their lives could be cultivated and these could be offered further training and support in meeting young people’s emotional needs.

Regarding educational and work experiences some developments have been made which should aid young peoples’ experiences such as Foster Carers as First Educators launched on 13th September 2006 by the Fostering Network and Include Youth and the LACE initiative. Bullying, teasing and isolation in school as a direct result of young people’s care experience, however, continued to emerge in this research as it has done in the past. It may be that more work needs to be done with schools around the understanding or ignorance of care. The development of the designated teacher role as outlined by Fletcher-Campbell et al. (2003) should also improve support in schools as well as improving the school experience and continuity of education. This research has highlighted a potential area of good practice such as the example of a school scheme run by senior pupils (the benefit of this has also been reported elsewhere - Stanley,

A ‘designated teacher’ is a teacher who understands about care and the impact of care upon education. Each school decides the most appropriate person to fill in this role (DfEE & DH, 2000).
2002). Thought also needs to be given to supporting young people's educational progress and creating a more positive educational environment for them as previously recommended by McLaughlin (2002). Again it is important to note that steps have been taken here as part of the LACE initiative and further pilot projects and developments are due under this initiative. Similarly, new initiatives like the Prince's Trust which targets young Care Leavers to encourage them into employment could prove useful and given the social psychological value of work greater links with the youth and voluntary sector could provide useful alternatives to paid employment, at least in the short-term.

Related to this, another protective area emerging from the research was leisure activities and interests. These often provided a means of socialising outside of care, a sense of ‘normality’ in young peoples’ lives, social and personal development and a space and time to themselves – all of which have been found to have a positive influence on emotional well-being. There did, however, seem to be more barriers to activities in residential care in terms of a lack of available and appropriate activities and barriers to accessing leisure activities outside of the care setting. This is an area which could be developed in terms of carrying out a needs-analysis with young people in residential care, adding to or adapting current ‘in-house’ facilities and finding more synergies between leisure and youth related organisations and Looked After Children/ Care Leavers. This may involve greater training of youth and community workers around the issues affecting the lives of young people in care, indeed as an issue this could be mainstreamed in the same way as disability is currently being done in the youth sector and in youth provision.

Finally, the young people involved in this research reported some of the consequences associated with their highly unsettled lives with a substantial proportion mentioning placement breakdown and the uncertainty they experienced as a consequence. While this clearly relates to all of the aforementioned points (i.e. establishing and maintaining relationships, the school/education experience, employment and work opportunities and the use of leisure time) at a more obvious level of impacting upon mental health, it was worrying to find that some young people felt ‘unfosterable’ after a certain age, that young people were moved even when happy in placements and that some felt dehumanised by the system. Taking many of these issues into account we must question whether the needs of the system are being met rather than the needs of young people. Indeed, we know from previous research that in two-thirds of cases need was not leading services (Mooney & Fitzpatrick, 2003). It is therefore necessary to examine the repercussions of all these changes and what implications this has for young people in the future. Furthermore, we have seen that aftercare can be an equally unstable environment and there is a legacy of care. For example young people could experience difficulties when filling in job applications (young people will have notable gaps in their CVs), when taking out a mortgage (some may not be able to remember all the places they have stayed in a given number of years) and in returning to education (often at a much lower level than many of their peers). While we cannot ignore the care experience, or indeed the pre-care experience and its impact on young people, the young people in this research identified factors which could protect them against at least some of the most extreme and negative outcomes of care.

While all may not be easy to achieve, there is a need for greater recognition and moves towards establishing and maintaining protective factors in the lives of young people in care and after care.
Meeting Young People’s Needs & Developing Services
The capacity of any service to meet young people’s needs is dependent upon its ability to assess and identify needs and regrettably there is considerable evidence to suggest that some Looked After Children fall through the net while in care and may leave the system without their needs being identified (e.g. McCann et al., 1996; Phillips, 1997; Dimigen et al., 1999; Richardson, 2002; Hill & Watkins, 2003; RCHP, 2004). In Northern Ireland, just over a third (37%) of placements occur due to ‘Assessed need’ and only 22% of arrangements for Looked After Children have been found to be working ‘well’ or ‘very well’ (Mooney & Fitzpatrick, 2003). This is a worrying scenario in the area where, unlike the rest of the UK, there is currently no regional assessment framework - although there is some hope that the ‘Strategic Framework for Children in Need and their Families’ currently being developed should bridge this gap (Bunting, 2004; McAuley, 2006). While some studies call for an extension of the ONS Meltzer et al. prevalence studies in Northern Ireland, the present study points to a number of areas of need which warrant immediate attention.

Some evidence has revealed the inadequacy of the LAC Review and care planning processes in meeting emotional needs with practical issues taking priority in Pathway Plans (Frankish & McCrossen, 2005) and young people not feeling active participants in this process (NICCY, 2006). Recommendations in previous research included making reviews less formal and more child-friendly, revising preparation and feedback tools, meeting with the young person to prepare for the review, involving the young person in the choice of attendees, appropriate timing and location, ensuring that an impartial advocate for the young person is present, ensuring reviews are responsive to the needs of the individual child and to further explore the use of split reviews or part attendance and other good practice initiatives (ibid.).

Developing services to meet young people’s needs and promote their mental health are no longer considered simply a statutory responsibility, but a responsibility of all working directly with young people (DHSSPS, 2004b). Key elements of service development therefore include engaging with carers and staff in the young person’s existing network and joined up working as well as developing services based on need. There has been some progress on engaging carers and staff in the young person’s existing network (Richardson & Joughin, 2000; James, 2002; Van Beinum et al., 2002; Hopkins, 2002; Prince, 2002; RCHP, 2004; Golding, 2004) and this has been recognised in the RMHLDNI/Bamford Review (2006). The importance and value of joined-up, inter-professional and multi-agency working (particularly in education and CAMHS) to meet the mental health needs of Looked After Children is well documented in research and policy literature (DFEE & DH, 2000; Pettitt, 2003; Kerfoot et al., 2004; RCHP, 2004), as is the need for the use of jargon-free language among professionals (Callaghan et al., 2003). One shining example of good multi-disciplinary working is the Residential Care Health Project (RCHP, 2004) which essentially linked together Looked After Children in residential care with existing services in order to meet their needs. A key element was that new services were not necessarily created; rather that existing ones were redirected. The project team made links with many agencies and where health initiatives were successfully underway did not duplicate effort.

With this drive towards multidisciplinary working, the need for information and training on the mental health needs of Looked After Children recurs in the UK.
Meeting Young People’s Needs & Developing Services

literature (e.g. Valios, 2002; PHIS, 2003b; Callaghan et al., 2003; RCPCH, 2004; Martin, 2004; Stanley et al., 2005) as well as in Northern Ireland (Kilkelly et al., 2004; McMaster, 2004; Sinclair, 2005; Wilson et al., 2005; SLT, 2006). Crucially, those who come into contact with Looked After Children/ Care Leavers with mental health problems are not always trained in mental health (RCPCH, 2003). While some training materials have already been developed which have components of, or relate specifically to mental health (Gilligan, 2001; Talbot, 2002; Hudson et al., 2003), a recent recommendation in Northern Ireland has been to enhance information provision by designing a CD ROM directory of potential agencies/resources both statutory and non-statutory which work therapeutically with children and young people with mental health needs (SLT, 2006).

Mental health services which young people can access in Northern Ireland either fall into Child and Adolescent Services (CAMHS) or Adult Mental Health Services. However, a number do not fit easily into either service which results in a gap in provision for those aged in the range between 16-19 years. CAMHS in Northern Ireland was found to be in a state of crisis in the recent Review of Mental Health and Learning Difficulty which emphasised that urgent strategic action was needed (RMHLDNI, 2006). Two key recommendations of the review were to formally adopt the Four Tier model (see NHS HAS, 1995 for more detail on this model) and to carry out a mapping exercise similar to that in England (RMHLDNI, 2006). Key problem areas include the fact that without a formal adoption of the Four Tier Model, services are fragmented with the result that many services operating at Tiers 1 and 2 do not see themselves as providing services which fall into the remit of CAMHs (RMHLDNI, 2006), the range of CAMH Services need to be developed across the various Tiers (O’Rawe, 2003; McAuley, 2004) and management, co-ordination and accountability needs to be improved (O’Rawe, 2003; Gilliland et al., 2005; SLT, 2006; Teggart, 2006). It is not surprising, therefore that in the few studies which have carried out service evaluations of CAMHS, dissatisfaction has related to service presence and responsiveness (Teggart & Linden, 2005). Across the number of potential solutions, a clear message is that what needs to change in Northern Ireland is developing CAMH Services which are based on need (O’Rawe, 2003; McTernan, 2003; RMHLDNI, 2006).

The question remains as to whether a specific mental health service for Looked After Children needs to be set up in Northern Ireland. If so, it would require partnership and sustained collaboration from the main stakeholders including service users, frontline carers, education services, social and health care services managers, child and adolescent services and voluntary sector agencies (Clinical Psychology SAC, 2002). Another related question is the capacity for progression in Northern Ireland of more joined-up working with voluntary agencies since previous evidence has shown limited partnership working between the voluntary and statutory sectors (McCristal & Fleming, 1999). A further question is whether more mainstream or specialist services are needed. White & Stancombe (2004) argue that while the established literature makes a strong case for investment in specialist CAMH Services, contradictory assessments of mental health needs challenge this viewpoint and propose a more mainstream and cost-effective range of support services.

