

Substance use
communication between
looked after young
people and formal carers:
A qualitative study

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Philosophy

Declaration

I, Hannah Carver, declare that this thesis is my own work and that no material contained in it has been submitted for another academic award.

A full list of references has been included, encompassing reference to parts of this work previously published: Carver, H., Elliott, L., Hanley, J., & Kennedy, C. (2016). Parent-child connectedness and communication in relation to alcohol, tobacco and drug use in adolescence: an integrative review of the literature. *Drugs: Education, Prevention and Policy* 27 (2) 119-133.

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Abstract

Background: Good parent-child connectedness, general and substance use specific communication are protective against alcohol, tobacco and drug use during adolescence. Previous research also suggests that general communication with foster and other statutory carers is associated with more positive outcomes, including relationships with caregivers and siblings. However, no studies have examined substance use specific communication between looked after young people and their carers.

Aims: The aim of this study was to gain an understanding of how carers and looked after young people communicate about alcohol, tobacco and drug use and the factors that shape communication, including the use of digital media.

Methods: A qualitative study was conducted, using in-depth interviews with 13 looked after young people in foster and residential care; two social workers; six foster carers and eight residential care workers. Interviews were audio-recorded, transcribed verbatim and the data were analysed thematically.

Findings: Relationships between carers and young people were crucial and acted as the antecedent to communication. Carers' role identity influenced their relationships with young people and their approach to and communication about substance use. Shared doing provided a way in which communication about substances could be facilitated in an environment which feels natural. The context in which communication occurred was important, with differences between foster and residential care. Digital media were viewed with caution, as something used to gain information about substances but not as a way of communicating with young people.

Conclusions: The findings have implications for foster carers and residential care staff working with looked after young people, in terms of relationships and communication about substance use. Carers should continue to develop

positive relationships with young people, whilst considering the potentially negative effects of conflicts in professional role identity. Techniques such as shared doing and encouraging natural conversations about substance use may help.

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Contents	
Abstract	3
Acknowledgements	5
Table of tables	10
Table of figures	11
Table of appendices	12
Glossary of Scottish terms	13
Glossary of Social Work Terms	14
Chapter 1: Introduction	18
Adolescence.....	18
Substance use.....	19
Risks of alcohol, tobacco and drug use.....	20
Positive perceptions of alcohol, tobacco and drug use.....	24
The Scottish perspective	25
Prevention and treatment of young people’s substance use and misuse.	27
Risk and protective factors	30
Connectedness and communication	31
Looked after young people.....	34
Foster and residential care in Scotland	39
Summary	44
Structure of the thesis	45
Chapter 2: Literature review	47
Background	47
Methods	48
Results	51
Connectedness.....	51
General communication.....	54
Substance use specific communication	57
Strengths and limitations of the review	64
Scientific rationale for the study.....	66
Professional role identity.....	69
Digital media use	74
Considering alcohol, tobacco and drug use together.....	75
Setting: foster and residential care	77
Examining connectedness and communication together.....	77
Examining how communication occurs.....	78
Aims and objectives of the study.....	79

Chapter 3: Methodology	81
Qualitative methodology	81
Rationale for choice of research methods	84
The research process.....	85
Identifying the study site and negotiating access to participants.....	85
Identifying potential participants for the research.....	87
Ethical considerations	92
Power imbalances	93
Informed consent.....	94
Confidentiality and disclosures	96
Recruitment.....	97
Recruitment of young people	97
Recruitment of carers	99
Conducting the interviews	100
Young people.....	100
Carers	102
Reflecting on the interview process.....	104
Rigour.....	108
Data saturation	110
Data analysis.....	111
Analytic approach	112
Transcription of interviews	114
Coding and theme generation.....	114
Introduction to the themes	118
Chapter 4: The influence of connectedness and professional role identity	121
The importance of relationships	122
Approaches to building relationships and trust.....	123
Relationships facilitate communication.....	128
Choosing your relationships	131
Role identity, communication and relationships.....	135
Summary of ‘the influence of connectedness and professional role identity’	139
Chapter 5: Constraints, boundaries and rules	140
Role identity, constraints and control.....	140
Being open about yourself.....	141
Conversations about your own substance use.....	143
Role identity, constraints and control.....	148

Different rules for different substances	156
Summary of ‘constraints, boundaries and rules’	167
Chapter 6: Doing communication.....	169
An introduction to the concept of ‘shared doing’	170
A less intense approach to communication	171
Creating an environment	175
The importance of context: differences between foster and residential care	183
Shared doing in foster care	183
Shared doing in residential care	186
Young people’s experiences of shared doing as communication	189
Digital media use as (not) shared doing	196
Shared doing and different substances	202
Summary of ‘doing communication’	204
Chapter 7: Discussion	206
Summary of the scientific rationale.....	206
Overview of the findings	207
1. How do carers and looked after young people communicate about alcohol, tobacco and drugs?	209
2. Which factors shape this communication?	215
3. To what extent do digital media play a part in this communication?	220
What this study adds to the existing evidence.....	223
Strengths and limitations of the study.....	227
Reflections on the use of qualitative methodology and the findings	229
Implications of the findings for policy and practice	234
Implications of the findings for future research	235
Conclusions	238
References.....	239
Appendices.....	287

Table of tables

		Page
1	Purposive sampling framework for young people	90
2	Purposive sampling framework for carers	91
3	Recruitment strategies for young people	99
4	Final sample of young people	99
5	Final sample of carers	100
6	Participant characteristics – young people	111
7	Participant characteristics – carers	112
8	Final themes and sub-themes	120

Table of figures

		Page
1	Examples of coding	116
2	Diagram of theme and sub-themes (the influence of connectedness and professional role identity)	121
3	Diagram of theme and sub-themes (constraints, boundaries and rules)	140
4	Diagram of theme and sub-theme (doing communication)	169

Table of appendices

	Page	
1	Publication resulting from PhD thesis	288
2	Flowchart of article selection	303
3	Tables of studies included in integrative review	304
	3.1 Connectedness	304
	3.2 General communication	307
	3.3 Substance use specific communication	311
4	Inclusion and exclusion criteria (Young People)	320
5	Inclusion and exclusion criteria (Carers)	321
6	Participant Information Sheet (Young People)	322
7	Consent form (Gatekeepers' consent for under 16s)	324
8	Consent form (Young People)	325
9	Consent form (Carers)	326
10	Flowchart for dealing with disclosures of sensitive information	327
11	Interview schedule (Young People)	328
12	Debrief sheet (Young People)	330
13	Summary of findings for participants (Young People)	332
14	Participant Information Sheet (Carers)	336
15	Interview schedule (Carers)	339
16	Debrief sheet (Carers)	341
17	Summary of findings for participants (Carers)	343
18	Example of field notes (Young Person)	347
19	Example of field notes (Carer)	348
20	Extract from a transcript	349
21	Example of memo	351
22	Extract from theme table used during data analysis	358
23	Diagram of themes and sub-themes	360

Glossary of Scottish terms

Annoyin'	<i>Annoying</i>	Loads	<i>Loads of</i>
Anythin'	<i>Anything</i>	Lotta	<i>Lots of</i>
Aye	<i>Yes</i>	Ma	<i>My</i>
Bein'	<i>Being</i>	Listenin'	<i>Listening</i>
Booze	<i>Alcohol</i>	Mare	<i>More</i>
Cannae	<i>Can't</i>	Maself	<i>Myself</i>
Cookin'	<i>Cooking</i>	Movin'	<i>Moving</i>
Cos	<i>Because</i>	Nah	<i>No</i>
Couldnae	<i>Couldn't</i>	Needin'	<i>Needing</i>
Dae	<i>Do</i>	No	<i>Not</i>
Dinnae	<i>Don't</i>	Nut	<i>No</i>
Doesnae	<i>Doesn't</i>	Pals	<i>Friends</i>
Doin'	<i>Doing</i>	Sayin'	<i>Saying</i>
Drinkin'	<i>Drinking</i>	Shockin'	<i>Shocking</i>
Dunno	<i>Don't know</i>	Shoulda	<i>Should've</i>
D'you	<i>Do you</i>	Shouldnae	<i>Shouldn't</i>
Everythin'	<i>Everything</i>	Smokin'	<i>Smoking</i>
Fag	<i>Cigarette</i>	Somethin'	<i>Something</i>
Feelin'	<i>Feeling</i>	Sorta	<i>Sort of</i>
Gettin'	<i>Getting</i>	Startin'	<i>Starting</i>
Givin'	<i>Giving</i>	Stayin'	<i>Staying</i>
Goin'	<i>Going</i>	Tae	<i>To</i>
Gonna/Gonnae	<i>Going to</i>	Talkin'	<i>Talking</i>
Hasnae	<i>Hasn't</i>	Tryin'	<i>Trying</i>
Happenin'	<i>Happening</i>	Wae	<i>With</i>
Havin'	<i>Having</i>	Walkin'	<i>Walking</i>
'Hing	<i>Thing</i>	Wanna/Wanta/Wantae	<i>Want to</i>
'Hink	<i>Think</i>	Wee	<i>Little</i>
Hurtin'	<i>Hurting</i>	Willnae	<i>Will not</i>
Junkies	<i>Drug users/addicts</i>	Wouldnae	<i>Wouldn't</i>
Ken	<i>Know</i>	Yeah	<i>Yes</i>
Kinda	<i>Kind of</i>	Yous	<i>You (plural)</i>
Knowin'	<i>Knowing</i>		

Glossary of Social Work Terms

Aftercare services

Local authority aftercare services provide advice, guidance and assistance for young people who have ceased to be looked after. The aim of these services is to provide support to make a successful transition from being looked after to independent adult living.

Care leaver

A care leaver is essentially a young person who is no longer eligible to be in a care placement. Local authorities have a statutory duty to prepare young people for when they leave care. Recently introduced legislation has increased access to aftercare services from 21 to 26 years.

Children's hearing

A children's hearing consists of panel members, who are trained volunteers from the local authority. They listen to the child or young person's views, as well as those of the family and considers information provided by others, such as social workers. The purpose of the hearing is to make a decision about what support and help is required and can make a compulsory supervision order, if necessary

Compulsory supervision order

A compulsory supervision order is a legal document which means that the local authority is responsible for a child or young person. The supervision order includes details about support, accommodation and contact.

Corporate parents

Corporate parenting is defined in the Children and Young People (Scotland) Act 2014 as: "the formal and local partnerships between all services responsible for working together to meet the needs of looked after children, young people and care leavers". Essentially, corporate parents are those who are accountable for the outcomes of these children, including local

authority social work, education and fostering services, the NHS, Police and elected members.

Foster care

Foster care provides young people with a temporary place to stay while their family is unable to care for them. Placements can be on a short or long terms basis. Local authorities can only place children with foster carers who have been approved by an agency registered with the Care Inspectorate. In the current study, these agencies were local authority and independent fostering organisations.

Kinship care

Kinship care is when a child is looked after by family members, such as grandparents, or close friends, within a formal kinship care arrangement with the local authority. Kinship carers are now paid an allowance to look after these children by local authorities.

Looked after at home

A child is looked after at home when they are placed under a supervision requirement but are still cared for by their parents at home. A local authority hearing panel will have decided that the child's welfare is best assured by living with their parents. Social workers and any other relevant partners must then work closely together as well as with the child and family to achieve to objectives for which the home supervision order was made.

Looked after away from home

Children who are looked after away from home are those who are placed with foster or kinship carers or in residential or secure care.

Looked after children and young people

Looked after children are those are those in the care of the local authority, either voluntarily or by court order, who are either looked after at home or away from home, in foster, kinship, residential or secure care. They are a particularly disadvantaged and vulnerable population.

LAC review

Looked after children's (LAC) reviews ensure that children and young people's needs are met. Reviews are a statutory requirement, ensuring that the local authority are fulfilling their obligations. Each review provides an opportunity to examine the child's needs at regular intervals; take into account parents' and children's views; assess the effectiveness of current plans; and formulate future plans.

Panel members

A panel member is a lay tribunal member who volunteers to sit on the Children's hearing. They play a vital role in making decisions in the best interests of looked after children and young people, to help improve their lives.

Residential care

Residential care homes, or units, provide young people a safe place to live away from their families. Residents live alongside a number of other young people in the home, cared for by staff who do not live on site. Most are run by local authorities, but the voluntary and independent sectors provide a range of residential services. As with foster care, residential units are inspected by the Care Inspectorate. Placements are temporary, on a short or long term basis.

