UNIT 4

DIFFERENT EXPERIENCES, COMMON PROBLEMS

Unit 4: SUMMARY OUTLINE

Exercise Number	Exercise	Alterations/Suggestions	Alternative Exercises/ Handouts
1	Recap first 3 Units	Cover all 3 previous Units	**AH 1**
2	Living with Racism	Exercise changed to young person's perspective Alternative questions provided in Tutor notes	**AH 2**
3	Different Experiences, Common Problems	Handouts changed to be more relevant	**AH 3** **AH 4** **AH 5** **AH 6**
4	The Meaning of Equity and Health	See notes below	None
5	From Social Exclusion to Social Justice	None	None
6	Group Project	None	None
7	Recap and summary	Take time to ensure key messages understood	None

Unit 4: Additional Summary Notes

Exercise 1: Recap from Units 1 -3

At this point it may be useful to recap on the first 3 units and gauge how the young people are feeling at this stage. The additional handout on the Social Model of Health can be given out to recap. Young people in the pilot group felt more comfortable with traditional teaching methods and wanted additional handouts which summed up discussion. **AH1**

Exercise 2: Living with racism

We suggest changing the scenario to one where it is the young person who is experiencing racism at school/college. The handout has been changed to read from a young person's perspective. **AH 2**

Suggested questions:

- How would you deal with the situation?
- Would you tell your teacher, if so how would you do this?
- Who else would you tell?
- How would you deal with the problems outside school?
- Could you do anything to develop better closer relationships with local young people if so what would it be?
- What affects might this situation have on your health and the health of your family?

Then generate discussion drawing upon their own experiences/feelings of exclusion, feeling different, or prejudice.

- Introduce ideas of media and stereotypes – how Scottish people are portrayed

Exercise 3: Different experiences, common problems

Some ***alternative handouts*** for this exercise are:

- children living with domestic abuse, parental substance misuse or parental health problems **AH 3**
- the education and employment of disabled young people **AH 4**
- factors that influence young people leaving care **AH 5**
- disadvantaged children at greater risk of adult mental health problems. **AH 6**
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Note that while they cover topic areas which are more relevant to young people they still contain quite complex language and so it is advisable to have one tutor per small group to support them through reading the documents and to answer any questions/queries they may have.

Exercise 4: The meaning of equity in health
Biscuit Game – when discussing this try relating the scenario to three local youth clubs bidding for funding.

Exercise 5: From social exclusion to social justice
Run through the exercise as normal.

Exercise 6: Group Project (planning)
Run through the exercise as normal.

Exercise 7: Recap and Summary
Try to spend a bit more time than normal on this exercise to ensure key messages have been learned.

Unit 4
AH1

Exercise 1
SOCIAL MODEL OF HEALTH HANDOUT

The Social Model of Health

What is Health?

"Health is a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political beliefs or economic and social conditions."
(Source: World Health Organisation 1948)

Different health definitions

What is the Social model of health?

The social model of health takes into account how other influences have an impact on people's health, rather than just the presence or absence of disease/illness. Some of these other influences are a person's culture and belief system, access to housing, how much money they have compared to others, how well they do at school. It also takes into account the wider environmental, political and socio-economic conditions in which people live. People's social and community networks also have an impact on health.