This section presents the views of adults who care for children and young people in
a range of care settings. For each element, we will begin by looking at the general findings and then note where there seem to be differences among the respondent groups. It describes factors they believe impact and/or help maintain positive mental health and how access to these can be improved as well as the extent to which common indicators of mental ill-health are present. It also explores the way in which these adults believe services can be developed to support care experienced young people into adult life and considers access and experience of these services. Finally it explores the carers’ attitudes and needs regarding support and training. Since, as expected, there was a low return rate for the birth parents, these will be discussed separately at the end.

For most of this section, an overall base size of 139 will be used. Quotes from the adult focus groups will be used (see section 2.3.2 for a profile of the participants) to enhance understanding of some areas of responses.

### Table 1 - Protective Factors impacting on young people’s mental health

<table>
<thead>
<tr>
<th>Factor</th>
<th>Overall (139)</th>
<th>Residential Workers (41)</th>
<th>Field Social Workers (44)</th>
<th>Foster Carers (54)</th>
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<tbody>
<tr>
<td>Significant adult</td>
<td>92</td>
<td>95</td>
<td>84</td>
<td>96</td>
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<tr>
<td>Stable placements</td>
<td>90</td>
<td>83</td>
<td>89</td>
<td>96</td>
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<td>Desired contact with family</td>
<td>84</td>
<td>95</td>
<td>95</td>
<td>67</td>
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<tr>
<td>Able to talk</td>
<td>84</td>
<td>80</td>
<td>84</td>
<td>87</td>
</tr>
<tr>
<td>Learning to cope</td>
<td>83</td>
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<td>80</td>
<td>87</td>
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<td>Friendships</td>
<td>83</td>
<td>83</td>
<td>95</td>
<td>72</td>
</tr>
<tr>
<td>Understanding care experience</td>
<td>81</td>
<td>76</td>
<td>82</td>
<td>85</td>
</tr>
<tr>
<td>Activities and interests</td>
<td>78</td>
<td>76</td>
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<td>81</td>
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<td>Physical health</td>
<td>71</td>
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<td>Staying in same area</td>
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<tr>
<td>Progressing in school/work</td>
<td>63</td>
<td>44</td>
<td>61</td>
<td>78</td>
</tr>
</tbody>
</table>

3% perceive a ‘strong’ or ‘very strong’ impact of each aspect
Some differences were notable among the respondent groups. Foster carers were less likely to perceive young people’s desired contact with their family (67%) or friendships (72%) as a strong factor but were more likely to see physical health (83%) and progressing in school or work (78%) as important. Conversely, residential workers saw progressing in school or work as having a much lesser impact (44%). One area where field social workers perceived a stronger impact than the other groups was regarding friendships (95%).

Other factors were mentioned as having a strong impact on young people. These included a safe or secure environment, the quality of relationships they had, gaining an honest understanding of their situation so as to deal with their past, leaving care, having their say and being listened to, bullying and pressures of group-living.

Remarkably, those factors perceived as having the most impact were not necessarily those which were met well in care plans as is shown in Chart 2. Across all but four factors care plans were falling short in important areas with the biggest disparity occurring in friendships. In two factors care plans were meeting need (desired contact with family and staying in the same area). However, in two other factors care plans seemed to be devoting more attention to areas beyond their perceived importance, that is, physical health and progressing in school or work.

Chart 2 -
Protective factors impacting on young people’s mental health and extent to which these are met

4 These were open ended responses given in an ‘other category’.
The findings therefore suggest that the care planning process may not be closely enough aligned with the mental health needs of the young people as suggested by the following quotes:

“I think we don’t put enough emphasis as an agency on young people’s mental health who are in care. And, at times it’s lip-service, especially in the LAC review...you don’t get a lot about mental health”  
(Field Social Worker focus group)

“You will get the behavioural bit where people will say this is as a result of his behaviour, and sometimes it’s not that, the behaviour is as a result of the emotional issues that are there. And I think that’s the bit that’s missed”.  
(Field Social Worker focus group)

This, of course, may well be due to the many factors which contribute to this situation including the scarcity of appropriate placements in certain areas and the complexity of the planning process around a young person coming into care, something which is well summed up in the following two quotes by field social workers:

“Whilst all the policies and all would tell you to be well planned for children coming into care, it just doesn’t happen. The crisis happens and you have to move that child, you have to take the first available placement even should it mean splitting families up. And more commonly it does mean splitting families up, so you have got that emotional bit and that’s something you do forget about at that point, or it’s not up to the forefront of your mind, at the forefront of your mind is getting these children placed. And how you manage to keep them together as a family and keeping those links and all going strong when one of them could be in Downpatrick and one in Antrim and one could have to change school, those things aren’t given priority at the outset. They’re maybe not given as high a priority as they should be”  
(Field Social Worker Focus Group)

“I wonder sometimes if we weight the risk. Which is greater, (I suppose that’s what you do anyway), of the young person being at home or being in care. Because, they’re up against so many other things in care, there is bullying, other people’s issues about the unit, their whole environment has changed, and they can be at risk, there’s no doubt about that.”  
(Field Social Worker focus group)

This puts the young people’s experiences, views and concerns regarding lack of stability etc. into context and reveals what is going on behind the scenes from the social workers’ perspectives. It demonstrates the confines in which they work in their ‘front line’ role and since they are the first point of contact for young people, they are more likely to get the blame.

### 6.1.1 Suggestions for Improved ways of meeting needs

This section provides some useful indicators as to how the planning process could be improved from numerous open-ended suggestions. These will each be dealt with under each factor in Table 1.

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5 These open-ended suggestions have not been quantified since it was felt they served better as discussion points for improvements.
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Having a significant adult
The link between a significant adult and stability was noted and those seen as already occupying significant roles were foster carers or residential staff. As the next quote demonstrates, there was a perceived need for building up the relationship with those living with, and working closely with the young person.

“The social worker sees the child once in a while. They see it as if they have built up a relationship. But, let’s be honest, you’re the person that needs to live with the person to build up a relationship, to know that person. As a parent and as a foster parent, I’m making the decision that I feel is right for my child, so I’m not going purposely out to make a wrong decision. So, yes, we do make mistakes, we are only human. But let’s hope that even in decision-making we make the right decision. And yes sometimes you have to go to Social Services.”
(Foster Carers focus group)

This tallies with young people’s views and shows that Foster Carer understand the issues that young people face despite the fact that young people do not always perceive this.

Other suggestions included the need for more links with family where possible and to identify and maintain contact with an adult within the family. The development of befriending, mentoring, independent visitor or advocacy schemes were also recommended. In residential care, suggestions included allowing young people the choice of primary or key worker and increasing the number of staff in residential care for more one to one time.

Stable placements
Increased choice of placements and more long-term planned admissions were noted. Suggested improvements for foster carers were training, fees and more support. The need for respite was mentioned by a few respondents which points to a discrepancy in what young people said about respite. In residential care, the need for sensitivity to the mix of young people in the units was highlighted. A note of pessimism was not uncommon:

“We’ve had inappropriate placements for years...we’d have to have a completely different unit...the whole system would have to change...there wouldn’t be any quick fixes to that”
(Field Social Worker focus group)

Desired contact with family
While a number of respondents regarded some familial relationships as too difficult or unsatisfactory to improve or believed no contact was in the best interests of the young person, a suggestion was to be more creative with the environment in which contact happened. Again, this is not dissimilar to young people who wanted the place or facilities to be more natural. Increased resources or funding were seen as necessary to boost frequency of contact. Regular reviews of how contact was working were also suggested as was family group conferencing. The following quote is very compatible with what young people were saying regarding their families:

“They need relaxation for a start, somewhere to wind down, they need people who will listen to them, not just a wee snippet from them. They need their families, no matter how bad they are...they still pine for that background...those children only want to be understood.”
(Foster Carers focus group)

Being able to talk
On the one hand, respondents saw the need to find someone the young person trusted or related to which should come
naturally from good relationships. On the other, they saw a need for one-to-one work or more development of therapeutic services. This is demonstrated in the quotes below. Furthermore, the potential to develop this from the LAC review and give young people more encouragement to talk was pointed out.

“Teenagers need to be with one another to let them see that they are not on their own. And they can talk out their feelings with one another. That they have somewhere to vent their feelings and know that somebody is listening to them.”
(Foster Carers focus group)

“You need someone to talk to them out of all that hurt that is inside them…they would need somebody well trained in the subject”
(Foster Carers focus group)

Friendships
Difficulties in making and maintaining friendships were noted partly due to the barrier of red tape. It was felt that friendships could be supported or encouraged more and there was a need to facilitate normality in young people’s lives. Overall, this shows that professionals and young people are on the same wavelength regarding friendships but to some extent workers’ hands are tied. They gave some examples of ways to assist with maintaining friendships including allowing visits in residential care, assisting with transport and staff talking to parents of friends [residential care]. The following quotes from field social workers show that social workers see friendships as a basic right for young people but the difficulty in maintaining them has not changed over the years.