Secure care

Young people are placed in secure care because they are a risk to themselves or others. They often have a range of complex needs, including mental health problems, learning disabilities, sexually harmful behaviour, sexual offences and violence. Secure residential care is similar to traditional residential care.

Throughcare services

Local authority provide advice, guidance and assistance for young people who are ceasing to be looked after. The aim of these services is to provide support to make a successful transition from being looked after to independent adult living.

Chapter 1: Introduction

The aim of this chapter is to provide an overview of the literature, serving as the background to the current study and introducing the need for such a study to be conducted in the current policy and research climate. In order to set the scene, adolescence and the use of alcohol, tobacco and drugs will be discussed. These substances will be considered, in terms of the risks of use, prevalence of use in Scotland and potential reasons for use by young people. Risk and protective factors, with regard to substance use by young people, will be introduced, which highlight the importance of the family in substance use initiation and ongoing use. The concepts of parent-child connectedness and communication will be discussed, as potential protective factors. The chapter will finish by looking at a particularly vulnerable group of young people in society, those who are looked after by the state. These young people have often grown up in difficult circumstances before being placed in care. In care, they require an environment in which they can develop and grow; thus connectedness and communication with carers may be essential to their future outcomes. The outcomes and lived experience of those in care will be discussed, to provide a background to the importance of the topic.

Adolescence

Adolescence is a distinct period of transition from childhood to adulthood, marked by physical, psychological and social changes, generally occurring between the ages of 10 and 19 years (World Health Organisation, 2015). Adolescence reflects a period in the life course in which young people experience greater independence and separation from parents; more autonomy; greater peer identification and acceptance; and more risk taking and experimentation (Christie and Viner, 2005; Op de Beeck, 2009; Romer, 2010; Santrock, 2007). It can be a time of both positivity and negativity, involving experimentation and testing boundaries (Offer, Ostrov, Howard and Atkinson, 1988).

Substance use

Adolescence is also the time during which most young people will first experience and experiment with substances, namely alcohol, cigarettes and drugs (Bonomo and Proimos, 2005; Howlett, Williams and Subramaniam, 2012; Mirza and Mirza, 2008). Young people use substances for a variety of reasons, which are often similar to, but can differ from, the reasons for which adults use such substances (Mirza and Mirza, 2008; Swadi, 2000). Most commonly, young people experiment with substances with peers, to satisfy their curiosity. They may also use substances more problematically: as a way of altering feelings and emotions, for pleasure seeking or to cope with stress and negative emotions (Mirza and Mirza, 2008; Swadi, 2000). Use may become habitual and regular, with accompanying behavioural problems; and finally, they can experience addiction to these substances, whereby they become tolerant to them and take them in order to feel normal (Mirza and Mirza, 2008; Swadi, 2000). Problematic use and addiction are rare during adolescence, with experimental use much more common (Bonomo and Proimos, 2005). For example, the most recent statistics in England show that just over 18,000 young people were accessing substance misuse treatment, compared to more than 288,000 adults (Public Health England, 2015, 2016). Later, the evidence regarding prevention and treatment will be discussed, which highlight the greater availability of and need for prevention than treatment programmes.

The earlier a young person uses substances, the more likely they are to use them more frequently and develop substance misuse problems (Bonomo and Proimos, 2005; Bremner, Burnett, Nunney and Mistral, 2011; Currie, Small and Currie, 2002; Feinstein, Richter and Foster, 2012; Mirza and Mirza, 2008). Alcohol, tobacco and drugs have very different use, risk and legal profiles. However, it is important to consider them together: young people tend to use more than one substance at a time (Fraga, Sousa, Ramos, Dias and Barros, 2011; Torabi, Bailey and Majd-Jabbari, 1993) so focusing on one substance does not necessarily reflect the reality of their use. These risks will be considered, as well as the positive perceptions of substance use, before moving onto consider the current situation in Scotland.

Risks of alcohol, tobacco and drug use

The use of alcohol, tobacco and drugs involves a range of different behaviours, practices, risks and outcomes. Each of these substances will be considered, detailing these factors, particularly in relation to young people's use.

There has been increasing concern in the United Kingdom (UK) regarding young people's drinking behaviour (Bremner et al. 2011; Coleman and Cater, 2005; Velleman, 2009). Alcohol use is a cultural phenomenon, and within Scotland, drinking is a common practice: more than 80% of adults report that they drink alcohol and almost half of men and a third of women exceed guidelines (Bromley et al. 2012). Exceeding recommended consumption is a public health concern: alcohol consumption has a detrimental effect on the entire human body, is a causative factor in more than 200 diseases and accidents, and is implicated in more than three million deaths each year (World Health Organisation, 2014). Alcohol is regarded as one of the most harmful substances, due to the high addictive potential, violent and aggressive behaviour, social harms, risk of ill health and death, and high costs to healthcare (Carhart-Harris and Nutt, 2013; Morgan, Muetzelfeldt, Muetzelfeldt, Nutt and Curran, 2010; Morgan, Noronha, Muetzelfeldt, Fielding and Curran, 2013; Nutt, King, Saulsbury and Blakemore, 2007; Nutt, King and Phillips, 2010).

Young people are rarely affected by the long term effects of alcohol consumption as diseases develop over a number of years (Newburn and Shiner, 2001), although there is evidence that rates of alcohol-related liver damage are increasing in young adults (British Liver Trust, 2013). They also do not view their alcohol consumption as affecting their health and wellbeing (Seaman and Ikegwonu, 2010). Young people tend to be affected by the acute harms of alcohol use, such as alcohol poisoning, facial injuries, drunkenness, accidents, involvement in drink driving and the consequences of risk taking (Coleman and Cater, 2003, 2005; Hayes, Smart, Toumbourou and Sanson, 2004). For young people, alcohol is often only perceived as causing harm when it is consumed frequently, at very high levels, with their

own use not usually being viewed as harmful (Fraga et al. 2011). Alcohol consumption is associated with crimes, particularly violent crimes (Plant and Plant, 1992) and with drug use (Newburn and Shiner, 2001).

Concerns regarding young people's alcohol consumption tends to focus on frequency and quantity (Coleman and Cater, 2005; Newburn and Shiner, 2001); when young people drink alcohol, their sole aim is to get drunk (Percy, Wilson, McCartan and McCrystal, 2011; Seaman and Ikegwuonu, 2010). Alcohol consumption can affect young people more negatively than adults and places them at increased risk of harm (Coleman and Cater, 2003; Newburn and Shiner, 2001): they are affected more quickly and severely by the effects of alcohol due to their smaller size; they experience greater intoxication; and they lack the experience of dealing with being intoxicated, putting them at increased risk of harm (Coleman and Cater, 2003; Newburn and Shiner, 2001). As young people are under the legal drinking age, they tend to consume alcohol in hidden places, particularly outdoors, rather than in licenced establishments, which can be more dangerous (Newburn and Shiner, 2001). Thus, alcohol consumption can be viewed as problematic, particularly when consumption exceeds recommended levels, due to the long and short term harms associated with its use. Concern around young people's consumption places their drinking within a viewpoint of something that should be prevented or minimised.

The use of tobacco, usually through smoking cigarettes, has been rated as more harmful than some illicit substances, including cannabis and ecstasy (Carhart-Harris and Nutt, 2013; Morgan et al. 2010, 2013; Nutt et al. 2007; 2010). Smoking has a different risk profile to other substances. It is highly addictive, hugely damaging to physical health, being implicated in large numbers of deaths and diseases (Morgan et al. 2013; Nutt et al. 2007). However, it is not associated with the same social and behavioural problems as alcohol and drug use (Plant and Plant, 1992). Smoking can also be harmful to others through passive smoking (Jayes, Britton, Vardavas and Leonardi-Bee, 2014). The problems associated with cigarette use do not manifest over the short term, with most deaths and diseases occurring in

later life (Plant and Plant, 1992). The use of cigarettes is strongly associated with the use of other substances, with many smokers also using alcohol and drugs (Fraga et al. 2011; Newburn and Shiner, 2001; Torabi et al. 1993). In recent years, there has been a marked increase in the use of electronic cigarettes, or e-cigarettes, by adults and young people (Dockrell, Morrison, Bauld and McNeill, 2013; Eastwood et al. 2015). Despite concerns about e-cigarette use encouraging young people to start smoking (Cooper, 2014), such use tends to be confined to those who are current smokers (Eastwood et al. 2015). Smoking increases with age and there is some evidence that cigarette use may act as a gateway to other substance use (Kandel and Kandel, 2015), although this is not always the case (Bonomo and Proimos, 2005). Thus, preventing young people from smoking is a key public health concern, given the high morbidity and mortality rates associated with tobacco use.

As with alcohol and tobacco, there is public concern regarding young people's drug use (Bonomo and Proimos, 2005; The Gallup Organization, 2011). It is important to acknowledge that the area of young people's drug use is complex. As the purpose of this thesis is not to look at drug use in depth, only a brief overview of these substances will be provided, to the same extent as the discussions above about alcohol and tobacco use. Despite being less common, drug use tends to be viewed as more dangerous than other substances, due to the perceived seriousness (Bonomo and Proimos, 2005). The use of illicit drugs is associated with serious health consequences, such as premature death, HIV and AIDS, mental health problems, increased risk of injury and high health care costs, as well as increased crime (Hawkins, Catalano and Miller, 1992; Plant and Plant, 1992). These consequences tend to be associated more with dangerous drugs, such as heroin. Drugs like heroin, cocaine and crack cocaine have been consistently rated as the most harmful illicit drugs (Morgan et al. 2010, 2013; Nutt et al. 2007; 2010). Despite drugs being viewed as the most harmful of substances, both alcohol and tobacco are more harmful to health than some drugs, particularly cannabis, the drug of choice of young people (Carhart-

Harris and Nutt, 2013; Meacher, 2013; Newburn and Shiner, 2001; Nutt et al. 2010).

Cannabis is the most commonly used drug by young people, in Scotland and worldwide (Currie et al. 2012; Wood et al. 2014), although regular use is less common (Bonomo and Proimos, 2005). Worldwide estimates suggest that 15% of girls and 22% of boys aged 15 years have tried cannabis, 6% and 12% of whom have used in the last month, respectively (Currie et al. 2012). Cannabis is viewed by young people as having less serious health risks than other drugs, such as heroin and cocaine (The Gallup Organization, 2011). Such a view is supported by experts, who rated cannabis as being more harmful than substances such as ecstasy and LSD, but less harmful than alcohol, tobacco, heroin, cocaine and crack cocaine (Nutt et al. 2007; 2010). Recent evidence suggests that cannabis use during adolescence is associated with later psychotic episodes (Gage et al. 2014), poor educational attainment (Silins et al. 2014) and increased risk of mental health problems, cognitive impairment and externalising and internalising problems (Currie et al. 2012).

Drug use during adolescence has some profound negative outcomes. Early initiation of drug use is associated with higher rates of use and misuse (Currie et al. 2012; Kung and Farrell, 2000). There is also the increasing concern regarding novel psychoactive substances (NPS), or 'legal highs', which are unregulated synthetic substances (Meacher, 2013). In Europe, 5% of young people have reportedly used legal highs; the rates were slightly higher in the UK, with 8% reporting that they had used these substances (The Gallup Organization, 2011). Concerns around NPS are due to the unregulated nature of these substances, and the lack of consistent information regarding short and long term harms (Meacher, 2013). In 2016, the Psychoactive Substances Act was introduced to limit the sale and distribution of NPS, in an attempt to reduce the number of young people using these substances (The National Archives, 2016).

Positive perceptions of alcohol, tobacco and drug use

Despite the previously mentioned risks associated with alcohol, tobacco and drug use, many people, including young people, continue to use these substances. Therefore, there must be reasons why people use substances that are known to be harmful to physical and mental health. Young people use alcohol, tobacco and drugs for a range of reasons. Alcohol use is viewed as an exciting, positive and pleasurable activity (Percy et al. 2011), which can increase confidence; reduce stress and enhance coping; and facilitate social interactions with friends (Boys, Marsden and Strang, 2001; Comasco, Berglund, Orelund and Nilsson, 2010; Fraga et al. 2011; Kuntsche, Knibbe, Gmel and Engels, 2005; Kuntsche et al. 2014; Percy et al. 2011). Alcohol use is viewed as an important part of teenage life, a normative behaviour that leads to social inclusion: those who do not drink can be excluded from peer groups (Percy et al. 2011). There is evidence that young people's alcohol consumption is affected by their motives for such use: those who use alcohol as a way of coping with problems or for social interaction tend to drink more and report more alcohol-related problems than those who use alcohol for other reasons, such as drinking to fit in or to gain respect from others (Comasco et al. 2010; Kuntsche et al. 2014). There is also evidence of variation between age groups and between countries: Kuntsche et al. (2014) found that younger age groups were influenced more by motives of enhancement and conformity, and less so by social motives in northern than in southern Europe, whereas the reverse was found for older ages.