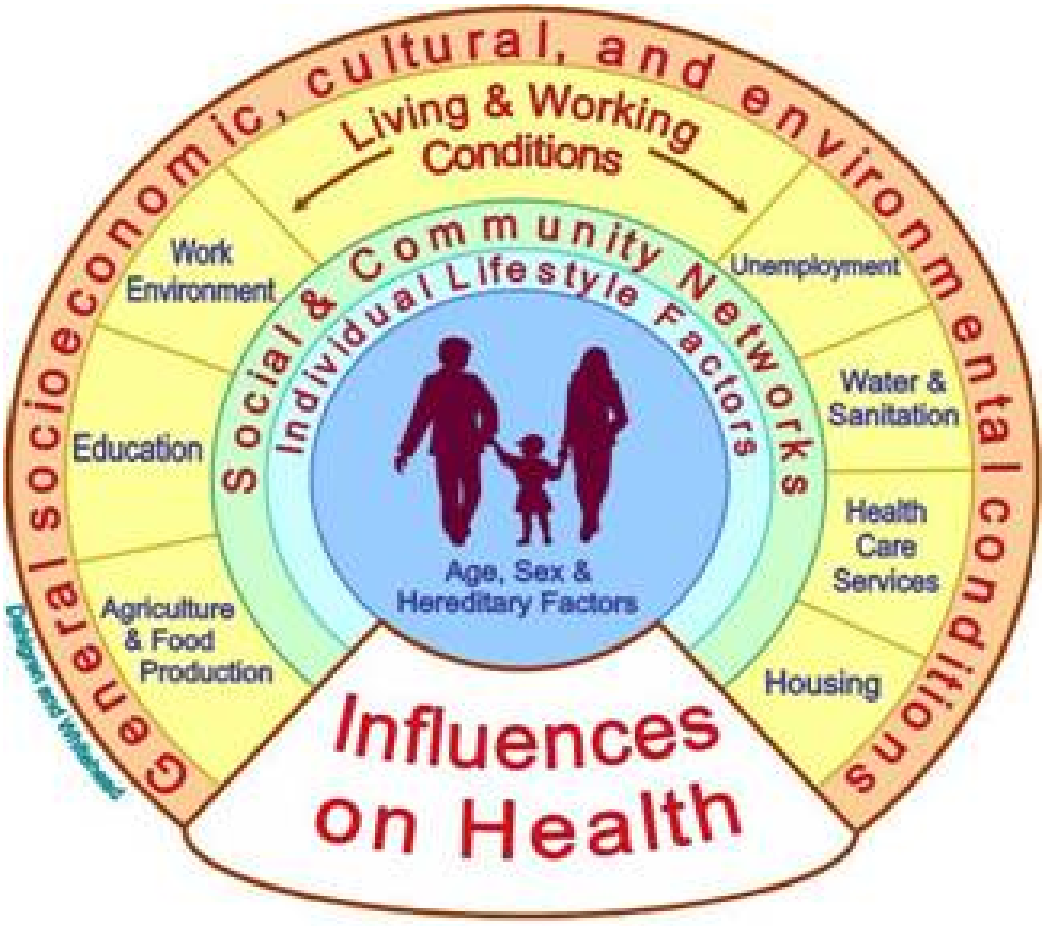
What is the medical model of health?

The medical model defines health mainly as the absence of disease. This is because of the belief that medical science must find cures for diseases in order to return people to health. This model of health may be easier to understand as it makes health an quality you can measure simply by determining if a disease is present or not.
However by only using the absence of disease as an indicator of good health and the reliance on the influence of medical science in health ignores the power of other very important factors.

Medical Model	Social Model
Focus on individuals	Brings people together collective solutions to problems
Agenda is set by professionals – their knowledge and skills are most important	Shares power, knowledge, skills, which help disadvantaged people develop ways to regain power over their lives
Views the body as a machine	Recognises other influences on health e.g. poverty, housing and

	unemployment
Evaluation is quantitative with no emphasis on participation or developmental process	Evaluation is qualitative and encourages participation, values process as well as outcomes

Why should we consider the wider determinants of health?



Using this model of health allows us to have a better understanding of why some people find it easier than others to look after their health.

We all know the difference between 'knowing' and 'doing' in relation to how we can achieve optimum health. For example most people know that smoking is unhealthy but some continue to smoke. Also research shows that most people know what healthy food is but do not always eat it. Some of the complexity comes from how various barriers exist which comprise health. This is where a broader understanding of the wider determinants of health helps to identify what influences health and therefore what can be a barrier to individual and community health.