“I certainly don’t vet every parent that my children go to. There has to be a level of risk there that you run with. And yes, all our children when they leave the house are vulnerable, and all our children are at risk. But it doesn’t mean to say that you have to wait six weeks on an answer to see if you can go and stay at someone’s house...especially for young people in care who want to have friends outside of that...for children in residential homes it’s nearly non-existent whatsoever like saying ‘come into my house, this is where I live’. I don’t think I’ve ever seen that happening...and they are all very basic things.”
(Field Social Workers focus group)

“That thing about bringing friends home and young people having friends and maintaining friends outside of the care group...I don’t think, I haven’t seen that change over the years...I think that’s one of the big factors for young people and their emotional health, particularly when they leave care”
(Field Social Workers focus group)

“Her perception of what she has is the people that she is in a residential unit with, or in secure with...If I had the time, I would spend a bit of time thinking about how you could use that, for her benefit, for her emotional well-being or whatever. Because without that you just have someone who is incredibly isolated.”
(Field Social Workers focus group).

Understanding their care experience and learning to cope with difficulty
A number of suggestions were given particularly around ensuring that life-story work took place or was enhanced and some went on to mention the need for this work to be done by an outside agency. What clearly arose was the need for honesty with young people or openness regarding their past. Foster carers spoke clearly of the need to be honest about young people’s past and deal with the fact of living in care.
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“That boy for instance he was never told his background and he always wanted to know.... the background is horrendous.... he still to this day does not know what happened to him when he was younger, nobody has told him, they kept telling me not to tell them, I would have told them on the spot”
(Foster Carers focus group)

“No matter what the situation they are coming from, it’s even worse going to somewhere they don’t want to go...And that goes through their mind, that they have been pushed into something that they didn’t want to go into. And that goes on with them the whole time that they are with you and they rebel then against anything you want them to do”
(Foster Carers focus group)

In assisting young people to deal with the difficulties they face, suggestions focused on assessment or identification of problem areas, the need for training in areas such as resiliency, better therapeutic links, the preparation for aftercare or independence or more support when young people leave care. Many social workers would like more one-to-one time with young people. The following quote shows how a foster carer sees the importance of young people dealing with the life change of coming into care.

“Every child should have a psychologist to talk to. Just picture, you are 3 years of age somebody comes and grabs you...you’ve to go straight to a doctor and get examined and then straight to a stranger’s house and live there. And that destroys your life before you even go on with your life. You see what happened before then, I think they can cope with that rather than that whole big change to them. It’s soul-destroying.”
(Foster Carers focus group)

Activities and Interests
Foster care was regarded as somewhat better at securing activities while the need for more links with outside activities in residential care was highlighted. Increased contact or links with community groups were seen as important accompanied by funding to make these links possible. It was felt that those working with or caring for young people needed to know what was available which could be eased by building up a directory of services. Encouragement to participate in activities or interests and the discussion of talents with young people was also put forward. The following two field social workers suggest ways that interests and activities could be enhanced.

“It would be mentioned in a LAC review if somebody had an interest, and I suppose, in a positive way you know, because that’s a nice way, at times forgotten about because the young person is there”.
(Field Social Workers focus group)

“What we’ve struggled with as a team in the past has been thinking about taking young people away together [from residential care], or having a sort of activity. There’s a great resistance to that which fascinates me. Because all these young people have these real friendships with one another, as they see them and for some of them that’s the only friendship they have. But yet there is a barrier to them getting together in a potentially positive way and not absconding. If I had the time I would work to pilot something like that, to get together the people who are around one another anyway in danger, take them somewhere safe and see what comes out of that. But I don’t think that would be supported, ...because they are all quite risk averse and I would have to accept that there are arguments for those people not to get together.”
(Field Social Workers focus group)
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Physical health
While this was usually the attribute that respondents felt was better met a couple of suggestions were still made. This included ensuring better or more regular check ups, improving the continuity of health records and passing on of health information and GPs being invited and involved in LAC reviews. This latter point, however, goes against the earlier findings among young people that there was a degree of overcrowding of professionals in their lives, and in particular at LAC reviews.

Staying in the same area
It is important to note here that many did not feel it was a good idea because changing areas allowed the young person to have a fresh start. For those who did feel it was important, suggestions included increased work in the community, increased foster carer capacity so as to maintain the young person in the same community, more work with the extended family to facilitate family placements and lastly more resources.

Progressing in school or work
Fundamentally the raising of expectations and goals as well as the encouragement to study (both in the approach and a suitable environment to study in) was suggested. Better co-working or communication between social services and education and more training for teachers was recommended as were better links with career services. A number of respondents suggested more tutoring. As one foster carer demonstrates the focus on education should always be paramount:

“There’s nobody to turn to for personal problems or that there…. one of the main aims is to make sure the child has education…. at the end of the day we all need it.”
(Foster Carers focus group)

6.1.2 Common indicators of mental ill-health

The following table shows the breakdown of responses overall and then the differences among groups. Overall, the top three perceived aspects in young people’s lives were challenging behaviour (86%), emotional difficulties (83%) and anxiety (78%). However, some differences were notable among the respondent groups. Almost all the attributes were perceived as more common by residential workers and least common by foster carers. The areas of most notable differences between these two groups were regarding trauma (90% compared to 24%), substance misuse (78% compared to 15%), sexually harmful behaviour (78% compared to 15%), depression (71% compared to 26%), loss and bereavement (73% compared to 28%) and deliberate self-harm (56% compared to 19%).

Beyond the factors directly asked in the questionnaire, other common factors cited by respondents included low self-esteem, suicidal thoughts (rather than completed suicides), attachment difficulties, difficulties making friends or social withdrawal. Set against these perceived needs, one newly qualified field social worker noted her sense of worry for the young people in her care:

“I suppose a lot of young people I work with, I hope they get to early adulthood [i.e. live], you know, and I mean that quite seriously...and if they get that far I hope they have some sense of calm. But maybe that is something that someone who has only been in the job a couple of years would say...”
(Field Social Worker focus group)

Open ended ‘other’ responses.
6.2 Services Available for Young People

Approximately three quarters of respondents felt they were well informed of the services available for young people with poor mental health. Nevertheless, the majority (89%) of respondents felt that a database of services would be useful. It seemed, though that this was less true for foster carers than field social workers or residential workers (41% compared to 82% and 80% respectively).

Regarding assessments of mental health needs, foster carers were most confident in their ability to make such assessments (89%), followed by residential workers (73%) and field social workers (61%). Just over three quarters (76%) of respondents felt that a regional assessment tool was necessary. This included 38 of 54 foster carers (70%), 34 of the 44 field social workers (77%) and 34 of the 41 residential workers (82%).

The main services accessed on behalf of the young people are shown in Table 3. These include GP Services (88%), psychologists (77%), community services (75%), counsellors (73%), child psychiatry or child and family clinics (72%) and voluntary agencies (71%). More specialist mental health services were more likely to be accessed by field social workers or residential workers. Further services mentioned were Family centres and Trauma Centres.

7 Open ended responses
Across all of the services, the respondent group least likely to use services was foster carers. Although the present study did not capture specific reasons for these differences, consideration of some potential reasons could be given. Do foster carers, for example, have an expectation that this is the role of the social worker, or do they not see this as an area in which they are skilled? Do they not see these services as relevant to the young people they are looking after? Is it simply a product of the fact that younger children tend to be in foster care?

Looking at the satisfaction levels at a general level, satisfaction was highest for GP services (82%), voluntary agencies (76%) and community services (65%). Satisfaction levels among CAMH Services were comparatively lower and although reasons for dissatisfaction were not asked, a number of pointers for the development of services are outlined in the improvements mentioned below. While attention needs to be paid to CAMH Services for obvious reasons, further attention could be paid to community and voluntary services which are currently being accessed by almost three-quarters of respondents and achieve comparatively higher levels of satisfaction than CAMH Services. One answer could be securing more funding for these services.

Table 3 - Services Accessed and Satisfaction

<table>
<thead>
<tr>
<th>Service</th>
<th>% Accessed (Base: 139)</th>
<th>% Satisfied (Base: those accessed service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Services</td>
<td>88</td>
<td>82</td>
</tr>
<tr>
<td>Psychologists</td>
<td>77</td>
<td>58</td>
</tr>
<tr>
<td>Community Services</td>
<td>75</td>
<td>65</td>
</tr>
<tr>
<td>Counsellors</td>
<td>73</td>
<td>56</td>
</tr>
<tr>
<td>Child Psychiatry/Child and Family Clinics</td>
<td>72</td>
<td>55</td>
</tr>
<tr>
<td>Voluntary Agencies</td>
<td>71</td>
<td>76</td>
</tr>
<tr>
<td>A&amp;E Services</td>
<td>66</td>
<td>61</td>
</tr>
<tr>
<td>Out-patient Child and Adolescent Services</td>
<td>60</td>
<td>35</td>
</tr>
<tr>
<td>In-patient Child and Adolescent Services</td>
<td>52</td>
<td>29</td>
</tr>
<tr>
<td>Day-patient Child and Adolescent Services</td>
<td>51</td>
<td>25</td>
</tr>
<tr>
<td>Adult Mental Health Services</td>
<td>42</td>
<td>22</td>
</tr>
</tbody>
</table>
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6.2.1 Suggested Improvements to Services

Respondents gave a number of suggestions to improve each of the services which invariably tended to focus on the reduction of waiting times, improved speed of response and enhanced resources illustrated in the following quotes:

“When you do refer young people for counselling you’re quite often waiting a couple of months. And it’s quite difficult for them even to get to the stage of ‘ok I’ll try it’...even waiting that length of time, quite often they need that that day or that week and then when it comes round the urgency has gone”
(Field Social Worker focus group)

“It’s about that early intervention and if you manage to resource it. Resources are thin on the ground...the young person’s name could be on a waiting list for quite a period of time, even right through to the CAMHS team.”
(Field Social Worker focus group)

While the above related to general areas of improvement, a number of specific suggestions were given for each type of service. Particular areas of improvement for GP services were training on a young people-friendly approach, longer appointment times and more links with GPs including the possibility for GPs to attend LAC reviews (although concerns about this have already been expressed). Training on young people’s emotional needs was also seen as necessary in A&E departments. Respondents sought increased communication and awareness of what was available through Voluntary and Community Services. In relation to Counsellors, psychologists, child psychiatry or Child and Family Clinics, more involvement of carers was seen as necessary as was speeding up the referral process, better provision of services outside of crisis, improved information on services (e.g. a directory of services), increased availability or capacity and specific services tailored to the needs of adolescents. Improvements for in-patient, out-patient and day-patient Child and Adolescent Services centred on increased capacity or more beds, less reliance on services in England and more resources. Finally, key suggestions for Adult Mental Health Services were improved transition between services and more provision for those falling in the gap between services.