There are several reasons as to why young people start and continue smoking. Tobacco use is often perceived by smokers as a positive activity, as a way of controlling weight and managing anxiety and to portray a particular identity and image (Scottish Executive, 2006). Müller and Schumann (2011) highlighted a number of positive effects of various substances; however, the only perceived benefits of tobacco use were in terms of weight loss and management. Cigarette use appears to have very limited benefits, which has also been highlighted by substance users in the study by Morgan et al. (2013), who viewed tobacco as high on harms and low on benefits.

Young people use drugs for the same reasons as they do alcohol and tobacco; for pleasure, to facilitate social interactions and fit in with friends, to block painful and traumatic memories and also to relieve stress and worry (Boys et al. 2001; Currie et al. 2012; Mirza and Mirza, 2008; Müller and Schumann, 2011). Experimentation with drugs predominantly occurs during adolescence (Plant and Plant, 1992; Viner and Macfarlane, 2005). There is evidence to suggest that cannabis users are as well-adjusted, in terms of social, health and peer outcomes, as those who do not use cannabis (Currie et al. 2012). Thus, young people will continue to use alcohol, tobacco and drugs, because they perceive them to have particular benefits.

The previously mentioned literature has highlighted the risks and harms associated with substance use, as well as the perceived benefits. The next section will examine the prevalence of alcohol, tobacco and drug use in Scotland, providing an understanding of the current context in which this research was situated.

The Scottish perspective

Many young people in Scotland report some form of substance use. Two surveys provide detailed prevalence rates of young people's substance use: the most recent Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS), which was conducted in 2015, provides data regarding smoking, alcohol use and drug use over time (Scottish Government, 2016c); and the 2009/2010 Health Behaviour in School-aged Children (HBSC) survey provides data from 43 countries across Europe and North America (Currie et al. 2012).

In Scotland, alcohol, tobacco and drugs each have different legal status: purchasing and consuming alcohol and tobacco is legal for those over the age of 18 years, while drugs are illegal to use, with exemption of NPS, with personal use being legal. In Scotland, young people grow up in a 'wet culture', whereby alcohol consumption is a normal behaviour which is often viewed as part of the transition from adolescence to adulthood (Hellandsjø Bu, Watten, Foxcroft, Ingebrigtsen and Relling, 2002; Newburn and Shiner,

2001; Seaman and Ikegwuonu, 2010). Scotland has some of the highest alcohol consumption in the world, being the sixth highest in terms of drunkenness before the age of 13 years (Currie et al. 2012). The most recent SALSUS survey shows that 45% of 13 year olds and 68% of 15 year olds have been drunk at least once, with 47% and 57% reporting drunkenness in the last week, respectively (Black, Setterfield and Murray, 2016a).

Since March 2006, smoking in enclosed public places has been banned in Scotland, resulting in considerable changes in the way in which cigarettes are sold (Scottish Government, 2013). While rates of smoking have reduced since these measures were introduced, considerable numbers of adults continue to smoke and small numbers of young people start smoking (Scottish Government, 2013; Wood et al. 2014). Despite rates being relatively low compared to some countries, such as Greenland, where more than half of 15 year olds smoke at least once a week, Scotland is one of the few countries with higher rates of smoking by girls than boys (Currie et al. 2012). Currently, 2% of 13 year olds and 7% of 15 year olds report being regular smokers and 1% and 3% report regular use of e-cigarettes (Black, Setterfield and Murray, 2016b).

Rates of drug use in Scotland are much lower than for alcohol and cigarettes, with 5% of 13 year olds and 19% of 15 year olds report having tried drugs (Black, Setterfield and Murray, 2016c). Currently, there is also a concern regarding NPS; 5% of 15 year olds report having tried NPS, compared to 17% who have tried cannabis (Black et al. 2016c). Interestingly, 27% of 13 year olds and 40% of 15 year olds report using alcohol at the same time as drugs (Black et al. 2016c), highlighting the importance of examining these substances together.

The literature presented so far suggests that substance use, particularly alcohol use, during adolescence is relatively common and increases with age. This is particularly true in Scotland, where alcohol use is common and perceived as a normal part of life. While most young people who use substances do not go on to develop substance misuse problems, there is

evidence that early initiation and increased use heightens their risk of developing subsequent problems, so there is a strong public health desire to prevent young people's alcohol, tobacco and drug use and misuse. Alcohol, tobacco and drug use are critical problems affecting the health and wellbeing of young people in Scotland (Jackson, Haw and Frank, 2011), the rest of the UK (Boys et al. 2001; Carney, Myers, Louw and Okwundu, 2014; Velleman, 2009) and beyond (Feinstein et al. 2012). While many young people do not develop problems, there is also some evidence regarding the types and effectiveness of interventions to treat such misuse. Therefore, the next section will examine the evidence regarding interventions to prevent and treat substance use and misuse by young people.

Prevention and treatment of young people's substance use and misuse

Early intervention to prevent or delay substance use in adolescence is a key public health priority because the earlier a young person uses alcohol, tobacco and drugs, the more likely they are to do so more frequently and to subsequently develop substance misuse problems (Bremner et al. 2011; Carney et al. 2014; Feinstein et al. 2012). Recommendations regarding prevention programmes include focusing on young people's motivations to use substances rather than trying to discourage use of a particular substance (Boys et al. 2001) and on a specific population, like young people, rather than on specific substances, as the route to dependence is similar across all substances (Ferri, Allara, Bo, Gasparrini and Faggiano, 2013). While the focus should be on young people's motivations rather than specific substances, some interventions do tend to discourage use of alcohol, tobacco or drugs. Zero-tolerance approaches in prevention programmes, which promote and expect abstinence from alcohol, tobacco and drugs, tend to be ineffective and can actually increase use (Toumbourou et al. 2007). Harm reduction approaches, on the other hand, recognise that some young people will experiment with substances and therefore attempt to teach strategies to reduce harm and negative consequences of use (Toumbourou et al. 2007). These approaches are effective in reducing harms but not always levels of use (Toumbourou et al. 2007).

Preventing or delaying young people's substance use and misuse can be a complex and often problematic task. The most effective method is through public health and Governmental policy, by restricting access to such substances through regulation, pricing, taxation and laws (Jackson et al. 2011; Toumbourou et al. 2007). Other interventions include those delivered through schools and the family. School-based programmes can be effective in preventing alcohol, tobacco and drug use. Programmes which utilise an approach based on social competence, social influence or social learning theory, which teach young people to develop the skills required to refuse offers of substance use, such as decision-making, problem-solving and social skills appear to be somewhat effective in preventing young people's alcohol, tobacco and drug use (Carson et al. 2011; Faggiano, Minozzi, Versino and Buscemi, 2014; Thomas, McLellan and Perera, 2013), whereas school-based policies appear to be ineffective (Coppo, Giordano, Buscemi, Bremberg and Faggiano, 2014).

Interventions which aim to reduce the use of substances and prevent substance misuse have also been evaluated within the school setting. Foxcroft and Tsertsvadze (2011b) concluded that generic approaches, which again teach young people specific social and cognitive skills, were more effective than alcohol specific approaches in preventing alcohol misuse. There is limited evidence to suggest that brief interventions within the school setting may be effective in reducing alcohol and drug use, but further research is required (Carney et al. 2014). Thus, school-based interventions to prevent and reduce substance use should teach young people the social, cognitive and life skills that may help them more generally, rather than focussing specifically on substance use.

There is also some evidence regarding family-based interventions in preventing and treating substance use. Interventions which encourage better family functioning and authoritative parenting styles as well as particular family based therapies appear to have some effect on substance use and misuse. Programmes and therapies, such as the Strengthening Families Programme, Preparing for the Drug Free Years, Multidimensional Family

Therapy and ecological-based family therapies, may be effective in preventing and reducing substance use and treating substance misuse (Baldwin, Christian, Berkeljon, Shadish and Bean, 2012; Bender, Tripodi, Sarteschi and Vaughn, 2011; Foxcroft and Tsertsvadze, 2011a; Gates, McCambridge, Smith and Foxcroft, 2009; Hogue, Henderson, Ozechowski and Robbins, 2014; Tanner-Smith, Wilson and Lipsey, 2013; Thomas, Baker, Thomas and Lorenzetti, 2015).

Carson et al. (2011) found that the most effective interventions in preventing smoking were those involving parents. Karki et al. (2012) also conducted a systematic review of family based interventions and concluded that the most effective interventions are those which involve parents and young people and aim to improve family functioning, support, monitoring, normative beliefs, social skills and self-efficacy. There is also limited evidence regarding the effectiveness of psychotherapies for preventing, reducing and treating substance use and misuse. Those based on motivational interviewing and cognitive behavioural therapy appear to have some effect on substance use outcomes (Altena, Brilleslijper-Kater and Wolf, 2010; Barnett, Sussman, Smith, Rohrbach and Spruijt-Metz, 2012; Bender et al. 2011; Hogue et al. 2014; Jensen et al. 2011; Rongione, Erford and Broglie, 2011; Stanton and Grimshaw, 2013; Tripodi, Bender, Litschge and Vaughn, 2010). Evidence is lacking, however, regarding the use of pharmacological treatment for young people's substance use (Minozzi, Amato, Bellisario and Davoli, 2014; Minozzi, Amato and Davoli, 2014).

Preventing and treating young people's substance use is complicated. Teaching young people appropriate life skills to help them deal with difficult events, offers of substance use and peer pressure along with population wide policies to deter substance use appear to be more effective than substance use specific interventions and treatments. There is a dearth of evidence on which to base these conclusions, however. The authors of these systematic reviews report that strong conclusions are difficult to draw, due to the lack of studies and poor quality evidence. Therefore, further research is required, using rigorous designs, to examine the effectiveness of interventions to

prevent, reduce and treat alcohol, tobacco and drug use and misuse. An examination of the risk and protective factors influencing substance use may provide greater insight into why young people start using alcohol, tobacco and drugs and what can be done to prevent and reduce such use.

Risk and protective factors

A wide range of risk and protective factors have been identified: risk factors are those which occur prior to substance use and are associated with an increased likelihood that substance use will occur, while protective factors mediate or reduce the likelihood (Hawkins et al. 1992). They fall into the categories of genetic susceptibility; individual personality traits, skills and behaviours; familial and parenting factors; school attendance and achievement; cultural norms, laws and availability of substances; and peer use (Bonomo and Proimos, 2005; Hawkins et al. 1992; Howlett et al. 2012; Jackson et al. 2011; Mirza and Mirza, 2008; Velleman, 2009). Evidence of the existence of these risk and protective factors has been corroborated across many longitudinal and cross-sectional studies and with diverse populations.

There are many risk and protective factors, but the family is one of the most influential and has received a great deal of attention in the literature. Parenting practices and the environment in which children are raised can have huge implications for their future outcomes, including their substance use behaviour (Coley, Votruba-Drzal and Schindler, 2008; Kingon and O'Sullivan, 2001; Velleman, Templeton and Copello, 2005). The family, and parents in particular, can act as both risk and protective factors in terms of substance use. Parents influence their children's knowledge, attitudes and expectations about substance use from a very young age (Dalton et al. 2005; Velleman, 2009). A recent report by the Institute of Alcohol Studies highlighted the important influence of parenting factors on the recent decline in underage drinking. Better parenting, through role modelling; parental approval; monitoring; warmth and openness of relationships; and family structure, was theorised as reducing young people's drinking (Bhattacharya, 2016). Of the seven theories suggested, declining affordability and better

parenting appear to be most influential in substantially reducing underage drinking in Scotland and England (Bhattacharya, 2016). Thus, the family plays a crucial role in terms of the substance use behaviours of young people, and one which is amenable to change through interventions.