Unit 4
AH 2

Exercise 2
LIVING IN PREJUDICIA (YOUNG PERSON'S PERSPECTIVE)

The Scenario

It is the year 2020. The economic situation in Scotland has deteriorated drastically over the past few years. There is large-scale unemployment and very little sign of an economic upturn. You and your family have imigrated to the country of Prejudicia, and you have begun to attend a local school.

Your first impressions of Prejudicia are:

- Scotland is portrayed as a poor, backward country, in need of aid. There are regular collections for 'poor Scottish babies' at your school.
- No mention is made of Scotland's major contributions to art, literature, science or sport. Scottish schooling and academics are seen as second rate and corrupt. On the other hand, Prejudicial culture and achievements in these fields are constantly emphasised.
- You are actively discouraged from speaking English at school, although there are other English-speaking young people there. So while you have to get extra help with Prejudiciac, other young people are progressing in other subjects.
- Similarly, if you or your family speak to each other in English while in public you get disapproving stares and general resentment.
- You were recently in hospital for a minor operation. Whilst there you were offered mince and tatties for your lunch because you were Scottish. Nobody spoke English and you have only learned basic Prejudiciac so you had difficulty explaining that you were vegetarian. You were also treated as a pest because of your different needs.
- All references to Scotland in books, newspapers or television have pictures of men in kilts, living in overcrowded, deprived estates, eating fish and chips and getting drunk. There is a general belief that it is a very violent and unsafe place.
- The Prejudicial people continue to treat you as outsiders – even those Scottish people who came here years ago and whose children were born in Prejudicia. All your concerns are trivialised and treated with contempt. If you persist you are accused of being fundamentalist and having a chip on your shoulder.
- There have been several instances reported in your area of Scottish young people being attacked. When you have mentioned this to your teachers you have been told not to over-react, and not be so sensitive. The attacks were probably nothing to do with them being Scottish. They live in a poor area and these things just happen.

You are unhappy because other young people won’t speak to you, you don’t understand the teacher or the lessons being taught, and the other young people call you rude names and make fun of your accent, behaviour and culture.

Exercise 3

Understanding what children say about living with domestic violence, parental substance misuse or parental health problems

Policy and services in the fields of domestic violence, parental substance misuse and health problems are traditionally focused on meeting the needs of the parent. They do not always recognise the possible impact on children and other family members and their need for support in their own right, alongside provision of support for parents. Children first and foremost want their parents to be well and happy and they want their family to be safe. Often they are more aware of what is happening in their family than parents think. However, they do not necessarily understand problems.

Children who live in families where there is domestic violence, parental substance misuse and to a lesser extent, mental health problems report overhearing, witnessing or experiencing violence. They say that fear of violence is made worse by the unpredictability of parents' moods and behaviour and children can feel they are 'walking on eggshells'. Fear, unpredictability and confusion do not just exist when there is violence, but also when there is relationship conflict.

Children report worrying about their parents much more than may be recognised, particularly if they fear for their parents' safety due to violence, self-harm or difficulty in coping. Relationships and dynamics within families are often complex and this is reflected in children's feelings. Children frequently describe close relationships with parents, and love and loyalty that are strong and enduring. They also often express a desire to help their parents overcome problems. Some children, however, may feel torn between love for parents and a dislike of parents' behaviour or restrictions placed on their own lives.

Sadness and isolation that children may experience can be perpetuated by the stigma and secrecy that surrounds domestic violence, parental substance misuse and ill health. Some children report feeling depressed, having problems making or maintaining friends, having a disrupted education or experiencing bullying. However,

children's accounts in the field of domestic violence show that they have a remarkable resilience and ability to heal from previous bad experiences.