6.3 Support and Training

A range of support needs were suggested including, the need for more therapeutic support and increased capacity in mental health services as well as on call, 24 hour support for carers. There was also mention of more multi-disciplinary working which was also linked to difficulties in recruiting and retaining social workers. This is well demonstrated in the following quote from one newly qualified field social worker who was shocked by the lack of administrative support and working conditions she was faced with:

“The Trust makes their promises and they make them very nicely, and they take their full page in the Belfast Telegraph. And I have qualified, I wanted the experience, I wanted to do the work, I still do. But, as for attracting people into it, I don’t know how they are going to address that. I mean the working conditions are not great, our offices are not great, our storage is not great, admin support for individuals... just in terms of the team and filing and file management, all that is not there for us so we are taking on that role as well as our actual work. So, I think our systems would need to change for people to think, yes that job’s all right, I’ll give that a go, I’ll do that for more than two years”
(Field Social Worker Focus Group)
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Training was a further area of importance. Most respondents had undergone some form of training, with three quarters having done so in the last three years although foster carers were least likely to have undergone training. As shown in Table 4, challenging behaviour was the area the majority of respondents had received training in (79%), followed by dealing with substance misuse (68%), general mental health issues (67%) and assessing emotional or mental health needs (65%). One difference among the groups was that residential workers received more training in therapeutic techniques (85%), trauma (71%) and Suicide Awareness Training (ASSIST) (63%).

Overall, respondents who had received training were most satisfied with training around challenging behaviour (83%). However, much lower levels of satisfaction were reported in relation to specific mental health issues. In particular, satisfaction levels with Suicide Awareness Training (ASSIST) was low at 20% although this was the area almost half of respondents wanted training in (45% - see Table 5).

Table 4 - Training Received and Satisfaction

<table>
<thead>
<tr>
<th>Training Type</th>
<th>% Received Training</th>
<th>% satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dealing with Challenging Behaviour</td>
<td>79</td>
<td>83</td>
</tr>
<tr>
<td>Dealing with Substance Misuse</td>
<td>68</td>
<td>62</td>
</tr>
<tr>
<td>General Mental Health Issues</td>
<td>67</td>
<td>59</td>
</tr>
<tr>
<td>Assessing emotional/mental health needs</td>
<td>65</td>
<td>50</td>
</tr>
<tr>
<td>Dealing with Loss and Bereavement</td>
<td>61</td>
<td>64</td>
</tr>
<tr>
<td>Dealing with Sexually Harmful Behaviour</td>
<td>60</td>
<td>50</td>
</tr>
<tr>
<td>Training in Therapeutic Techniques</td>
<td>56</td>
<td>55</td>
</tr>
<tr>
<td>Dealing with Deliberate Self-Harm</td>
<td>54</td>
<td>49</td>
</tr>
<tr>
<td>Dealing with Trauma</td>
<td>51</td>
<td>38</td>
</tr>
<tr>
<td>Mental Health Promotion</td>
<td>45</td>
<td>27</td>
</tr>
<tr>
<td>Dealing with Eating Disorders</td>
<td>45</td>
<td>27</td>
</tr>
<tr>
<td>Mental Health First Aid</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>Suicide Awareness Training (ASSIST)</td>
<td>37</td>
<td>33</td>
</tr>
</tbody>
</table>

Respondents expressed an interest in receiving more training in the following issues shown in Table 5. The main issues were suicide awareness (ASSIST) with almost half of all respondents overall requesting this (45%), followed closely by training in therapeutic techniques (41%), assessing emotional or mental health needs (40%) and dealing with trauma (40%).
As can be seen in the above Table there was also variation between the groups in the types of training requested. Residential workers were most likely to request training compared to the other groups in all areas with the exception of challenging behaviour, dealing with trauma and substance misuse and assessing emotional or mental health needs. In these cases, it was field social workers who requested this type of training. Foster carers were less inclined to see the need for training overall which again could point to a number of reasons which are outside of the confines of the current research.

For field social workers, on the other hand, key areas of training need were assessing emotional or mental health needs (57%), dealing with trauma (57%), suicide awareness (ASSIST) (50%) and dealing with self-harm (50%). Of course, it may well be that these differences are a function of the level of training already received and/or the nature of the respondent’s job so for example field social workers report the difficulties of giving training priority over the other tasks they perform on a daily basis.

“We never get the chance to go to training because inevitably something more important will come up and you have to sacrifice that... I think it’s about management prioritizing their staff needs... I think it’s a battle to get to it at times.”

(Field Social Worker focus group)

Furthermore, ongoing training was, in some cases, seen as preferable to one-day courses:
“Being able to focus on that one area, six months training that you go on once a week, or once a month or whatever. Whether it is something more substantial than a one day course.”
(Field Social Worker focus group)

One specific area in foster care where training was seen as necessary was regarding foster carer’s birth children. 30 (of the 54) foster carers had children of their own living at home at the time of the research. Of these 30 respondents, 13 reported their children having received training in the foster situation. 36 of the 54 foster carers, however, felt that training in the foster situation was necessary. The three main reasons cited for the need for training were to gain an understanding of the fostering situation and the difficulties foster children might have, to prepare the children for the change in their living environment so that they would know what to expect and since the fostering situation was seen as affecting the whole family, they saw their children as being part of the whole family which fostered.

6.4 Birth Parents

A short overview of the five birth parents’ questionnaires will be given here as far as possible. Only one birth parent agreed with their child coming into care and was satisfied with the level of care provided. Only one of the parents felt uninformed about what was happening in her child’s life. Responses of the parents to important factors were relatively similar to the general research findings, with all five parents noting that having a significant adult ‘very strongly’ impacted on their child or children.

“To have someone steady throughout your life will have an impact on the child’s life, they would be more settled”
(Birth Parent).

Most gave suggestions to improve meeting young people’s needs. Regarding having the contact they want with family, being allowed more contact and overnights was seen as important as was the social workers getting to know the family and encouraging meetings. One mentioned that:

“Sometimes it’s not suitable, they won’t settle if they see family very regularly, not unless they are coming home”
(Birth Parent)

Finding a hobby together was suggested in developing activities and interests. Joining groups at school or local centres could also improve friendships as was staying away from bad company and drink and drugs. Progress in school or work could be enhanced by ensuring that a basic education (e.g. 5 GCSE’s including English and Maths) was in place and not allowing a child to leave school without this and ultimately by praising or showing an interest in their child. To encourage more stable placements, a suggestion was to find a placement somewhere similar to home or to constantly be there for them ‘you being settled means a settled child’.

Regarding physical health, suggestions included knowing the facts of life and having regular six monthly visits to the dentist, doctor etc. In order to assist the child with understanding their care experience one noted she had already contributed to her child’s life book and another cautioned that this should only be done when the young person is ready to

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8 Either ‘very’ or ‘quite’.

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discuss through the use of a scrapbook of photos for example. Learning to cope was seen to be enhanced by talking either through meeting other children, having a special person or telephone number to contact, by sitting down and talking or talking to social workers. When asked directly about improving young people's ability to talk about difficult times, one parent noted that if a child could not talk to parents or social workers they should have counselling. Another stating they should talk to social workers. Regarding staying in the same area one parent stated:

“IT’s not necessary as parents can travel. Sometimes it’s not healthy as you could bump into them a lot and be upsetting”

(Birth Parent)

Finally suggestions for improving the relationship with their social worker were, to have more contact with the social worker, the social worker could be more understanding and look at the whole picture and meet the family. Two were happy with their relationship with the social worker.

6.5 Key Similarities and Differences – Young people and Adults

The research provides a valuable insight into the views of those adults surrounding young people and convergences and divergences in opinion should be examined. While most of the important protective factors would seem to converge with young people’s own statements, the research has shown that being able to talk is not always something that young people saw as important, to the same extent as adults.

Looking back at the uncertainty and misinformation in young people’s lives regarding their care experience/s and their wish for more open and honest communication, the findings in the adult questionnaires seem to agree. Suggestions in the adult questionnaires were that more use could be made of life-story work. Like the young people's views, professionals saw the need for honesty and transparency regarding young people’s care experience and coping with difficulties.