It is important to note that the presence of such risk factors does not necessarily mean young people will use substances or develop problems (Velleman and Templeton, 2007b; Velleman, 2009); although there is strong support for a cumulative effect (Hawkins et al. 1992). If young people grow up in an environment in which there are poor parenting practices, access to substances, poor coping skills, and friends who use substances, they are more likely to start using substances, use them more frequently and go on to develop substance misuse problems. However, there are some who grow up in these environments who do not experience such problems, suggesting a complex relationship between these risk and protective factors. The next section will examine two factors which may be protective against young people's substance use.

Connectedness and communication

As mentioned above, factors relating to parents and families are some of the most widely researched and influential in terms of young people's substance use. Parents exert a great deal of influence throughout childhood, in adolescence and into adulthood, affecting knowledge, attitudes and behaviours around substance use (Velleman, 2009). Having good relationships with parents, which involve trust, warmth and love; suitable discipline; clear rules and expectations; open communication; supervision; spending time together; and suitable modelling of behaviours may be essential to young people's development more generally, as well as their substance use behaviours (Velleman, 2009). The concept of parent-child connectedness encapsulates these vital factors. Connectedness has received increased attention in social science in recent years and is highly relevant to current policy which prioritises early intervention within the context of the family (Jackson et al. 2011; Scottish Government, 2008).

The concept of connectedness has gained recognition in recent years due to its apparent protective effects in terms of the health and development of young people and human growth more generally (Barber and Schluterman, 2008; Townsend and McWhirter, 2005). Connectedness has been expressed in a variety of ways within the literature and a clear, universal definition is lacking (Barber and Schluterman, 2008; Townsend and McWhirter, 2005). Many types of connectedness exist, including to self, parents and family, friends, school, community, society and life purpose (Barber and Schluterman, 2008; Townsend and McWhirter, 2005). Due to the strong influence that parents have on their children's lives, the focus on connectedness in this study will be on parent-child connectedness.

Parent-child connectedness provides a vital way of conceptualising particularly important factors which influence young people's substance use. Parent-child connectedness has been described as feelings of closeness, warmth, love and satisfaction a child has with their parents, as well as in terms of relationships and bonds (Barber and Schluterman, 2008; Markham et al. 2010; Resnick et al. 1997; Townsend and McWhirter, 2005). While there is no consistent definition, for clarity, Lezin and colleagues' definition of connectedness has been adopted for this study. In their definition, parent-child connectedness is characterised "by the *quality* of the emotional bond between parent and child and by the degree to which this bond is both *mutual* and *sustained* over time" (emphasis in original) (Lezin, Rolleri, Bean and Taylor, 2004, p. 6). In the literature, connectedness has been measured in terms of feelings, satisfaction, affect, identifying with parents and particular parental behaviours (Barber and Schluterman, 2008; Townsend and McWhirter, 2005).

Barber & Schluterman (2008) highlight the apparent similarities between connectedness and attachment, but explain that there are important differences in terms of how these theories are assessed and conceptualised. The key difference is that attachment is often used to refer to a one-sided relationship between parent, often mother, and child, with the caregiver playing an active role; within connectedness, both parents and children play

active roles in the relationship (Lezin et al. 2004). Examining parent-child connectedness rather than attachment means that relationships with both parents can be examined, providing a wider examination of important relationships in young people's lives, which is not just limited to the mother, but instead extended to those in a parental role. Thus, parent-child connectedness was chosen as one of the theoretical frameworks in this study; it provides a way in which understanding can be gained regarding particularly influential factors in terms of communication, which will be discussed next.

Parent-child communication is a key part of connectedness (Lezin et al. 2004) and refers to the extent to which young people and parents feel they can talk to each other about a range of topics. Communication between parents and their children is an important element of parent-child connectedness as it appears to facilitate and improve bonds (King and Vidourek, 2011; Kingon and O'Sullivan, 2001). Two particular types of communication have been identified, which are influential in young people's substance use behaviours, namely general communication and substance use specific communication. General communication refers to conversations which cover general topics, such as activities, feelings and topics of interest (Ryan, Jorm and Lubman, 2010; Ryan et al. 2011). Substance use specific communication refers to targeted conversations about alcohol, tobacco and drug use that parents have with their children, covering a range of topics, such as depictions in the media, negative effects and risks of using substances (Ryan et al. 2010). These types of conversations are regularly promoted in prevention campaigns (Miller-Day and Dodd, 2004).

A balanced approach between parent-child connectedness, communication and other parenting factors is optimum, with adequate levels of supervision, good communication between parents and children, knowledge of young people's activities and rules regarding information provision as protective against substance use (Lippold, Greenberg and Collins, 2013; Wang et al. 2013). More specifically, the proposed protective effect of effective communication with parents is based on positive parent-child relationships

and family processes through which parents and children develop common values which are thought to reduce the risks associated with substance use (Nonnemaker, Silber-Ashley, Farrelly and Dench, 2012).

Thus, parent-child connectedness provides an important theoretical framework in which to contextualise parent-child communication. Within connectedness, effective communication can only occur when relationships are good. However, growing up in a family in which there are poor relationships and a lack of love and care from parents can have detrimental effects on young people's future outcomes, including substance use (Kington and O'Sullivan, 2001; Velleman, 2009). There are groups of young people within society whose family life is far from optimal, putting them at increased risk of poor outcomes in life. Before moving on to examine the evidence around parent-child connectedness and communication in terms of substance use, it is useful to first look at a group of young people who may find it difficult to benefit from these apparent protective factors due to their negative past experiences.

Looked after young people

Looked after children and young people are a particularly vulnerable population (Simkiss, Stallard and Thorogood, 2013). In the UK these young people are in the care of the local authority, either voluntarily or by court order; they can be looked after at home or placed with extended family, in foster care and residential care (Jones et al. 2011). In Scotland, rates have been increasing since 2001: in 2015 there were more than 15,400 looked after children and young people, with the majority being looked after in the community, by parents, extended family and foster carers (Scottish Government, 2016b). There are some differences in the proportion of looked after children and young people in each type of care placement in Scotland compared to other countries. For example, 25% of children and young people in Scotland live at home with parents, compared to four percent in England and seven percent in Australia (Australian Institute of Health and Welfare, 2015; Department for Education, 2016; Scottish Government, 2016). In the United States of America (USA), almost half of looked after young people

(45%) live in foster care, compared to 36% in Scotland and 35% in Australia (Australian Institute of Health and Welfare, 2015; Scottish Government, 2016; U.S. Department of Health and Human Services, 2015); in England, 74% of children and young people live in foster or kinship care (Department for Education, 2016). Thus, rates are generally comparable, with higher rates of young people living with parents in Scotland than in other countries. As Colton, Roberts, and Williams (2008) state, there has been a global shift towards foster care, with rates of residential care reducing; such a trend is apparent in Scotland (Scottish Government, 2015a). While there can be differences in terms of care settings, the ways in which children and young people are cared for and the challenges facing them and their carers are similar across the world (Blythe, Wilkes and Halcomb, 2014; Colton, Roberts and Williams, 2008; Colton and Williams, 1997).

There are varied reasons as to why these young people are removed from their parents, including physical, emotional and sexual abuse; neglect; parental substance misuse; parental mental health problems; domestic violence; and the imprisonment or death of a parent (Dregan and Gulliford, 2012; Jones et al. 2011; Lipscombe, Farmer and Moyers, 2003). For these young people, life has been extremely difficult. The effects of their negative past experiences as well as experiencing difficulties when being placed in care can affect their physical and mental health, as well as future outcomes around education, relationships, substance use, among others (Jones et al. 2011).

Looked after young people have been found to have poorer physical health (Farruggia and Sorkin, 2009; Sullivan and van Zyl, 2008) and higher rates of mental health problems than the general population (Havlicek, Garcia and Smith, 2013; McAuley and Young, 2006). Rates of psychiatric disorders, conduct disorders, anxiety and depression are higher in looked after young people (Blower, Addo, Hodgson, Lamington and Towlson, 2004; Dregan, Brown and Armstrong, 2011; Pilowsky and Wu, 2006). Rates of mental disorder are higher than in the general population: 35% of 11-15 year olds in

care had a conduct disorder, compared to only 6% in the general population (Meltzer, Lader, Corbin, Goodman and Ford, 2004).

Young people in care also have more difficulties in developing relationships, poorer attachment and higher rates of challenging behaviours (Lipscombe et al. 2003); poorer school engagement and more academic difficulties (Meltzer et al. 2004; Pears, Kim, Fisher and Yoerger, 2013; Shin, 2003); and higher rates of arrests and delinquent behaviours (Cusick, Havlicek and Courtney, 2012; Grogan-Kaylor, Ruffolo, Ortega and Clarke, 2008; Ryan, Testa and Zhai, 2008). There is evidence that of all looked after young people, those in residential care fare worst, followed by those in foster care, while those who are looked after by family or have been adopted tend to have the best outcomes (Dregan and Gulliford, 2012; Farruggia and Sorkin, 2009; von Borczyskowski, Vinnerljung and Hjern, 2013). Residential care is often viewed negatively, with the young people who are placed in such settings viewed as problematic (Abrams, 1998). Residential care settings will be discussed in more detail later in this chapter, along with foster care.

As von Borczyskowski et al. (2013) note, the factors which increase the risk of substance misuse in adults are also the reasons that many children are placed in care. Looked after young people report higher rates of substance use than the general population (Backović, Marinković, Grujlčić-Šipetić and Maksimović, 2006; Cheng and Lo, 2010a, 2010b; Dregan et al. 2011; Goldstein et al. 2011; Kepper, Monshouwer, van Dorsselaer and Vollebergh, 2011; Kepper, van den Eijnden, Monshouwer and Vollebergh, 2014; McCrystal, Percy and Higgins, 2008; Thompson and Auslander, 2007; von Borczyskowski et al. 2013; Ward, 1998), although some reports suggest that rates of alcohol use are similar to those of the general population (Backović et al. 2006; Goldstein et al. 2011). These young people are also at increased risk of developing substance misuse problems (Blome, Shields and Verdieck, 2009; Braciszewski and Stout, 2012; Narendorf and McMillen, 2010) and report initiation of drug use at an earlier age (Backović et al. 2006; Blome et al. 2009; McCrystal et al. 2008; Ward, 1998) than the general population. Given what is known about early initiation, higher rates of use and associated

problems, it appears that looked after young people are particularly vulnerable in terms of substance use.

Children and young people are placed in care for a variety of reasons. Prior to entering the care system, their lives would have been marked by a number of negative experiences and circumstances (Jones et al. 2011). Life has been a challenge for these young people: they may have experienced neglect; physical, sexual or emotional abuse; parental substance use or mental health problems; domestic violence; parental death; involvement in the criminal justice system; complex disabilities; poor family relationships; and other factors which impede parents caring for them (Centre for Excellence for Looked After Children in Scotland, 2014; Jones et al. 2011). Children and young people in care have experienced difficult childhoods; some of these experiences are so traumatic that they are unable to talk in detail about them and have significant effects on their mental health (Mullan, McAlister, Rollock and Fitzsimons, 2007). They talk of a loss of childhood, being failed by parents and of being abandoned (Mullan et al. 2007).

These experiences are reflected in the literature pertaining to the reasons for which children and young people are placed in care, such as sexual abuse, parental mental health problems, domestic violence, parental death and parental substance misuse problems. Basic needs, such as food, clothing and warmth, may have been neglected (Backett-Milburn, Wilson, Bancroft and Cunningham-Burley, 2008; Bancroft, Wilson, Cunningham-Burley, Backett-Milburn and Masters, 2004; Cleaver, Unell and Aldgate, 2011; Wales, Gillan, Hill and Robertson, 2009). Parenting may be inconsistent or neglectful, communication can be poor and relationships are often strained or non-existent (Bancroft et al. 2004; Barnard and McKeganey, 2004; Ellis, Dowrick and Lloyd-Williams, 2013; Lee and Whiting, 2007; McGee, 2000; Velleman and Templeton, 2007b). Taking on caring roles from an early age is common; children and young people are expected to look after younger siblings, and sometimes their parents, and may take on difficult and inappropriate tasks (Backett-Milburn et al. 2008; Bancroft et al. 2004; Corbett, 2005; Gladstone, Boydell, Seeman and McKeever, 2011; Kroll,

2004; Trondsen, 2012; Velleman and Templeton, 2007b). This role reversal can lead to feelings of guilt, resentment, confusion, and may contribute to their feelings of a lost childhood (Bancroft et al. 2004).