Children's accounts of living in a family with a parent with physical or mental health problems are mixed. Some children talk about difficult aspects of providing care and support to parents and feel as if they are missing out on social or educational opportunities. Children living in situations where there is domestic violence, parental substance misuse or health problems may not necessarily undertake more practical tasks in the home than other children, but they may feel more responsible.

Lack of communication is a major barrier to children and young people getting the help they need. There are problems of communication between parents and children and professionals. Within families this is often because of a shared desire to protect one another, secrecy and shame surrounding problems, parents finding it hard to know how to talk to children and feeling too upset themselves to talk about problems. Children in the studies on domestic violence, in particular, stressed wanting parents to talk to them more. Not talking to children may perpetuate their confusion and isolation and lead to misunderstandings.

First and foremost, children use informal sources of support. They are most likely to turn to parents (usually mothers) and friends, then siblings, grandparents or pets. Support may come in the form of talking or spending time with someone and feeling safe. Children say that they want to talk to someone who they trust, who will listen to them and provide reassurance and confidentiality.

Some children will not talk to anyone about the problems at home. This may be because of fear of violence, fear of the consequences of talking about problems (for example, being separated from parents, hurting other people), fear of not being believed or because of distrust, not feeling anyone can help, and possible stigma surrounding problems. Boys in particular may find it hard to talk about problems and they are more likely to leave talking to someone until nearer crisis point than girls. Many children report using avoidance or distraction as a coping strategy when there are problems at home. Using this strategy is likely to make children even harder to identify and support. We do not really understand what would make boys more likely to talk about problems and seek support.

Children rarely approach professionals initially and do not know where to go to get formal help. Unwanted intervention and stigma are the main reasons children and parents give for not approaching professionals. They may be more encouraged to do

so, either through helplines or by having spaces provided in which they can feel safe. Having time to build up relationships of trust is likely to help children discuss problems at home:

Children mention a need for confidential support such as helplines, universal and specialist support. Although there are overlaps in the types of feelings and coping strategies children may use, there are many differences in individual experiences and there is a need for some specialist services that can work with children alongside those for parents. Children's most urgent request, however, is for age-appropriate information about the problems their parents are experiencing. The following personal account reflects this experience. Children also talk about welcoming an opportunity to have a break away from home, have some fun and to get to know other children experiencing the same problems.

1. **What are the children in the study torn between?**
2. **What do the children report feeling?**
3. **What happens as a result of providing care and support to parents?**
4. **Why are there communication problems between families and professionals?**
5. **Why will children not talk to anyone about problem?**
6. **What do children say will help?**

Exercise 3
The education and employment of disabled young people

Disabled young people have not always been encouraged to see themselves as having a valuable role in adult society. Previous research on a sample of young people born in 1958 reported that the proportion of disabled youngsters aspiring to semi-skilled and unskilled jobs was six times that of non-disabled youngsters with those aspirations (A Walker, 1982, Unqualified and underemployed: handicapped young people and the labour market, Macmillan).

A study by the London School of Economics asked whether the gap between disabled and non-disabled young people's aspirations, and the even larger gap in their subsequent attainment, has persisted for those born more recently. The research analysed data from cohort studies of children born in 1970 and in the early 1980s.

The study found that in general:

- three in five young people wanted to stay on after 16, whether or not they were disabled;
- one in three disabled young people aspired to a professional occupation, compared with one in four non-disabled;
- The average weekly pay that disabled and non-disabled 16/17-year-olds expected from a full-time job was similar.

Some groups of disabled young people seemed to be at risk of lower aspirations, they included:

- young people with mental health problems
- those with more severe impairments or more complex needs
- Those who became disabled later in childhood.

For both disabled and non-disabled young people, there was a strong gradient of educational and occupational aspirations relating to their parents' educational and social class background. Young people whose parents lacked educational qualifications were more than four times as likely to intend leaving education at 16 than those who had at least one parent educated to degree level. Young people's own motivation and outlook were also crucial, especially in the case of disabled young people. Those with a firmer belief in their ability to shape their future were more likely to aim high.