It is also worth exploring further the divergences in opinion surrounding respite care. While young people noted the hurtful and excluding effects of respite, the adult findings suggested a greater use of respite care.

As outlined by the young people, frontline workers can also do much in relation to promoting and maintaining mental health. So building a sound and stable relationship with a young person could be as, or more, beneficial as “therapeutic” intervention.

6.6 Conclusions

While the sections up to this point have noted a sense of disorientation among young people, the present section shows how the care system mirrors this in its struggle to best meet young people’s needs. This points to the need for more centralised resources such as regional policy and procedures and a regional statement on purpose of care. A change from the philosophy of removing the child from harm or vulnerability to promoting positive emotional well-being would be an element of this.

Prior to any care planning, a key issue is to begin with an understanding of the needs of young people. Might the answer be to screen young people for mental health issues at the point of becoming looked after? The nature of how such an approach might unfold obviously...
Meeting Young People’s Needs & Developing Services

necessitates further discussion, particularly in relation to how assessments would be carried out and who would be involved in the decision making process of what the therapeutic need or intervention might be. A key problem in Northern Ireland at the moment is the fragmentation of services for young people and a ‘referral on’ culture inherent within the present system. It seems that there is a need to co-ordinate resources, join together services and one potential avenue could be incorporating therapeutic elements into the LAC review and care planning process.

There is evidentially a need for holistic assessments including the environment into which young people are going. The adult findings suggest that need is not always driving services and that there is a lack of placement choice for young people, as was backed up in the young people’s own accounts of their care experiences. A number of different models could be designed to cope with young people entering care in moments of crisis. These could include emergency foster care, process mapping of the flow through residential care or an assessment unit when a young person initially enters care: a short period in order to prepare them more fully for the care experience and work directly upon issues for their move into care. Other young people, however, will not have entered care at a moment of crisis and alternative mechanisms would be necessary.

Another emerging finding is the need in the first instance for care plans to be adapted to tackle mental health more specifically and pay particular attention to protective and risk factors. One of the areas where care plans are meeting needs less relates to friendships. Within the care planning process, some consideration needs to be given to the therapeutic needs of the young person (in the broadest sense).

Those working with young people play an important role in the process of helping young people with their mental health and in order to do this they need the correct tools, training, confidence and support. From the findings, and in line with other research (e.g. McLaughlin, 2002) it seems that attention has to be paid to the training and support needs of those working or caring for young people. Further thought, however, needs to be given to the model of training which would be most useful for frontline workers. Are events needed or would on-site provision throughout the year be more appropriate? It could be useful to develop or build on existing training packages for all levels of staff and translate these into models for all sectors involved with Looked After Children. There are however, issues with the uptake of training and as one of the field social workers pointed out, crises may take precedence. Ways of reducing the barriers to training need to be developed and particular work may need to be done to uncover the reasons for foster carers perceived training needs in differing from other workers/carers.

At a more general level, a wider variety of mainstream services could be offered to young people (see White and Stancombe, 2004), particularly given the relatively high uptake and satisfaction levels with community and voluntary initiatives. Improving the provision of voluntary and community services could usefully impact for example on activities and interests. This would involve increasing funding and links with voluntary and community groups which could also be enhanced by a directory of services. One solution might be to develop a stakeholder group to process map current care provision and research alternative models, including the voice of young people and all interested
With direct relation to specialist mental health services, this research revealed low levels of satisfaction with such services when accessed. If adequately resourced these services could provide input directly to young people, their families (to improve contact) and to caregivers (advice and guidance, training, emotional support, etc.). This research has crucially looked at the young person’s emotional journey through care and their related well-being which focuses on all levels of need and is not restricted to those young people with more diagnosable and chronic conditions. While professional services for more chronic conditions are indeed necessary, it is evident that information and services also need to filter down to the lower tiers. Since the needs of young people vary in relation to severity, so too must the system be developed according to tiers whether it is in relation to CAMHS or adult mental health services which builds on services at the lower levels with the support of higher level services. In Northern Ireland at the moment, services are hugely fragmented and the reality is that at present CAMHS appears to be more focused towards the higher tiers. As such, the system as it stands, would not deal with many of the needs of the young people expressed in the present research, such as those related to contact, placement issues, coping with new placements and being able to talk about their feelings. The present research therefore corroborates previous findings that there is a need for more centralised and robust CAMHS in Northern Ireland rather than reliance on informal networks. Furthermore, across any service provided to young people, key issues which continually arose in this research and which require attention were, the speed of response, waiting lists and resources (see also Hopkins, 2002; Teggart and Linden, 2005).
Conclusions
Conclusions

Throughout this report detailed conclusions have been drawn at the end of each section and this overall conclusion begins to bring together those specific conclusions into more general overarching and common issues or themes. However, perhaps, firstly we should note that the most striking point which has underpinned each section and stands out well beyond the intricacies, individuality and poignant of many of the accounts, has been the everyday emotions of young people in care and aftercare. One clear message to emerge from this is the need to understand the attitudes, experiences and behaviours of these young people within the context of their lives. Like all young people in society these young people have emotional needs, yet their experiences before care, during care and indeed after care intensify these needs. Their feelings and behaviours are best viewed as natural responses to what might be seen as ‘unnatural situations’ (e.g. poor family relationships, living in care and multiple placements), yet society at large and the care system itself through its response, can pathologise these behaviours.

While this research identified many issues impacting upon these young people’s emotional well-being, five key areas arose consistently and persistently – the transition into care, transitions while in care, the care experience, the transition out of care and family contact. As discussed throughout and particularly in section 4, direct work with young people is needed around these areas alongside changes to current systems, policies and procedures. It is also worth noting again here that different care experiences and/or placements appear to influence and impact upon young people in different ways. For example, the potential ‘contaminative effect’ of residential care is one that has to be acknowledged and we must ask if the corporate parent should be held responsible when the system is ‘failing the child’ (e.g. in terms of education, drug and alcohol use). In contrast, in foster care we should be mindful of the significant number of young people who told us how respite care made them feel excluded, hurt and not part of the family (again reinforcing their feelings of difference and rejection). This is particularly interesting in light of the very different findings of the adult research (see section 6) which suggest greater use of respite care. This difference in views and experiences suggests a real conflict of need and further research on young peoples’ views and experiences of respite care and those of foster carers and other professionals is needed to better understand this. However, regardless of type of placement it was often the instability and uncertainty in young peoples’ lives which emerged as most unsettling and impacted upon feelings of well-being.

Returning to our original definition of mental health (see section 3) this research reveals that positive mental health is not being experienced, promoted or adequately supported on a number of levels. For example, intellectual development (educational encouragement) did not appear to be facilitated adequately and young people reported struggling to gain basic qualifications. Similarly, with all the changes in young peoples’ lives it is often difficult for them to develop and maintain mutually satisfying personal relationships. Furthermore, many young people (particularly in residential care) are also denied the right to use solitude. On another level, however, and moving beyond our chosen definition, factors associated with poor mental health such as self-harm, anxiety, sadness, fear and depression feature to a high degree in these young peoples’ accounts of their lives.

Additionally, a number of overarching
Conclusions

Themes emerge from this research. The first is that young people feel very disoriented in care in relation to the reasons why they were placed in care and/or remain in care. Left unchecked this disorientation can persist after they leave care. This disorientation is perpetuated by young people's lack of knowledge about the system, how it is supposed to work, what it is supposed to achieve and their role and voice within it. Such awareness was something which was evident among very few of the young people we spoke with.

Secondly, the care system to some extent reflects the disorientation of the young person with workers and foster parents appearing confused about how best to meet the emotional as well as physical needs of the child. How carers understand their support role can enhance or negate the orientation process for the young person. The focus is often on trying to fit young people into an 'unnatural system', rather than the system trying to mould around the needs of the young person. While training can be important here the need for a cultural shift is perhaps more pressing. By this we mean a shift away from tightly regulated rules, regulations, controls and 'referring on' to one where more freedom, control and decision-making powers are given to key workers and significant people in young peoples' lives. This could potentially lead to the development of healthy and supportive relationships based on trust and a more ‘normal’ experience of growing up.

The third theme is the number of ways in which the system can better meet the needs of young people particularly in the light of this crucial disorientation. We need to move away from responding to behaviour and understand that how these young people behave in light of their circumstances is not unnatural or surprising. Key staff and carers provide a crucial role in promoting young people’s emotional well-being but the tension between their role description and the reality of what young people may want has to be addressed. Across all potential solutions there needs to be a balance between safeguarding children and child protection.

The way in which services are structured also requires some revision. This is tied into the need for an assessment at the point of coming into care, then some form of monitoring young people with sensitivity to their location and how corporate parenting is fulfilling its aims. Referral structures likewise need to be able to deal with young people's needs and ways of empowering and supporting carers and key staff to recognise and meet mental health needs should be considered. The development of tiered mental health services to more fully take account of lower and higher level need is essential. Coupled with this, greater links with and promotion of more mainstream services within the community and voluntary sector could be made as a means of enhancing the personal and social development of young people and again, bringing a sense of ‘normality’ to their lives.