Fear is a common experience for these children and young people: of abuse; parents' moods and worsening mental illness; parents' suicide, death or disappearance; violence; and separation from parents (Bancroft et al. 2004; Foster and Hagedorn, 2014; Gladstone et al. 2011; Kroll, 2004; McGee, 2000; Trondsen, 2012; Velleman and Templeton, 2007b). Their lives are often marked by disruption, uncertainty, confusion, instability and unpredictability, due to parents' mental health or substance misuse problems, abuse or parental death (Backett-Milburn et al. 2008; Bancroft et al. 2004; Cleaver et al. 2011; Gladstone et al. 2011; Kroll, 2004; Mallon, 2011; Templeton, Velleman, Hardy and Boon, 2009; Trondsen, 2012; Wales et al. 2009). These studies highlight the stressful, challenging, chaotic and distressing nature of the lives of some children and young people prior to being placed in care. Being placed in care can itself be a traumatic and chaotic experience; there can be confusion about the reasons for placement and young people can feel they are lacking control and normality in their lives (Lee and Whiting, 2007; McAuley and Young, 2006; Mullan et al. 2007). Thus, these young people have experienced a number of challenges and difficulties prior to being placed in care, as well as the traumatic experience of becoming looked after.

Life for young people after they have left their care placement can also be difficult. Young people are expected to enter adulthood, and therefore fend for themselves, at a much earlier age than their peers (Stein, 2005). Young people have reported experiencing problems in terms of a lack of support; feelings of loneliness, isolation and abandonment; poor or unsuitable housing; financial concerns; and lack of employment and education opportunities (Duncalf, 2007; Rainer, 2007; Stein, 2005). There are concerns that these young people are leaving care unprepared for life (Duncalf, 2007; Soldevila, Peregrino, Oriol and Filella, 2013). Fortunately, recent legislation in Scotland has been introduced to improve outcomes for young people in care.

The Children and Young People (Scotland) Act 2014 will ensure that those leaving care at the age of 16 will have immediate access to aftercare services; that the age in which care leavers are entitled to aftercare support is increased from 21 to 26 years; and that those born after 1999 will be able to stay in care until the age of 21 years (Scottish Government, 2015c). In England, young people are entitled to support until the age of 21 years (UK Government, 2017); in USA, most young people leave care at the age of 18 years (Children's Rights, 2017).

Foster and residential care in Scotland

As mentioned previously, young people can be looked after in a range of settings, including at home, with family, in foster care and in residential care. In the current study, the focus was on foster and residential care; the reasons for this choice will be outlined in detail in subsequent chapters. Therefore, in order to provide context to the lives of young people in care, it is important to examine the current situation of foster and residential care in Scotland, where the study was conducted. In the most recent estimates in Scotland, of the 15,404 children and young people who were looked after in 2015, 5478 were placed in foster care and 564 were living in a local authority home (Scottish Government, 2016b). The majority of the remainder were living at home with parents or with friends or family, with a minority placed with prospective adopters, or other residential care (Scottish Government, 2016b).

Placing children and young people into care has a long history in Scotland. From the early 1800s, children and young people were moved from town and city centres to new homes in rural areas as a way of dealing with poverty; they were 'boarded out', being sent to live with foster families (Abrams, 1998). The middle class image of family was viewed as optimal for bringing up children, resulting in traditional residential care, orphanages and institutions, being considered second-rate (Abrams, 1998). Estimates suggest that approximately 60,000 young people lived in residential care in Scotland between 1880 and 1940, although true numbers are difficult to estimate as these institutions were unregulated (Abrams, 1998). There has been a steady decline in the number of children and young people in

residential care since the 1950s, while numbers placed in foster care and with prospective adopters have increased (Abrams, 1998; Scottish Government, 2015a).

As mentioned previously, residential care is often viewed as a “last resort option”, with family based care being prioritised (Emond, 2003, p. 322). Young people who are placed in residential care are viewed as being the most troubled and difficult, with challenging behaviours and numerous placement breakdowns (Emond, 2003; Gallagher and Green, 2012; Smith, 2009). Numerous abuse cases by staff working in residential care have given this type of care setting a negative image (Colton and Roberts, 2007). Fortunately, improvements in inspections and care standards have attempted to prevent such abuse occurring in the future (Milligan, Kendrick and Avan, 2004).

Despite the often negative view of residential care, it can be viewed as a positive resource by the young people who are placed there. Emond (2003) conducted an ethnographic study in two residential units in Scotland to understand the relationships between young people. The young people talked about the provision of support and advice from the other young people in the unit; being with other young people who had similar experiences and understanding of their lives was particularly important (Emond, 2003). Relationships between young people and staff in residential care appear to be important, but particularly problematic (Emond, McIntosh and Punch, 2014; Kendrick, 2013; Mason, 2008; Smith, 2009). Smith (2009) discusses the complexity of developing relationships in residential care: enabling young people to develop relationships with supportive adults is one of the key aims of residential care. However, professionalism and boundaries can mean that building such nurturing relationships is problematic. Residential care staff’s work is driven now by outcomes, rules and regulations, meaning that building intimate, loving relationships is viewed as inappropriate, despite such relationships being considered essential to young people’s wellbeing (Smith, 2009). Building relationships with young people in their care can be a difficult task for residential care staff; the highly stressful environment in which they

work and associated high rate of burnout can have a profound negative impact on the quality of care they provide and the relationships they have with young people (Heron and Chakrabarti, 2002).

Conversely, Kendrick (2013) argues that residential care is not necessarily a negative experience for young people, and many develop good relationships with their carers. These positive experiences and good relationships are often articulated by young people as like being part of a family. While residential care staff might take on the roles and responsibilities of parents, it is very clear that they are not the parents. However, the introduction of 'corporate parenting' suggests a somewhat parental role in residential care (Kendrick, 2013). A definition of corporate parents is provided in the Glossary of Social Work terms (page 13). Thus, relationships between young people and staff in residential care are complex but necessary to the wellbeing of both parties.

The aim of foster care is to provide children and young people with a permanent substitute family until they leave care (Biehal, 2014). However, enabling those in foster care to develop relationships with foster carers can be particularly difficult given their negative past experiences, disordered relationships and attachment issues (Biehal, 2014). Young people do appear to value their relationships with foster carers and social workers, particularly when they are characterized by reliability, everyday acts of kindness and caring and are sustained over time (Holland, 2010; Mason, 2008). Young people's sense of belonging in foster care can vary, with Biehal (2014) identifying different patterns in her qualitative study with 13 young people. Some young people viewed their foster carers 'as if' they were their parents, with a strong sense of attachment and love; others felt 'just like' part of the foster family, whilst also belonging to their birth family; some young people experienced confusion and ambivalence regarding their place within the foster family, feeling both rejection and loyalty to their birth parents (Biehal, 2014).

Foster care can also be both a beneficial and a difficult experience for the foster carers; they describe their experience of fostering as rewarding and fulfilling, with the experience of caring, feeling useful and being respected as motivating (Blythe, Halcomb, Wilkes and Jackson, 2013; Blythe et al. 2014). They tend to be motivated by altruism, wishing to provide a better life for these children and young people (Blythe et al. 2014; Delfabbro, Taplin and Bentham, 2002; Kirton, 2001; MacGregor, Rodger, Cummings and Leschied, 2006; Wilson and Evetts, 2006). They do, however, experience a range of negative emotions and events throughout the course of fostering, including stigma, hostility, stress, fear, grief, lack of trust, lack of emotional support from professionals and the difficulties in dealing with challenging behaviours (Blythe, Jackson, Halcomb and Wilkes, 2012; Blythe et al. 2014; Farmer, Lipscombe and Moyers, 2005; MacGregor et al. 2006).

One of the most widely discussed issues within the literature is whether foster carers regard themselves as professionals or parents (Blythe et al. 2013, 2014; Colton et al. 2008; Hollin and Larkin, 2011; Kirton, 2001; Kirton, Beecham and Ogilvie, 2007; Kjeldsen and Kjeldsen, 2010; Schofield, Beek, Ward and Biggart, 2013; Wilson and Evetts, 2006). Their identity appears to be dependent on the type of care they provide, with short term foster carers viewing themselves as professionals and those providing long term care as parents (Blythe et al. 2012, 2013).

The relationships that looked after children and young people have with their social workers are also of importance. Social workers are viewed as having an important role, being responsible for many aspects of these young people's lives (Leeson, 2010). Good social workers are described as being supportive, trustworthy, honest, reliable, accessible, and approachable, as an ally who will not abandon those they are responsible for (McLeod, 2010; Munro, 2001). While some social workers are considered to have an important role in their lives, the young people in Holland's (2010) study rarely mentioned social workers as people with whom they had relationships. Young people spoke of having numerous social workers throughout the time that they have been in care, having little time to build up a relationship with

them (Holland, 2010; Munro, 2001). Feelings of abandonment, lack of caring and being of low priority to social workers led to young people perceiving them as minor, if not negative, people in their lives (Holland, 2010; McLeod, 2010; Munro, 2001). Social workers report struggling to spend enough time with the children and young people they are responsible for (Leeson, 2010); Holland (2010) recommends that social workers should be given more time to spend with young people in order to build good relationships with them.

The abovementioned research provides an insight into the difficult lives of the children and young people who enter the care system. These studies highlight the importance of providing an effective, nurturing environment in which these children and young people can develop, grow and mature. Therefore, it seems that developing good relationships and bonds, or connectedness, as well as good communication, will be vital for this population. Young people in the study by Mullan et al. (2007) talked about the importance of supportive relationships from family and professionals whilst in care; having a good relationship with a looked after young person was facilitated by being friendly and approachable, having good listening skills and knowing them well. Providing these relationships to children and young people in care can significantly improve their lives, in the present and the future (Drapeau, Saint-Jacques, Lépine, Bégin and Bernard, 2007).

Carers' own identities and professional boundaries, however, can affect these relationships. The studies mentioned above suggest that good relationships are crucial to young people's experiences of care and future outcomes; that relationships need to be sustained over time; that carers need to be reliable; and that spending time together is vital to developing good relationships. All of these factors related to relationships are suggestive of connectedness, of bonds which are high quality, mutual and sustained over time (Lezin et al. 2004). Therefore, it appears that the concepts of connectedness and communication may be vital in the lives of children and young people in care, in improving their lives and reducing negative outcomes, including substance use. However, these young people often

have difficulties in developing relationships with those who care for them (Biehal, 2014).

Summary

This chapter has provided an introduction to the topic of adolescent substance use, highlighting the key concepts and issues. Young people's substance use is typically viewed as a normal part of growing up, but delaying initiation has clear public health benefits. Parents play a crucial role in these substance use outcomes, and parent-child connectedness and communication are two particularly important factors to consider. However, for looked after children and young people, their experience of growing up in difficult circumstances and negative past experiences have a detrimental impact on their ability to develop trust and relationships with caregivers. Relationships with supportive adult caregivers, nevertheless, are important to them and are essential to their future wellbeing (McLeod, 2010). Looked after young people are particularly vulnerable in terms of increased risk of substance use. The relationships they have with their carers, and the conversations which take place about substance use, may be important.

The literature presented above provides context regarding young people's substance use in Scotland, the factors which influence their use as well as current policy around prevention. Connectedness and communication are two important factors which affect young people's likelihood to use alcohol, tobacco and drugs. However, for some young people, relationships with parents are difficult or non-existent and care is provided by someone else, a professional. The literature has also shown that relationships within foster and residential care are critical to young people's experiences of care and future outcomes, but often challenges arise in developing these relationships. Based on the existing literature and policy, the study reported in this thesis was necessary for several reasons. Looked after young people are some of the most vulnerable in society, with higher rates of substance use and misuse, so determining ways to improve their outcomes is hugely important. Policy has focused on developing relationships between young people and carers, but some young people still report experiencing challenges with these

relationships; connectedness can provide a theoretical framework to understand these relationships and other factors.

As the findings of the integrative review detailed in Chapter 2 will show, very little research has examined connectedness and general communication within this population, and no studies have examined substance use specific communication. Most studies have examined adoptive or foster families, rather than residential care. It is important to examine residential care settings because some of the most vulnerable young people reside here; also, there is evidence that some young people do actually view these units as homes, and the staff as family. Therefore, it is essential to gain an understanding of how communication about substance use occurs within the settings of foster and residential care, as well as how connectedness and other potential factors shape this communication. The insight gained from this study can potentially improve communication about general topics and substance use and relationships between carers and young people, in a group of young people for whom relationships and communication can be a particular challenge. Thus, this study was conducted to examine how carers and young people communicate about substance use, as well as how particular factors, such as carers' identities and relationships shape this communication.