<u>Educational outcomes</u>

At age 16/17:

- 71 per cent of non-disabled respondents were in full-time education, compared with 62 per cent of disabled respondents
- Three-fifths of non-disabled people reported that they got the education or training place or job they wanted; only just over half of disabled youngsters said the same.

By age 18/19:

- the highest qualification of 48 per cent of disabled young people was at the equivalent of NVQ level 1 or below (GCSE grades D-G or below, including those with no qualifications), compared with 28 per cent of non-disabled young people
- Disabled young people still in education at this age were more likely than their non-disabled peers to be pursuing secondary-level or vocational qualifications.

Analysis showed that educational aspirations were an important, independent influence on educational outcomes, for disabled and non-disabled young people alike. Controlling for other characteristics like parental education, young people who became disabled between the ages of 16 and 26, and those who were disabled at both ages, had lower educational attainment relative to their aspirations than did their non-disabled counterparts.

Occupational outcomes

The gap between the proportion of disabled and non-disabled young people out of work widened as they got older:

- at age 16/17, disabled young people were about twice as likely as non-disabled to be out of work or 'doing something else' (13 per cent compared with 7 per cent);
- by age 18/19, disabled young people were nearly three times as likely to be unemployed or 'doing something else' (25 per cent compared with 9 per cent);
- at age 26, young people who were disabled at both age 16 and age 26 were nearly four times as likely to be unemployed or involuntarily out of work than young people who were disabled at neither age (13.8 per cent compared with 3.7 per cent).

Even among those who were in employment, earnings were lower for disabled than for non-disabled employees. At age 26, disabled young people were earning 11 per cent less than their non-disabled counterparts with the same educational qualifications.

Conclusion

The study concluded that poverty of aspiration is not the main barrier for young people with physical or sensory impairments. Rather than advice and encouragement, the main effort should focus on transforming the actual opportunities available to disabled young people, for example through:

- ensuring continuity of support (including funding, equipment and personnel), especially in the transition from secondary to further education
- opportunities to return to education, focusing on acquiring higher qualifications, not just basic skills
- work placements related to each young person's expressed interests, with support from Access to Work.

Evidence of unequal pay between disabled and non-disabled young people with similar qualifications and in similar occupations requires urgent investigation. Moreover, the widening gaps between disabled and non-disabled young people's participation in employment as they move into early adulthood indicates that the Government's professed goal of opportunity for all is far from being achieved.

1. **What groups of disabled young people seemed to be at risk of lower aspirations?**

2. **For both disabled and non disabled young people what was the strongest gradient?**

3. **What did the study show to be an independent influence on educational outcomes?**

4. **What happened to the gap between the proportion of disabled and non disabled young people out of work as they got older?**

5. **What should be done to help?**

Exercise 3
Factors that influence young people leaving care

Research by the Social Exclusion Unit has shown that young people leaving care are less likely to be involved in education, training or employment and are more vulnerable to social exclusion in later life. This study examined the factors that help and hinder care leavers' transition to independent living and their involvement in education.

Young people who enjoyed a relatively stable experience in care were more likely to be settled after 16. Important factors that affected their care experience included: the age they entered care and the reasons that brought them there; and the number and type of placements they experienced. Young people on care orders were least likely to be engaged in any economic activity. Care experience affected the young people's ability to build and maintain significant relationships, their education, and their attitudes and self-esteem. The young person's care experience also had an impact on their educational achievement. The majority of young people entered care aged 14, just before they started GCSE courses. Because of their disrupted childhoods, a number of young people were already struggling with their schoolwork when they entered care. In some cases, frequent moves to new placements also required moves to a new school. This left young people struggling to keep up because schools followed different curricula. Getting behind in their work also undermined young people's motivation and self-confidence. This had a bearing on their educational achievement; most young people left school with few or no qualifications.