While there is no single answer or easy fix to ensure or maintain the positive mental health of young people in care, it is apparent that creating new services is not necessarily needed, those which currently exist could be adapted, linked better and the quality of provisions improved. Training also emerges as another means of the system better meeting the needs of young people. This should include enhancing frontline workers' skills in relation to identifying mental health problems, a clear understanding of what the needs of young people are, a description of symptoms which have to be taken seriously in the absence of a diagnosis, demystifying
Conclusions

therapeutic work, developing common terms of mental and emotional health as well as understanding protective factors. Through training there is also a need to increase expectations of young people and ambition for their future e.g. careers and future courses (e.g. McLaughlin, 2002). Clearly, any training provision needs to be as child-centred as possible.

In order to ensure that the recommendations from this research are brought forward, a strategic commitment is needed and developments are currently underway not least in the Children and Young People’s Strategy and the Fostering Strategy. Issues and recommendations from the present research need to be prioritised by those in decision-making roles under the new administration. Beyond this strategic commitment, a practice commitment is also needed and the research has to be addressed at an immediate and local level and in individual children’s homes and foster homes.

Finally, it emerges from the present research that there are still gaps in knowledge and future research is necessary in order to increase our understanding and inform policy and practice. Such research might include an examination of ways to promote resilience (Gilligan, 2000; Richardson 2002; Richardson & Lelliott, 2003) and ways of dealing with challenging situations among Looked After Children/Care Leavers (as has recently been commissioned by SCIE). As already noted, there is a need for a comprehensive regional assessment of the mental health needs of Looked After Children and Care Leavers in Northern Ireland either through a study similar to Meltzer et al. (2003; 2004a; 2004b) or through studies embracing a wider definition of mental health rather than focussing on the presence of symptomatology and diagnosable disorder as has traditionally been the case (Teggart, 2006). Related to this, while previous research points to between 50-97% of young people in care having mental health needs, it has tended not to separate those needs preceding care and those resulting from the experience of being in care. In Northern Ireland, there is also a need for more CAMHS specific research (SLT, 2006) in relation to the numbers referred to CAMHS, who go on to enter AMH Services or suffer major mental health disorders later in life (Koprowska & Stein, 2000). Most importantly the findings from the current research have further demonstrated that an essential aspect of any study involving young people is that their perspective is included though still, to this day it is not always sought (Stanley, 2002; Berridge, 2005).

On a concluding note, the implication that these young people are not being allowed ‘normal’ teenage development while in care is unacceptable. This research suggests that more needs to be done to make care a more ‘normal’ and ‘natural’ way of life and while it is noteworthy that it is hard to create normality in a system which is inherently artificial there is a need to find creative ways of enhancing the day to day experiences of Looked After Children while in care.
Strategic Recommendations
Strategic Recommendations

1. To implement the following recommendations and improve the emotional health and well-being of Looked After Children requires a Ministerial Champion supported by a taskforce to drive forward an agenda for change in this time of administrative and political restructuring.

2. Northern Ireland requires a local centralised body of expertise and knowledge focusing on Looked After Children.

3. Children experience a risk-adverse care system. There are distinct tensions between bureaucracy and a child-centred approach. Children engaged in a therapeutic process, coming to terms with their issues should be afforded confidentiality unless the child or another child is deemed in immediate risk. The tensions between statutory functions versus children’s needs must be explored through the facilitation of a high level cross-sectoral debate.

4. Where a child lives, may not dictate who they are but the attitudes of others can influence who they believe they could be. A public information campaign is required to dispel the negative images and myths about children in care, thereby directly reducing the stigma and discrimination faced by them.

5. Every child entering the care system experiences huge trauma and distress. This should be recognised and action taken to support the child to make sense of their experience and understand how and why they feel as they do. The provision of age appropriate information and communication is a critical factor in developing sound relationships with children and young people who experience severe disorientation when entering care. A training strategy is required to support staff and carers to have the skills and resources to take responsibility for this critical aspect of the work.

6. The high levels of instability experienced by children in the care system contribute to mental ill-health. This instability results from lack of contact with family, placement moves, change of workers, change of school, and friendship networks. Further research is required to identify how to minimise the negative impact of growing up in care.

7. Care experienced children and young people need assistance through the development of Positive Health Promotion Programmes to have an understanding and language which empowers them to take more control of their emotional health and well-being.

8. In managing emotional health and well-being, the culture of ‘referring young people on to specialist services’ needs to be challenged. The value of the key relationships in the young person’s life are currently not adequately recognised. These key relationships should be identified, connected into a network of professional advice and guidance and supported in a process of capacity-building to enable them to address and assist the young person to manage their issues.

9. Children move out of families and risky situations into care and experience the stress of new cultures, new families and substantial change. This change presents different risks to their
Strategic Recommendations

emotional health and well-being and has implications for policy and practice:

a. Emotional well-being needs to be a central concept in placement planning.

b. The assessment process needs to be child-centered with specific focus on emotional health and well-being; understanding the impact of past experience and the potential impact of each placement.

c. To ensure the effectiveness of the assessment process, training is required by staff and carers to understand the impact of loss, stigma, change and new family cultures.

d. Child-friendly tools need to be developed, which support this holistic approach, and mainstreamed into the current assessment process throughout a child’s life in care.

10. Contact with parents, siblings and significant members of the extended family remains a critical factor in determining the emotional health and well-being of the child and young person. This needs to be recognised, resourced and integrated fully into all care plans and supported by key professionals in the child or young person’s life.

11. Continuity of social work, thereby developing strong, sound relationships and having time outside crisis situations was identified as a key protective factor by children. This requires staff having dedicated and sufficient time, through smaller case loads, to build relationships with children in distress. A training and development strategy promoting one-to-one individual work skills with children will ensure effective implementation.

12. The decision-making process, particularly the LAC Review, is viewed by children as procedurally driven and not child-centred. Children need to be active participants, have more control and be empowered to come to terms with decisions.

a. A small core group of decision makers needs to be wrapped around the child and mandated to assess and manage risk, providing ongoing and immediate decisions based upon the best therapeutic outcome for the child.

b. A Departmental Review of care planning procedures needs to be carried out with a view to devising a range of models that meet both statutory requirements, but also facilitates young people’s participation, taking account of current circumstances. Such a review should address:

- Preparation and planning
- LAC forms
- Procedures
- Social Work Report
- Content and process of reviews
- Content of Plans
- Timescales
- Young people’s engagement

13. Respite care presents a range of competing needs, that is the foster carer’s need for a break, the child’s need to feel part of the family and the
system’s need to support the placement. Children require an open and honest discussion from the outset to explain respite care and address the impact on the child. It is critical that the child retains a sense of belonging, stability and emotional security.

14. Education, training and employment provide children and young people with a range of protective factors. The findings of the Caspar Project need to be presented to and integrated into current initiatives:

a. Implementation of the Children Leaving Care Act, with particular reference to the training strategy for Pathway Planning and Personal Advisors.

b. The Regional LACE Project. Particular issues to be addressed will include:

i. Awareness raising in schools through Citizenship Education and PSE

ii Anti-bullying strategies

iii Managing personal information

iv Designated teachers

v Personal development

15. Engaging in leisure activities presents the greatest challenge for residential care and work is required to increase children and young people’s confidence and ability to participate. Leisure should be promoted in the individual care plan and supported by a well-funded leisure strategy.

16. Transition to adulthood presents particular emotional issues for young people and there is often a need for ongoing support:

a. Protocols need to be developed with Adult Mental Health to ensure continuity of the provision of mental health services.

b. There needs to be training for frontline workers in Adult Mental Health services, including Accident and Emergency Services, about the particular emotional and mental health needs of young adults who have an experience of care.

c. There needs to be some flexibility for those young people who are approaching the age of 18, but are still engaged in therapeutic work with CAMHS, to allow them to complete this work.

d. A mental health professional should be attached to Leaving Care teams to provide ongoing support to those young people who require it, until the age of 21.

17. Currently in Northern Ireland CAMH Services are hugely fragmented. This research supports the Bamford, (2006), recommendation 30, outlining the need to develop a model for LAC.

a. A cornerstone of the model must be close collaboration between social services and the networks surrounding the child.

b. The present CAMHS Tier 3 & 4 are not fully responsive to the needs of young people in relation to contact, placement issues, coping with new placements.
Strategic Recommendations

and talking about feelings. Further investment in Tier 1 & 2 is required to develop and enhance preventative work. It is also important that young people are able to access services at the time of need.

c. Training for staff across the different levels of provision within the LAC continuum is required to ensure the effectiveness of a preventative model.
References
References


References


References


References


References


References


References


Appendices
MEMBERSHIP OF PROFESSIONAL ADVISORY GROUP AND MANAGEMENT GROUP

Members of the Professional Advisory Group
- Colleen Christie (Fostering Network)
- William Coman (North and West Belfast HSST)
- Cathy Galway (Department of Education Northern Ireland)
- David Gilliland (Homefirst HSST)
- Prof Robbie Gilligan (The School of Social Work and Social Policy, Trinity College Dublin)
- John Growcott (North and West Belfast HSST)
- Billie Hughes (Young People’s Centre)
- Cathy Jayat (Foster Care Associates)
- Prof Colette McAuley (University of Southampton)
- Rosemary Kilpatrick (Institute of Child Care Research, Queens University Belfast)
- Dr Angela O’Rawe (Young People’s Centre)
- George Russell (CAMHS Policy Directorate, DHSSPS)
- Liz Stevenson (Armagh and Dungannon HSST)
- Dr Tom Teggart (Craigavon and Banbridge HSST)

Members of the Management Group
- Marion Reynolds (Deputy Director, EHSSB) who had previously acted as a member of the Professional Advisory Group
- Bria Mongan (Operations Manager-Children’s Services, Down and Lisburn Trust)
- Alan Cowie (Programme Planner, EHSSB).
- Theresa Nixon who was a member while at the EHSSB.
Appendix 2 - Sample of Research Materials

Young People’s Invitation Letter

Hi, how’s it going?
Your name has been chosen at random (in a lottery style!) This letter is asking if you’d like to take part in something that could help other young people in care and get some money as well, so keep reading!