Structure of the thesis

This thesis is divided into seven chapters. This introductory chapter provided an overview of the relevant literature and policy, in order to situate the study and provide a contextual summary as to why this study was necessary. Chapter 2 will present the findings of an integrative review, to examine whether connectedness and communication are protective against substance use in adolescence, in general and looked after populations. This chapter will detail the evidence regarding connectedness and communication in delaying and reducing young people's substance use. A number of factors will also be introduced, as part of the scientific rationale of the study, which challenge the notions of communication and connectedness within the population involved and the context in which this study was conducted. Chapter 2 ends with the

study rationale and research questions. Following this, Chapter 3 details the methodology used in conducting the study, in terms of research decisions, data collection and data analysis. The findings of the study are presented in Chapters 4 to 6. Three major themes are detailed in each of these chapters. These chapters are presented in a different order to the research questions for a particular reason: during engagement with the literature, in the interviews and during data analysis, it was clear that relationships are essential, they act as an antecedent to communication. Therefore, the findings related to relationships and the associated constraints and boundaries are presented prior to the theme of 'doing communication'. Finally, Chapter 7, the discussion chapter, presents the key findings, implications to practice and future research, the strengths and limitations of the study and finally, the conclusions which can be drawn.

Chapter 2: Literature review

An integrative literature review was conducted to examine the influence of parent-child connectedness, general and substance use specific communication on young people's alcohol, tobacco and drug use. The findings of this review have been published in an edited form, in the journal *Drugs: Education, Prevention and Policy* (Carver, Elliott, Kennedy and Hanley, 2016), which can be found in Appendix 1. The background and rationale for this review is explained first, followed by the methods used to conduct the integrative review. The findings of the integrative review are then presented, followed by a discussion of the gaps. The scientific rationale for the study will then be presented, which highlights several circumstantial factors that are unique to conducting research with the populations and in the context of the current study. These factors are professional role identity; digital media use; the examination of connectedness and communication; the setting of foster and residential care; the examination of alcohol, tobacco and drug use; and the examination of how communication occurs. Finally, this chapter ends with the aims of the study and the research questions.

Background

In Chapter 1, the concepts of connectedness and communication were introduced, as potential protective factors affecting young people's substance use. Previous reviews of the literature provide evidence regarding the potential protective effects of connectedness and communication against substance use during adolescence. Kingon and O'Sullivan (2001) examined family factors as protective assets during adolescence, across a range of health behaviours. Connectedness, which was identified under the 'family support' asset, was shown to be protective against all alcohol, tobacco and drug use and suicidal ideation. General communication was found to be protective in terms of smoking prevention, condom use, and depression; however, substance use specific communication was not evaluated by the authors. Ryan et al. (2010) conducted a systematic review to examine parenting in relation to alcohol use and found that general communication

was protective; there was a lack of evidence regarding communication about alcohol use. The findings were limited to alcohol use and studies which used a longitudinal cohort design; they also did not examine connectedness.

The findings of these two reviews are rather limited: connectedness and communication were considered separately, despite an important interaction between the two concepts (Lezin et al. 2004) and they fail to integrate both concepts and all three substance use behaviours, of alcohol, tobacco and drug use. It is essential to examine all three substances together, as young people tend to use more than one substance at a time (Fraga et al. 2011; Torabi et al. 1993). These studies also did not consider more vulnerable populations. For looked after young people, relationships with parents are difficult or non-existent and care is provided by professionals. These two protective factors, connectedness and communication, may be important in the lives of young people in care, but these previous reviews have failed to examine such populations.

An integrative review of the literature was conducted to answer the following question: what is the relationship between parent-child connectedness and communication and young people's substance use? This question was broad in order to examine the literature in both mainstream and looked after young people's populations, given that connectedness and communication do not necessarily have to occur with a biological parent, but instead with someone in a parental role. Connectedness, general and substance use specific communication were examined to provide a detailed picture of the influence of these three interconnected protective factors.

Methods

Using the method outlined by Whitemore and Knafel (2005) for conducting integrative literature reviews, a comprehensive search of the literature was conducted. Six health and social science databases were searched between December 2013 and August 2014 for relevant literature and searches were re-run in March 2016. Search alerts were also set up for each of the databases, in order to ensure all of the available literature were included in

the review. The databases and the date parameters were PsycINFO (1980-2016), Psychology and Behavioral Sciences Collection (PBSC; 1945-2016), Applied Social Sciences Index and Abstracts (ASSIA; 1950-2016), Cumulative Index to Nursing and Allied Health Literature (CINAHL; 1945-2016), Medical Literature Analysis and Retrieval System Online (MEDLINE; 1945-2016) and Web of Science (1900-2016). Key search terms were identified using Google Scholar, from the key words in relevant review papers and from discussions with the Subject Librarian. The key words used were: parent-child connectedness; parent-child communication; parent-adolescent connectedness; parent-adolescent communication; parent-child relationships; parent-child bonds; alcohol; alcohol use; alcohol drinking; binge; intoxication; drug; smoking; cigarette; tobacco; substance use.

The inclusion criteria were (i) young people (aged 10-19 years of age; this age reflects the World Health Organisation definition of adolescence (World Health Organisation, 2015)) (ii) English language; (iii) peer-reviewed journal articles; (iv) original research, using any study design; (v) related to smoking or alcohol or drug use; and (vi) related to parent-child or caregiver-child connectedness or general communication or substance use specific communication. As there is a lack of universal definition of parent-child connectedness, a decision was made to include studies which involved research into emotional bonds and relationships with parents. Barber and Schluterman (2008) note that the concept of attachment is assessed in an entirely different manner to connectedness and related concepts. For this reason, studies examining attachment with parents or caregivers were excluded. Reference lists of relevant papers were also searched for potentially useful studies.

In total, 84 articles were included in the review; the details of the literature search process are presented in Appendix 2. Of these studies, 34 used a longitudinal survey design, with one also including an observational task, involving a discussion of everyday life, a problem solving task and a discussion of cigarette smoking; 33 used a cross-sectional survey design, with five also including an observational task. In three studies, this task

involved an inkblot task and a story, in which family members had to come to an agreement regarding the outcome; in another, the task involved a fun family activity followed by a discussion of and an attempt to resolve a particular family issue; and in the fifth, a discussion of a conflict topic and a discussion of substance use. Fourteen studies were qualitative, utilising mostly individual interviews, with either young people or parents; and three papers reported on four interventions. One paper included two interventions, one which aimed to improve connectedness and the other general communication. One paper is included in terms of both connectedness and general communication, as it presents the results of two interventions which aimed to improve relationships and general communication.

Including both qualitative and quantitative studies, despite their different approaches and analyses, should provide a deeper and more comprehensive understanding of the topic (Whittemore and Knafl, 2005). Forty-two studies were conducted with young people only; 34 with parents/carers and young people; four with young people and mothers; and four with parents only. The follow-up period from the longitudinal studies ranged from one to 14 years, with most having two or four year follow up periods. The vast majority of studies, 49 in total, were conducted in the USA. The remainder were conducted in the Netherlands (n=18), the United Kingdom (n=7), Italy (n=3), Canada (n=2), New Zealand (n=1), Australia (n=1); United Arab Emirates (n=1), Vietnam (n=1), and a multi-national study conducted in Canada, Italy and France (n=1). Of the studies identified, 71 papers involved young people from more mainstream populations, and 13 were conducted with young people in foster or adoptive care.

Papers were rejected if they did not meet the inclusion criteria. For example, papers which examined college age students were excluded, as the focus was on those aged 10-19 years; those which examined attachment were also excluded, as the focus was on connectedness. Papers were initially divided into three subject areas, connectedness, general communication and substance use specific communication, and examined separately. Within these subgroups, papers were examined in terms of the methodology used;

cross-sectional and longitudinal survey studies were considered independently of qualitative studies.

The key features of each paper, such as sample size, methods used and outcomes measured, were recorded in a database, to assess the quality of the literature. Whitemore and Knafl (2005) highlight the difficulty of quality appraisal in integrative reviews, as studies with different research designs are often included in one review. The quality of quantitative and qualitative studies were assessed separately using the tools developed by Crombie (1996) and Critical Appraisal Skills Programme (2013) respectively. Each paper was read several times to extract the key findings, which were coded and entered into a database to allow for comparison. These codes were then compared to identify patterns and similarities and differences were identified within these patterns. Finally, major themes were identified and then synthesised, to provide a “comprehensive portrayal of the topic of concern” (Whitemore & Knafl, 2005, p. 551). The findings of the review are presented in terms of the three concepts: connectedness, general communication and substance use specific communication.

Results

Connectedness

Twenty studies examined the association between parent-child or caregiver-child connectedness, relationships or emotional bonds and substance use. Studies measured connectedness and the related concepts in terms of feelings of closeness, love, care and warmth; talking to parents or carers about problems or when upset; relying on parents or carers if required; spending time together; attention from parents or carers; understanding of needs; and satisfaction with relationships. Eleven of these studies specifically measured connectedness; nine examined bonds, closeness and quality of relationships with parents. However, all studies used similar measurements to examine these concepts. Table 3.1 in Appendix 3 provides details of these studies.

High levels of connectedness and high quality relationships were associated with lower rates of alcohol use, binge drinking and drunkenness (Ackard, Neumark-Sztainer, Story and Perry, 2006; Arunachalam and Nguyen, 2015; Resnick et al. 1997; Stevens-Watkins and Rostosky, 2010; White and Halliwell, 2010; Yang, Tan and Cheng, 2014); lower likelihood of smoking initiation (Mahabee-Gittens, Xiao, Gordon and Khoury, 2012, 2013); lower rates of tobacco use (Arunachalam and Nguyen, 2015; Carter, McGee, Taylor and Williams, 2007; Resnick et al. 1997; Tilson, McBride, Lipkus and Catalano, 2004; Yang et al. 2014); and lower rates of cannabis and other drug use (Ackard et al. 2006; Resnick et al. 1997; Yang et al. 2014).

There was also evidence from two cross-sectional surveys, with sample sizes of 908 and 4987, respectively, of indirect effects of high quality emotional bonds with parents and feelings of closeness to fathers, with lower alcohol, cannabis and other drug use (Claes et al. 2005; Dorius, Bahr, Hoffmann and Harmon, 2004). This evidence suggests that high levels of parent-child connectedness and high quality emotional bonds and relationships may be protective against substance use by young people. While high levels of connectedness are protective, there are some situations in which the effects of connectedness appear to be reduced. In their cross-sectional survey with more than 600 young people, Carter et al. (2007) found that medium levels of connectedness were associated with higher levels of binge drinking; however, the authors of the study were unable to provide an explanation as to why this was the case. This finding may be due to a methodological issue, in that connectedness was measured in relation to stressful events, not generally.

The protective effects of connectedness may reduce over time; connectedness may be particularly protective during early adolescence, with the effects diminishing over late adolescence into adulthood, as shown in two longitudinal surveys, involving 5705 parent-child dyads and 1599 young people, respectively (Mahabee-Gittens et al. 2013; Stevens-Watkins and Rostosky, 2010). High levels of parent-child connectedness were found to be protective against cigarette use, but only in families where parents were non-

smokers; there was no effect when parents smoked, suggesting an effect of parental modelling, as found by Tilson et al. (2004) in their cross-sectional survey with 428 parent-child dyads. There is also evidence that brief family interventions, which aim to improve parent-child bonds, had positive effects on reducing initiation and use of alcohol, tobacco and cannabis (Spoth, Redmond and Shin, 2001). This intervention involved a randomised trial of two programmes: 'Preparing for the Drug Free Years' and 'Iowa Strengthening Families Program' which aimed to improve parent-child bonding. A total of 667 families comprising two parents and one young person, were randomised, with a follow-up period of four years (Spoth et al. 2001). Those in the intervention groups reported lower rates of substance use than the control groups up to four years post-intervention (Spoth et al. 2001).