Young people were deterred from continuing with their education or undertaking training by concerns about how they would support themselves during that time. Training and benefit allowances reflect an expectation that a young person will be living in the parental home, without the costs associated with independent living. Although young people could find part-time work to supplement their income they were discouraged from doing so because of the complicated rules on housing benefit. The interviews also revealed that a number of young people were poorly informed about their entitlement to benefits as care leavers. Both professional and informal support were crucial in enabling young people to overcome the difficulties

arising out of their childhood experiences and current circumstances in order to enter and remain engaged in employment, training or education. Young people benefited from help in finding out about their career options, developing plans and accessing opportunities. Young people who had emotional support fared better. This type of support ranged from: encouragement to apply for jobs or training; exhortation to stick at what they were doing; someone who was available when so much else in their lives was changing. Young people who had a history of being moved on were most in need of this type of support because they were most likely to drop out when life became challenging. In general, emotional support was provided by family - or substitute family - members, but some young people found this type of help from 'befriending' professionals, such as sessional workers, who did not have the statutory duties that the interviewees associated with social workers.

The circumstances surrounding the care leaver's transition to independence played a significant part in influencing his or her success. Being in settled circumstances after 16, such as accommodation, relationships and health, was associated with the likelihood of being in paid work or training schemes. Young people in secure accommodation - ideally living with family members, in a substitute family structure, or in supported housing - were more likely to enter and remain engaged in their chosen activity. Young people who had to cope with difficult issues and a significant amount of change after care struggled to stay in work or continue with a course of study. Factors that affected them included: substance abuse; ill-health; the breakdown of friendships and relationships; bereavement; and frequent house moves. Young people were more likely to be able to ride out these difficulties when they had the support of a significant other available to them.

Care leavers' self-reliance and attitudes to themselves were important factors in helping them to achieve a successful young adulthood. Attitudes to education were also important. These underwent a shift after leaving care when young people were exposed to the difficulties of obtaining reasonably paid work with few qualifications. Many of the care leavers expressed regret that they had not fared better at school and, in some cases, a desire to continue with their education in order to improve their future prospects.

In view of the adverse circumstances of their childhood, and in some cases, their experience in care, many of the young people showed remarkable resilience and

success in the transition to young adulthood. Faced with many more obstacles than their peers from stable backgrounds, they overcame financial difficulties, substance abuse, relationship breakdown and ill-health at the same time as they sought to find and hold on to settled housing, establish themselves in a new work or educational environment and 'keep house' for the first time.

While some young people succeeded, others struggled under the challenges and responsibilities they faced on leaving care. The findings point to a number of areas where developments in policy and practice may enhance care leavers' likelihood of a successful transition to young adulthood, these include:

- Improving the professional support available to young people, for example, by making it more appropriate to the care leaver's new, young adult status; by making it flexible and tailored to the young person's needs, and ensuring it is provided by a few professionals who are a consistent presence in the young person's life.
- Facilitating the development of young people's informal support networks.
- Tackling the numerous financial barriers to training and education, including barriers to resuming a basic education in later life or engaging with further study.
- Helping young people to be informed about and to access the range of benefits and support available to them on leaving care.
- Minimising disruption to the young person's education while in care and maximising their involvement while at school by ensuring schools follow the same curriculum; by helping a new pupil catch up with classmates; and by exploring new initiatives such as learning mentors.
- Developing strategies to address financial and practical issues arising out of living in a sparsely populated, rural area, including: young people's difficulties in keeping in touch with people when moved to new placements; the lack of local opportunities; and poor transport links.
- Developing support that tackles young people's emotional and behavioural problems before they become entrenched and enabling young people to build on the considerable resilience and self-determination they demonstrate both during and after care.