A few years ago Voice of Young People in Care started a project called CASPAR. The Casper project is about how well people in care feel emotionally. By the end of the project we want to be able to make loads of suggestions on how to improve the services that young people like you get.

WE NEED YOUR HELP!

We need to speak to young people who know about living in care

• We want to have a one-to-one chat with you +1 of the Caspar team
• We want to have a small group discussion with you, a few young people +2 Caspar staff
• We also want to speak to carers, staff and parents

(you can do both)

Thanks for your time: you’ll get £5 for the chat and £10 for the group!

If you’d like to know more take a look at the information leaflet enclosed. Ok, so what happens?

• If you don’t want to take part tick no on the reply slip below and return it using the envelope that came with this letter.
• If you do want to take part tick yes on the reply slip below and return it using the envelope that came with this letter.

Cheers
Lelia, Christine + Fiona (The Caspar Team)

Do You want to take part in the Caspar Project Research?

Yes □ No □

Name ___________________________ Date ___________________________

Signature ___________________________
Appendix 2 - Sample of Research Materials

Young People’s Information Leaflet

THE CASPAR PROJECT

STOP

READ THIS AND THEN DECIDE IF YOU WANT TO JOIN IN?

¿ WHO ARE VOICE OF YOUNG PEOPLE IN CARE
We work with children and young people who live in or who used to live in care. The clue is in the name, we want people like yourself to be listened to and make sure that you have a say in decisions that affect your life.

¿ WHAT IS THE CASPAR PROJECT
It’s about NEEDS, FEELINGS and EMOTIONS
Letting us know what support you have
We want to talk to YOU about issue like these
We’ll chat to others (foster carers, residential staff, field workers and parents)
We’ll plan how to meet these needs in future

¿ WHAT’S INVOLVED
WHAT      WHO WITH      HOW LONG      U GET!
One to one chat  1 of Caspar team  30-45 mins   £5
Group Discussion 2 of Caspar team  1.5 - 2 hours £10

¿ HOW COME I’VE BEEN ASKED
Couldn’t be simpler, your name was chosen at random!

¿ WHAT IF I DON’T WANT TO TAKE PART
The choice is yours. If you don’t want to you don’t have to & you can stop our conversation at any time.
Appendix 2 - Sample of Research Materials

Young People’s Information Leaflet

CONFIDENTIAL CONFIDENTIAL CONFIDENTIAL

Everything will be ANONYMOUS and CONFIDENTIAL. Nothing you say will be linked to you. We’d like to tape record the conversations so that we can write up what has been said without forgetting anything. After this has been done the tapes will be destroyed!

CONFIDENTIAL CONFIDENTIAL CONFIDENTIAL

ATTENTION

- When we speak to carers, staff and parents, we’ll be chatting in general - we WON’T be talking about any individuals.
- If you tell us something that is harmful or illegal we will have to pass this on to another person.
- If you have to pay for travel, childcare or anything else to take part, hold onto your receipt and we’ll give you your money back.
- If anything comes up that upsets you then we’ll make sure you can contact someone for some support.
- If you have any questions at all then please get in touch with either Lelia, Christine or Fiona at 9 - 11 Botanic Avenue, Belfast BT7 1JG

YOU HAVE THE RIGHT TO COMPLAIN

SHOUT OUT

WHAT IF I’M NOT HAPPY AFTER I’VE TAKEN PART

If you are in any way unhappy with how the one-to-one chat or the group discussion went we would like to know about it! Phone or write to:

Vivian McConvey (Director of VOYPIC) 9 - 11 Botanic Avenue, Belfast BT7 1JG
Phone: 02890 244888

If you’ve a complaint to make about your Trust, it’s important that these are followed up too. You can contact:

LIAISON PERSON
or
VOYPIC’s Advocacy Co-ordinator - Karen McAlister

IF YOU MAKE A COMPLAINT, WE’LL MAKE SURE...
1. You’ll be listened to
2. You’ll be treated with respect
3. It will be acted upon
4. You’ll be kept up to date with what’s happening
5. We’ll let you know the outcome as soon as possible
Appendix 2 - Sample of Research Materials

Sample Guide for In Depth Interviews

When you meet the Young Person:
Welcome the young person, go through information leaflet, explain confidentiality, roles and what interview is about. Ensure that young person understands and go through consent form.

1. GETTING TO KNOW EACH OTHER

Today I’d like to talk to you about a few different things. But, first of all you might want to know a bit about me. Add in what you do in VOYPIC, what you like, hobbies, sport, TV, films etc…

To start off, could you tell me a little bit more about yourself: (IF DON’T ALREADY KNOW – Age, Where do you live? Who do you live with? Likes, dislikes, interests, hobbies etc)

2. HOW THINGS ARE AT THE MOMENT

SHOW TIME LINE FOR AGE GROUP
How happy are you with how things are going for you right now? How have things been for you lately? Compared with others your age, how would you say your life is? How would you describe your situation now?

Support: At the minute, Is there someone you would say is the most important person in your life? PROBE FOR: Is there someone you trust, cares about you, understands you, is there for you, helps you feel good about yourself, helps you develop new skills, notices and appreciates your efforts? Describe X to me – personality/qualities; how to contact them, relationship.

Friends: would you say you have a really good friend/someone you could share your secrets with? PROBE FOR: Ideal friend? Any friends who are also in care?

Family: do you get to see them/see them much? PROBE FOR: Do you have brothers and sisters? Do you get to see them much? What do you think of that? Ideally, what way would you like to see your family?

Positive role models: Is there anyone in your own circle (i.e., not a famous person – someone you know in real life) you would really like to be like? Why?

Negative role models: is there anyone you don’t get along with/don’t like? Why?

3. HOW THINGS ARE LOOKING IN THE FUTURE

SHOW CRYSTAL BALL for future
What are you looking forward to at the moment? Where do you see yourself in a year’s time? Is there anything you can’t wait to do? What would you like to be when you grow up/are older?

4. HOW THINGS HAVE BEEN BEFORE NOW

GO BACK TO TIME LINE - WHEN YOU WERE SMALL
How have things been for you before now? PROBE FOR: Friendships over time, professionals involved in life, type of care etc.
Appendix 2 - Sample of Research Materials

5. FEELINGS

IF NECESSARY USE FEELING CARDS/PICUTURE
What sorts of problems or difficulties do young people have to deal with when they are in care/Care Leavers?

Tell me 3 things that
• make you happy/feel good about yourself?
• make you feel unhappy?
• make you angry?
• make you feel stressed?
• make you afraid?

How do you feel about change? How do you feel about meeting new people?
Do you find you get down much?

6. COPING MECHANISMS

What do you do to feel better when you feel down? How do you cope when bad things happen to you?

Control - How much control do you feel you have over your life? How much do you feel you have control over what happens to you? How involved do you feel in planning your future? Do you get a say in decisions?

Ready for leaving care - For those close to 16 - do you feel ready for leaving care? How will you cope?
For those over 16 - Did you feel ready for leaving care? How did you cope?

7. SUPPORT

Is there anyone you can talk to about your feelings/talk to when you have problems/tum to for support/cheer you up when you are down? If you needed help immediately in a crisis who would you contact? Who?
PROBE FOR: Carer, Parent, Aftercare Worker, Field Social Worker, Counsellor, Doctor, boyfriend/girlfriend, family, friends (USE SUPPORT CARD IF NECESSARY)

How long does it take to get in touch with these people? Are they available to you?

Do SUPPORT PRIZE EXERCISE for the person you could give a prize to for being most supportive
Have you been offered the support you want?

IF NOT: Is there anyone you would like to talk to? What would you like? Is there any help/support you would like to have? What other services or supports do you think would be helpful?

8. CARE EXPERIENCE

How do you feel about being/having been in care? PROBE FOR LAC reviews, procedures and policies, rules, discipline.

How did your life change when you went into care? What kind of changes? PROBE FOR: Appropriateness of placement (e.g. country/city/cultural identity/needs). Did you know what was happening to you? Did anyone explain it?

How do you tell people about where you are living? What do you say to a new person you meet about being in care?

Is there anything you feel you miss out on?
Appendix 2 - Sample of Research Materials

9. UNDERSTANDING HEALTH (& MENTAL HEALTH)

If I use the word ‘health’ what does that mean to you? **For younger - Draw a picture** of a healthy boy or girl and write words around them that they need to stay healthy (if they don’t want to draw, have a picture ready – matchstick)

What does the term mental health mean to you? What would you say emotional health means? **PROBE FOR:** How do you think other people react to young people with mental health problems?