For looked after young people, feelings of closeness to, strong emotional bonds and high levels of connectedness with parents and caregivers were associated with lower levels of heroin, crack and cocaine use (Cheng and Lo, 2010), cannabis use (Cheng and Lo, 2011), prescription drug misuse (Cheng and Lo, 2012), and alcohol and drug use (Traube, James, Zhang and Landsverk, 2012). In one study, a cross-sectional survey of 122 young people in out-of-home placements, high quality relationships with female caregivers were associated with lower rates of depression, but not substance use behaviours (Guibord, Bell, Romano and Rouillard, 2011). Overall, the findings from this small number of studies suggests that good relationships and high levels of connectedness with caregivers can be protective against substance use in young people who are in care. As Cheng and Lo (2011) note, the protective effect does not depend on having good relationships with biological parents; those in a caring role, such as foster carers, can protect young people from substance use by providing strong, affectionate bonds.

These studies highlight the importance of high levels of connectedness, characterised by good relationships between parents or carers and young people, in delaying and reducing alcohol, tobacco and drug use. When connectedness is low, young people may use substances as a way of

coping, or as an act of rebellion (Maggi et al. 2014). In two qualitative studies involving focus groups, young people talked about the importance of good relationships with parents in affecting substance use behaviour. There was a belief that when young people have good relationships with their parents, they are less likely to use substances (Alhyas et al. 2015; McLaughlin, Campbell and McColgan, 2016). When relationships are good, communication is more effective and young people are more likely to be open about their substance use (Alhyas et al. 2015; McLaughlin et al. 2016), highlighting the connection between connectedness and communication. Ensuring that parents or carers and young people have high levels of connectedness appears to have important public health implications: early initiation and use of substances may be prevented by improving relationships with those in a parental role.

Thus, connectedness can have an important effect on young people's substance use outcomes, including looked after young people. Having strong bonds and good relationships with someone in a parental role, whether it is the biological parents, or a paid carer, appears to protect young people against early initiation and ongoing use of alcohol, tobacco and drugs.

General communication

The effect of having open communication with parents and young people's substance use behaviour was reported in 19 studies. General communication was measured in terms of frequency of conversations; satisfaction with communication; ease of talking to parents; talking to parents about problems; and sharing feelings and thoughts. Table 3.2 in Appendix 3 provides details of these studies.

Most authors reported that good, open communication with parents was associated with lower rates of cigarette (Luk, Farhat, Iannotti and Simons-Morton, 2010; Tobler and Komro, 2010); alcohol (Cable and Sacker, 2008; Guilamo-Ramos, Jaccard, Turrisi and Johansson, 2005; Oman et al. 2004; Tobler and Komro, 2010; Yang et al. 2007) and drug use (Luk et al. 2010; Stanton et al. 2002; Tobler and Komro, 2010). There is evidence from two

cross-sectional surveys of an indirect association between general communication and alcohol and drug use, suggesting that good communication can moderate other risk factors, including low body esteem (Fang, Schinke and Cole, 2009), academic motivation and choice of friends (Razzino et al. 2004). Communication with parents predicted alcohol use, but it was a weaker predictor of use than family loyalty and trust, as found by Horton and Gil (2008) in their longitudinal study, with 451 young people. Evidence of gender differences was reported in two studies: in a cross-sectional survey with 1308 young people, Luk et al. (2010) found that communication with mothers was protective against smoking, and with fathers against cannabis use, in boys but not girls. Conversely, in their longitudinal study, with 817 participants, Yang et al. (2007) found a small association between communication and alcohol use for girls, but not boys. There is also evidence that brief family interventions which aim to improve general communication and other risk factors, can be effective in reducing young people's alcohol, cigarette and cannabis use (Spath et al. 2001). Details of these interventions are provided in the previous section, and in Table 3.2 of Appendix 3.

In terms of looked after young people, eight studies examined general communication with adoptive and foster parents. It is important to note, however, that these studies did not examine substance use behaviours; instead they examined quality of communication and other outcomes, which may be indirectly related to substance use (Velleman, 2009). A decision was made to include these studies in the review, to gain a better understanding of general communication with looked after young people. In these studies, 253 to 615 biological, adopted, divorced and foster families were included. Adopted children reported more positive communication with parents when compared to foster children and biological children (Lanz, lafrate, Rosnati and Scabini, 1999; Rosnati and Marta, 1997; Rosnati, lafrate and Scabini, 2007), although one study found that adopted children reported poorer communication than their biological counterparts (Rueter, Keyes, Iacono and McGue, 2009).

In their cross-sectional survey with 253 families, Rosnati et al. (2007) found that foster carers reported more problems communicating with young people in their care, and also had the lowest quality of communication compared to adoptive and biological parents. Poor communication between young people and their adoptive or foster parents was associated with negative outcomes and adjustment problems, such as delinquent behaviour, internalising and externalising behaviours, hostility to caregivers, lower levels of closeness to siblings and problems at school (Rueter and Koerner, 2008; Samek and Rueter, 2012; Vuchinich, Ozretich, Pratt and Kneedler, 2002). This finding suggests that general communication with adults in a parental role can act as a protective factor against a range of negative behavioural and emotional outcomes for young people who are in care.

The only UK based study used a number of qualitative methods, including interviews, relationship maps and diaries, to explore food, mealtimes and communication in 10 foster families (Rees, Holland and Pithouse, 2012). Foster families used mealtimes as a way of communicating and interacting with family members; they shared stories, news and worries and discussed problems. The authors noted that mealtimes were the perfect time to discuss sensitive issues, as the young people had little choice but to sit at the table if they wished to be fed (Rees et al. 2012). The findings of this study suggest that mealtimes are essential to communication within foster families, and may be where discussions of substance use take place, but this is yet to be studied. As no studies examined the general communication in terms of substance use, it is impossible to tell whether communication with foster and adoptive parents is associated with alcohol, tobacco and drug use.

General communication can have an important effect on young people's substance use outcomes. Good, open communication with parents appears to protect young people from early initiation and ongoing use of alcohol, tobacco and drugs. For looked after young people, good communication with those in a parental role is protective against a range of factors, but there is no evidence regarding substance use.

Substance use specific communication

The majority of studies in this review, 46 in total, reported on substance use specific communication. This type of communication was measured in terms of how frequently conversations occurred; how often in recent months; the duration of these conversations; the content of the conversations; and the perceived quality of communication. Some conversations covered all three substances, while others focused on one substance, such as alcohol. Quality of communication was measured in terms of whether conversations occurred easily, parents were interested in young people's opinions and felt they were understood and taken seriously. Table 3.3 in Appendix 3 provides details of these studies.

Generally, there is evidence to suggest that communication about substance use between parents and young people can be effective in reducing alcohol, tobacco and drug use (Kam, 2011; Kam and Lee, 2013; Mares, van der Vorst, Engels and Lichtwarck-Aschoff, 2011). There is also evidence of indirect associations between such communication and substance use. More communication has been associated with more negative attitudes towards substance use and substance users (Cleveland, Gibbons, Gerrard, Pomery and Brody, 2005; Huansuriya, Siegel and Crano, 2014; Huver, Engels, Vermulst and de Vries, 2007; Otten, van der Zwaluw, van der Vorst and Engels, 2008; Wills, Gibbons, Gerrard, Murry and Brody, 2003) and better self-efficacy to refuse offers of substances (Kam and Middleton, 2013; Koning, Van den Eijnden and Vollebergh, 2014; Miller-Day, 2002; Otten et al. 2008). The more people a young person has available to talk to them about substance use, the lower the likelihood of them using substances (Kelly, Commello and Hunn, 2002). The findings from these studies suggest that substance use specific communication with parents can be protective against alcohol, tobacco and drug use during adolescence, by directly influencing their behaviour and indirectly through influencing the attitudes they hold about substance use, as well as enabling them to effectively refuse offers to use substances.

The current review also highlighted particular types of communication which enhance the overall understanding of substance use specific communication. Including qualitative literature in this review enabled a more detailed understanding of the particular messages and methods of communication which are either beneficial or detrimental to substance use, within the context of the findings from quantitative studies. Talking to young people about substance use can be a challenging task, as highlighted by parents in the qualitative study by Sherriff, Cox, Coleman and Roker (2008). Open communication about drug use can be especially difficult due to the stigma attached (Highet, 2005; Mallick, 2003), while conversations about alcohol tend to occur more openly and easily (Highet, 2005). There is a recognition, from parents and young people alike, of the need for clear messages and open communication when talking about substance use (Ebersole, Miller-Day and Raup-Krieger, 2014; Guilamo-Ramos, Bouris, Dittus and Jaccard, 2008; Highet, 2005; Kulbok et al. 2010; Peterson, 2010; Sherriff et al. 2008).

The way in which parents talk to young people about substance use is crucial; when they are perceived as lecturing them, young people are often unreceptive and do not assimilate these messages (Guilamo-Ramos et al. 2008; Levy et al. 2010; Maggi et al. 2014; Metzger et al. 2013; Sherriff et al. 2008). Having constructive conversations in which parents and young people participate equally appears to be more effective (Chaplin et al. 2014; Highet, 2005). The study by Chaplin et al. (2014) measured young people's heart rate, blood pressure and cortisol levels during observed discussions with their parents about substance use. When parents were observed using more critical parenting and less open communication, young people's physiological responses indicated more discomfort. When conversations were open and involved discussions rather than lectures, young people felt more comfortable and reported lower rates of substance use (Chaplin et al. 2014).

In terms of alcohol use, parents often feel that it is necessary to negotiate boundaries around drinking behaviour, preferring to use a harm reduction than an abstinence based approach (Bourdeau, Miller, Vanya, Duke and Ames, 2012; Highet, 2005; Sherriff et al. 2008). As might be expected, such

an approach does not extend to smoking and drug use, where young people are specifically told not to engage in these behaviours, as highlighted in three qualitative studies using interviews with young people (Highet, 2005; Levy et al. 2010; Maggi et al. 2014).

Parents have reported a range of issues when communicating with young people about substance use. Difficulties in starting conversations and concerns about providing inconsistent messages were highlighted by parents (Bourdeau et al. 2012; Sherriff et al. 2008). Parental worries about young people's substance use influenced how they communicate, by avoiding having these discussions (Levy et al. 2010) and by providing lower quality communication (Koning et al. 2013). Although parents report such communication to be challenging, they feel that doing so is important, so they report using a number of strategies for communicating with young people about substance use. These include discussing rules (Bourdeau et al. 2012); talking about the associated health risks and dangers (Sherriff et al. 2008); and promoting moderation and sensible drinking behaviours, with a view that sensible use is part of normal adult life (Bourdeau et al. 2012; Sherriff et al. 2008).

In their longitudinal study with 537 parent-child dyads, Ennett et al. (2001) made the distinction between 'harder' and 'softer' communication. Harder communication refers to conversations in which parents specifically tell young people not to use substances and present them with particular rules around use; while softer communication involves conversations about the possible consequences and harms (Ennett et al. 2001). When parents only talk to young people about rules and tell them not to use substances, young people feel threatened and report increased rates of alcohol, tobacco and drug use (Chaplin et al. 2014; Huver, Engels and de Vries, 2006; Kam, 2011), although in one longitudinal study with 5864 parent-child dyads, the results were positive but not statistically significant (Nonnemaker, Silber-Ashley, Farrelly and Dench, 2012). In a qualitative study with 35 young people, participants reported that when their parents use such communication, they are likely to ignore what is said (Maggi et al. 2014).

Conversely, young adolescents who were current smokers reported higher readiness to quit scores when they had been told by their parents not to smoke; however, no such effect was found for older adolescents (Bandi, Cokkinides, Westmaas and Ward, 2008). This finding suggests that in some cases, being told not to smoke may be beneficial, but only for those in younger age groups who currently smoke.

Softer communication, on the other hand, appears to be viewed more positively (Guilamo-Ramos et al. 2008; Kulbok et al. 2010; Maggi et al. 2014) and is associated with more positive outcomes. When parents include messages about health risks and potential consequences of use, young people are less likely to use substances (Chaplin et al. 2014; Huver et al. 2006). However, in their longitudinal study with 1511 parent-child dyads, Reimuller, Hussong and Ennett (2013) found that discussion of consequences had no effect on alcohol use; in another study these discussions had a detrimental effect on cannabis use initiation (Nonnemaker et al. 2012). It appears that talking about consequences of use has a detrimental effect unless these conversations involve discussions of health risks. Overall, it appears that harder communication is only effective when communication is of high quality; and softer communication is beneficial when young people are informed about health risks and when these messages are educational and informative (Chaplin et al. 2014; Maggi et al. 2014).