1. **What were the important factors which affected their care experience?**

2. **What did care experience affect?**

3. **Why were young people deterred from continuing with their education or undertaking training?**

4. **How could professionals support young people?**

5. **What factors affected young people who had a significant amount of change after care?**

Unit 4

AH 6

Exercise 3

Disadvantaged children 'at greater risk of adult mental health problems'

Children growing up in local authority care or in severely disadvantaged homes are at greater risk than others of experiencing emotional difficulties when they become adults, according to research supported by the Joseph Rowntree Foundation.

It concludes that a tendency towards adult depression and other psychological problems is more strongly associated with social deprivation or experiences of care during childhood than with the type of family - two parents, a lone parent or stepfamily - in which children have been raised.

Based on data from the National Children Development Study (NCDS), which tracked the lives of 17,000 people from birth to age 33, the research emphasises that only a small minority of children became prone to emotional problems as adults.

By separating out the 'structure' of the families in which children were raised (living with two birth parents, in a stepfamily, or with a separated or widowed lone parent) from the 'context' (growing up with severe disadvantage or an experience of care) the study found that:

- Differences in the level of risk of mental health problems were especially significant for those who had been taken into care as children, or those raised in socially deprived families with low incomes and inadequate housing.
- Among women, later difficulties were more strongly associated with past experience of severe disadvantage than having been in care. The reverse was true for men.
- Children who grew up in families with both birth parents - and who did not experience disadvantage or any placement in care - had fewer psychological

problems than others. Even so, family structure was generally less important in determining risk than the social context.

- The likelihood of psychological problems as an adult was also influenced by other factors as children grew up, regardless of family background. Those who gained qualifications and found jobs were at reduced risk; those who smoked and drank heavily were at added risk.

Family conflict

The study's authors, Ann Buchanan and JoAnn Ten Brinke from the University of Oxford's Department of Applied Social Science and Research, also examined links between early childhood circumstances and subsequent conflict with parents. They found that:

– While 23 per cent of children raised by both their birth parents reported serious disagreements at age 16, the same was true of 33 per cent of children in stepfamilies and more than half those living with a lone parent, whether separated or widowed.
– Conflict with parents was associated with an increased risk of psychological problems in adolescence and adulthood.

Attitudes to parenting and family life

When last interviewed at age 33, seven out of ten NCDS participants agreed it was acceptable to have children outside marriage. A majority also disagreed with the statement that 'couples who have children should not separate'.

Adults who had grown up in lone parent families were among the least likely to support a view that parents should always marry and never separate Ü as were working women and individuals with a high level of non-verbal skills or men with qualifications.

Satisfaction with life

Most 33 year olds reported high levels of satisfaction with their present lives. However, men who been in care during their childhood were significantly less content.

Women who were mothers by the age of 23 were significantly less satisfied with life than those who had no children. Moreover, when other factors were taken into account, those who had become parents by age 33 appeared no more satisfied with their lives than those who were childless.

Ann Buchanan said: "Generally speaking, children who were brought up by both birth parents to the age of 16 and who had no experience of care or early disadvantage enjoyed higher levels of life satisfaction, more family support, fewer psychological problems and less conflict as adults.

"However, the differences between these children and those who grew up in step families or with a widowed lone parent were not significant for most of the outcomes studied. Results for children raised in other lone parent families were more variable. But children who came from disadvantaged homes or who spent time in care - irrespective of family type - were the most vulnerable of all."

She added: "The vast majority of children did not develop emotional problems as adults. The study, nevertheless, highlights opportunities to prevent depression and other psychological disorders by offering early support to children and adolescents most at risk. Measures to improve the quality of care for young people being looked after by local authorities could yield particular benefits."

1. **What is a tendency towards adult depression and other psychological problems more strongly associated with?**
2. **What distinction does the report say about structure of family from the context?**
3. **What did the report say were the links between early childhood circumstances and subsequent conflict with parents?**
4. **Who were least likely to support a view that parents should always marry and never separate?**
5. **What does the report say about children who were bought up by both birth parents to the age of 16 and had no experience of care or early disadvantage?**