**USE FIGURE and circle (inside figure is good for mental health, outside is not good)**

Would you say you have mental health needs? Follow up if yes, with mental health problems?
- Do you feel anyone has tried to help you with these?
- Have you ever been referred to a counsellor/psychologist? Did you go? What do you think of counselling? What do you think it is about?
- Do you take medication? How do you feel about medication?
- Have you ever been through Accident and Emergency in a hospital? How was it?
- Do you think that all people with mental health problems are in the same boat?

**TELL YP THAT IT IS COMING NEAR THE END - JUST WANT TO WRAP IT UP**

10. CONTRIBUTING TO DEVELOPING SERVICES

What would make an ideal care/aftercare service? Just say anything you like. **PROBE FOR:** Support/training; In an ideal world, who would offer this support?

If there was one thing you could change about **(PLACEMENT)** - what would it be?

11. TIME TO REVIEW AND CHECK OUT WHAT YOU HAVE SAID

Can I take some time to look at what you have said and to be very sure that I have understood your points properly? **Spend a few minutes making sure the Young Person has had an opportunity to say all they want to say.** If they wish to add anything/take anything out, take time to allow them to do so.

Ask if would like to add anything/any further questions?
Again, ensure confidentiality and tell them they will get feedback from the Young People’s report. If they need any support – just give us a call or liaison person.

**GIVE YOUNG PERSON THE INCENTIVE - SIGN FORM**

12. MINI - FOCUS GROUPS

We are going to continue this discussion in a small group - only 3-5 people. It will be bringing together all the information from young people and seeing how to put this in place. If you are interested would you please sign this form?
Appendix 2 - Sample of Research Materials

Sample Projective Techniques

Timeline for 12 - 14 year old

When you were small there was........ How are things at the minute?

What would your ideal friend be like?

Most important person to you?

How are things in your family?
Appendix 2 - Sample of Research Materials

Group Discussions Consent Form

GROUP DISCUSSIONS CONSENT FORM

Caspar staff members: Lelia Fitzsimons Christine Mullan Fiona Rollock

• Before we can have our group discussion we need to make sure that you agree to what’s happening and that you give us the go ahead to continue

• Just tick the boxes you agree with

1. I understand the information leaflet

2. I’ve had a chance to ask questions about the study

3. I know I don’t have to take part if it don’t want to

4. I realise I can drop out of the research at ANY point, without giving any reason, and this’ll be OK

5. I know the group discussion will be taped but I decide if I don’t want it to be used.

6. I approve of the discussion being taped □ Yes □ No

7. I want to take part in this group discussion □

Your name ___________________________ Today’s date ________ Your Signature ___________________________

Caspar staff’s name ___________________________ Today’s date ________ Your Signature ___________________________
Appendix 2 - Sample of Research Materials

Guide for Focus Groups

INTRODUCTIONS AND ‘GETTING TO KNOW YOU’ SESSION.

GO THROUGH LEAFLET, DRAW-UP GROUP CONTRACT AND ENSURE CONSENT IS UNDERSTOOD AND FORM SIGNED

SESSION 1

Family fortunes
Explain exercise - that it is giving them an idea of what was said in the focus groups. Ask to guess how many people said each. Probe for reasons why

Infested waters
Explain infested waters exercise – need to set up 3 points to get to end goal. Want to get from not understanding what their MH needs are to understanding their MH needs by identifying three steps which will allow them to other side where they can say “I know what I need to look after my mental health needs”. Get them to write down the step on a sticker and attach to rock on ground.

SESSION 2: Vignettes

Give young people the vignette (according to age group) then ask exploratory questions around support and mental health issues.

TIME TO REVIEW AND CHECK OUT WHAT YOU HAVE SAID

Spend a few minutes making sure the young people have an opportunity to say all they want to say. If they wish to add anything/take anything out, take time to allow them to do so.

GIVE YOUNG PEOPLE THE INCENTIVES - SIGN FORM

DEBRIEF

Explain when they are going to get information about the group
- Young People’s Report (let us know if change address)
- Info on VOYPIC
Appendix 2 - Sample of Research Materials

Focus Group Techniques - Family Fortunes

We asked 51 people about things to do with mental health...

<table>
<thead>
<tr>
<th></th>
<th>LIFE IS GOING WELL AT THE MOMENT</th>
<th>HAPPY WITH AMOUNT SEE FAMILY</th>
<th>HAVE GOOD FRIENDS</th>
<th>GET ON WELL WITH PEOPLE</th>
<th>HOPES FOR THE FUTURE</th>
<th>TALK TO SOMEONE ABOUT THINGS</th>
<th>BEING IN THE RIGHT PLACEMENT - SUITS THEM</th>
<th>GO TO SCHOOL/TECH/HAVE A JOB</th>
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</table>
Appendix 2 - Sample of Research Materials

Focus Groups - Case Vignettes

The following are stories made up by the research team and were described as follows: 'this story is an example and has been entirely made up by Christine and Fiona, it is totally fact free!' The stories were adapted for either gender.

STORY FOR 12-14 YEAR OLD MALE
Joseph went into care when he was 11. Before coming into care Joseph lived in south Belfast with his mum, 1 brother, Jake and 2 older sisters. Joseph went to live with a foster family in Downpatrick with his brother Jake, while his older sisters got a flat of their own. At first Joseph and his brother thought that they would just be staying a little while with their foster carers but they ended up staying for 2 years. During this time Joseph has settled in his new school and made friends in the area. Joseph, Jake, their 2 sisters and mum meet up once a week at their granny’s house. Joseph’s social worker is moving to a new job next month, this is bad timing as Joseph’s placement has now broken down after lots of arguments between him, Jake and their foster carers. Aged 14 Joseph moved to Hollyoaks Children’s Home in Strangford while Jake has gone onto another foster placement. Joseph has moved to another school closer to his new home, a lot has changed.

STORY FOR 15 – 17 YEAR OLD FEMALE
Carol is from Dundonald and went into care aged 9, her younger brother still lives at home with their mum. She has lived in 5 foster placements in Bangor, Newtownards and Donaghadee and moved to a children’s home in Kircubbin aged 15. Carol’s attendance at school used to be good but it’s started to slip recently. Carol used to have family contact arrangements that she was happy with but this has changed too. She tries to visit her best friend as often as possible but she lives in Bangor so this can cause problems as Carol has to be in by 10pm on week days. Spending time with her best friend is important to Carol as they can talk about stuff and she also likes to get out of the home as there seems to be quite a lot of rows there. Carol has been feeling down recently and doesn’t feel she knows her new social worker well enough yet to mention it. After her 16th birthday Carol would like to get a place of her own.

STORY FOR 18-20 YEAR OLD FEMALE
Noelle is from Glenavy and now lives in the Christmas Pines hostel in Belfast. Noelle and her boyfriend are expecting a baby in May but don’t have anywhere for the 3 of them to live. Noelle has been in care since she was 12 and has lived in hostels and B&B’s since leaving. She goes to tech and a work placement, which she enjoys and is training to be a chef. At age 15, following a series of unsuccessful placements and while she was sniffing and abusing solvents Noelle was referred to a counsellor, but she didn’t really like these sessions and she stopped going. Thinking back Noelle thinks she was depressed at the time, she isn’t sure about this but and sometimes she still feels low. Over time relationships with her family have really deteriorated and she doesn’t really see any of them. Noelle is on a waiting list for a house and is eager to move. She gets along well with her aftercare worker Gabriella, who is there for her when she needs her. She is worried about the future and would like to find out about what benefits she is entitled to and how flexible tech will be once she has her baby.
### Foster Carers (n = 54)

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<tr>
<td>South and East Belfast HSST</td>
<td>8</td>
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<tr>
<td>Ulster Community and Hospitals HSST</td>
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<thead>
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<td>11 - 15 years</td>
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<td>16-20 years</td>
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<tr>
<td>More than 21 years</td>
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<td><strong>Total</strong></td>
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<thead>
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<tr>
<td>Short term/Respite foster care</td>
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<td>Kinship carer</td>
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<td>Social work assistant</td>
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### Field social workers (n = 44)

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<td>Female</td>
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<tbody>
<tr>
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<tr>
<td>North and West Belfast HSST</td>
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<tr>
<td>South and East Belfast HSST</td>
<td>13</td>
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<tr>
<td>Ulster Community and Hospitals HSST</td>
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<tr>
<td>Other</td>
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<td><strong>Total</strong></td>
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<table>
<thead>
<tr>
<th>Length of time working</th>
<th>Count</th>
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<tr>
<td>6-11 months</td>
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<td>1-3 years</td>
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<td>4-5 years</td>
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<td>6-10 years</td>
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<td>11 - 15 years</td>
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<td>16-20 years</td>
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<td>More than 21 years</td>
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<td><strong>Total</strong></td>
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<table>
<thead>
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<th>Job Title at time of research</th>
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<tr>
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<td>Senior practitioner</td>
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<td>Social worker (Basic Grade)</td>
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<th>Team work in</th>
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## Appendix 3 - Profile of Adult Participants

### Residential workers (n = 41)

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<td>South and East Belfast HSST</td>
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<td>Senior practitioner</td>
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39 worked in a residential Children’s Home and one in a respite unit.

### Birth Parents (n=5)

All 5 birth parents were female.

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### Children’s home/unit’s statement of purpose and function

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