It appears that particular types of substance use specific communication may be protective, such as conversations about the health risks of smoking (Huver et al. 2006) and strict rules about alcohol use (Koning et al. 2014), while permissive messages (Reimuller et al. 2013) and communication about consequences of substance use (Kam, 2011; Komro, McCarty, Forster, Blaine and Chen, 2003; Nonnemaker et al. 2012) may be detrimental. The way in which parents communicate with young people is more important than how often they do so. More frequent communication is associated with higher rates, more positive attitudes and lower self-efficacy to refuse cigarette use (de Leeuw, Scholte, Harakeh and Engels, 2008; de Leeuw, Scholte, Vermulst

and Engels, 2010; Harakeh, Engels, Den Exter Blokland, Scholte and Vermulst, 2009; Harakeh, Scholte, de Vries and Engels, 2005; Harakeh, Scholte, Vermulst, de Vries and Engels, 2010; Hiemstra, Otten and Engels, 2012; Huver et al. 2006; Otten et al. 2008); higher rates of alcohol use and associated problems (van den Eijnden et al. 2011; Koning et al. 2013; Spijkerman et al. 2008; van der Vorst et al. 2005, 2010); and higher rates of cannabis use initiation (Nonnemaker et al. 2012).

It is unclear as to the direction of this relationship: parents' frequent communication may be ignored and young people start using substances; or parents communicate more frequently when they believe young people are using substances. However, one study, which involved a cross-sectional survey with 1349 parent-child dyads, found that more frequent communication was associated with more negative expectancies of alcohol use (Mares, Lichtwarck-Aschoff and Engels, 2013), suggesting an indirect protective effect. Authors have suggested that the latter may be the case but longitudinal studies are required to examine the direction of the relationship (Harakeh et al. 2005, 2009, 2010; Huver et al. 2006; van der Vorst et al. 2005).

High quality communication, on the other hand, is associated with lower rates of smoking, more negative attitudes towards and higher self-efficacy to refuse cigarette use (de Leeuw et al. 2008, 2010; Harakeh et al. 2005, 2010; Otten et al. 2008; Ringlever et al. 2011); lower rates of alcohol use and higher self-efficacy to refuse (van den Eijnden et al. 2011; Koning et al. 2013; Mares et al. 2013; Spijkerman et al. 2008). While Koning et al. (2014) found no association between the quality of communication and alcohol use, the authors still promote the use of high quality conversations. Three studies, two of which were longitudinal studies with five year follow ups, found that frequent communication was indirectly protective against alcohol, tobacco and cannabis use, but only when combined with high quality communication and high connectedness with parents (Cleveland et al. 2005; Huansuriya et al. 2014; Huver et al. 2007).

Thus, having frequent conversations with young people about substance use is not enough; these conversations must also be of high quality. High quality communication appears to refer to communication which is reciprocal and young people feel they are participating equally, involving conversations that are “constructive and respectful” (de Leeuw et al. 2010, p. 1003). It may be that when young people are frequently told not to drink alcohol, smoke or take drugs, they ignore the information from their parents. However, when these conversations are of high quality and are based on high connectedness and open communication, the messages are more effective. One study, a longitudinal study with 428 families, found that when parents had more alcohol related problems, they talked more to young people, with more frequent communication associated with lower rates of alcohol use and fewer alcohol related problems (Mares et al. 2011). This finding suggests that for those living in environments in which alcohol use is problematic, more frequent conversations may have a positive effect, by encouraging young people to drink less. However, generally, more frequent communication without high quality messages and connectedness can be detrimental.

Parental worries about substance use by young people (Koning et al. 2013) and their own use of cigarettes (Harakeh et al. 2010) appear to reduce the quality of these conversations. Parents often talk about their own or others’ substance use as a way of initiating conversations and to convey messages about health risks (Guilamo-Ramos et al. 2008; Kulbok et al. 2010; Sherriff et al. 2008). However, there is some evidence that such an approach is actually detrimental and can increase substance use. When mothers reported high levels of alcohol use, they were more likely to talk about their own negative experiences of alcohol use and when they did so, young people were more likely to consume greater amounts of alcohol (Handley and Chassin, 2013). Parental disclosures are also associated with more favourable beliefs towards substance use behaviour (Kam and Middleton, 2013). One study, however, found that parental disclosures were associated with higher self-efficacy to refuse alcohol (Mares et al. 2013). Thus, parents should exercise caution when discussing their own negative experiences, particularly around alcohol use, as they may normalise these behaviours for young people,

leading to increased use (Handley and Chassin, 2013; Kam and Middleton, 2013).

Two studies of interventions were identified which aimed to improve communication between parents and young people about alcohol and cigarette use. Both interventions were conducted in the USA and used written information which was aimed at encouraging parents to talk to young people about alcohol use (Carlson et al. 2000) and alcohol and cigarette use (Beatty, Cross and Shaw, 2008). Parents in the intervention groups of both studies reported more communication, longer discussions and better engagement. In the study by Carlson et al. (2000), these findings were limited to white parents, who were less likely to talk to young people at baseline than black parents. However, there is no evidence regarding whether such conversations had any effect on young people's substance use behaviours and the findings are limited to alcohol and cigarette use. Interventions to improve communication around drugs seem to be particularly important, as parents report more difficulties than with alcohol and tobacco (Hight, 2005; Mallick, 2003).

Contrary to the findings of the systematic review conducted by Ryan et al. (2010), there does appear to be evidence that substance use specific communication with parents can be protective against alcohol, cigarette and drug use. Ryan and colleagues' review was somewhat limited by their focus on alcohol use and studies using a longitudinal design. The current review encompassed a wider assessment of the literature. The most crucial message of the literature, by far, is that simply having frequent conversations is not enough; these conversations must be of high quality in order to be protective. Conversations about substance use must be two-sided, involve explanations regarding why young people should avoid substances and are likely to be facilitated by good general communication and high connectedness between parents and young people.

Strengths and limitations of the review

It is important to recognise the strengths and limitations of this review. Firstly, a systematic and comprehensive search of the literature was conducted, with six databases searched on more than one occasion. Doing so ensured that as much of the available literature as possible was included in the review. Secondly, including qualitative studies has enabled a greater understanding parents' and young people's experiences of connectedness and communication in relation to substance use, highlighting messages that would not have been raised in the quantitative literature alone; for example, participants explicitly stating that substance use is influenced by the quality of the relationships young people have with their parents. Thirdly, these findings have been demonstrated in cross-sectional and longitudinal studies from ten different countries.

There are a number of caveats which mean that the results should be interpreted with caution. Firstly, only English language studies were included in the review, which may bias the results. Secondly, of the 84 studies, 49 were conducted in the USA and 18 in The Netherlands. While the findings of these studies may be applicable to UK settings and populations, there are slight cultural and policy differences. For example, the legal drinking age in the Netherlands and the UK is 18 years, compared to 21 years in the USA (Jernigan, n.d.); the law in the Netherlands, however, has recently changed so the legal drinking age was 16 years at the time that most of these studies were conducted (Dutch Institute for Alcohol Policy (STAP), 2013). Three studies were conducted in the UK, all of which were qualitative, so there is a lack of quantitative studies examining whether communication between British parents and young people can be protective against alcohol, tobacco and drug use. Thirdly, due to the nature of the studies included in the review, a meta-analysis was not possible. While integrative reviews may be viewed as lacking the rigour and objectivity of systematic reviews and meta-analyses, the methods used in this review were comprehensive and rigorous, using the approaches specified by Whitemore and Knafel (2005).

In terms of the literature on connectedness, there is little evidence regarding whether connectedness is protective against other types of drug use, as only cannabis has been examined in terms of connectedness. There is evidence that concepts related to connectedness, high quality relationships and emotional bonds, may be protective against other drug use (Cheng and Lo, 2010, 2012; Claes et al. 2005; Traube et al. 2012). Thirdly, the studies examining connectedness and relationships with looked after young people did not examine smoking behaviour, only alcohol and drug use. This might reflect the small number of studies and authors' preferences to examine drug rather than tobacco use.

With general communication, the greatest caveat is that no studies have been conducted with looked after young people to examine the effects of general communication on substance use. The previously mentioned studies looked at other outcomes, which may be indirectly related to substance use, but none looked specifically at alcohol, tobacco and drug use. The evidence suggests that general communication with those in a parental role may be beneficial to looked after young people, but carers and young people experience difficulties in communicating. Given the relationship between connectedness and communication, it may be that these difficulties are due to poor relationships, that looked after young people and carers only report good, open communication when levels of connectedness are high. More research is therefore required to examine whether such factors are influential in looked after young people.

In terms of substance use specific communication, the greatest caveat is that none of these studies included looked after young people. This is a major gap in the literature as these young people are at increased risk of using substances and developing substance misuse problems. In these studies, most participants were recruited from mainstream settings, such as schools, households or communities. Only two studies were conducted with more vulnerable populations: with children of alcoholics (Handley and Chassin, 2013) and those diagnosed with depression (Levy et al. 2010).

The literature supports the assertion that connectedness, general communication and substance use specific communication may be protective in deterring and reducing the use of alcohol, tobacco and drugs. Existing studies have used robust methodologies in the form of cross-sectional and longitudinal survey designs; elicited both parents' and young people's views; with sample sizes ranging from 116 to more than 82,900; follow up periods of one to 14 years in longitudinal studies and one to two months in interventions. The inclusion of qualitative studies provide valuable insights into views of the importance of relationships on substance use as well as the experiences of parents and young people in talking about substance use.

The findings from this integrative literature review and the gaps identified above highlight the need for a study to examine these factors with looked after young people. There are a number of factors which have been raised through consideration of the existing literature and the gaps in this literature. These factors need to be carefully considered in relation to the current study, particularly due to the population and the context in which the study was conducted. Next, these factors will be presented in terms of the scientific rationale of the current study.

Scientific rationale for the study

No studies have been conducted to examine substance use specific communication between looked after young people and carers. This gap in the literature is a particularly important one to address: these young people are at increased risk of early initiation of substance use and report higher rates of use and misuse. This review has highlighted the abundance of evidence regarding substance use specific communication and the particular factors involved in effective communication. There is also evidence regarding the ways in which such communication can be improved through interventions, with parents subsequently reporting better engagement, longer conversations and more communication (Beatty et al. 2008; Carlson et al. 2000). Therefore, the available evidence provides carers with ways in which to improve these conversations.

Furthermore, no research has examined whether these conversations actually take place or whether particular factors influence the context in which these conversations might occur. As mentioned previously, for looked after young people, communication and relationships with adults can be particularly challenging, suggesting that conversations about substance use will also be. Parents have reported that while they understand that such conversations are beneficial, they too experience challenges in having these conversations with their own children, in a family in which there are unlikely to be the types of adverse events experienced by looked after young people. If these conversations are difficult to have in families where relationships are good, it is likely that these conversations may be even more challenging, or non-existent when they are between carers and looked after young people. Therefore, gaining an understanding of these challenges and how communication occurs is vitally important to ensuring looked after young people do not experience such vulnerability in terms of substance use and misuse.

Providing looked after young people with the opportunity to develop good, strong emotional bonds and relationships with caregivers and providing high quality communication may be protective against negative outcomes, such as substance use, mental health problems and delinquent behaviours. However, providing young people with these opportunities may be problematic. For example, in their conclusion, Rosnati et al. (2007) state that poor quality communication between foster parents and young people may be due to the challenges of caring for and having a relationship with someone who is living in their home, but is not a formal part of their family. These tensions may affect the extent to which young people and foster carers communicate. This purported tension raised the question regarding whether the professional role identity of carers affects levels of connectedness and communication with young people in care.

As described in Chapter 1, looked after young people are likely to have experienced difficult lives and adverse events, which will affect their future relationships with adults, making communication more difficult than in a

family. Some of these young people, particularly those whose parents misuse substances, have been brought up to be mistrustful of professionals and services, thus making them wary about opening up to and building relationships with professionals (Corbett, 2005; Kroll, 2004). Young people in the study by Mullan et al. (2007) highlight a number of issues in relation to having relationships and communicating with professionals. They viewed talking to professionals as important, but sometimes the confidentiality of these conversations was not adhered to and trust was broken. This breach of trust and confidentiality subsequently affected young people's ability to open up to professionals. It appears that some professionals' roles can affect their communication with young people in care. Staff need to follow professional guidelines and pass on information, even though such a task is deemed by young people as a breach of trust (Mullan et al. 2007).

Thus, their professional role identity may affect the way in which they build relationships and communicate with looked after young people. Secondly, young people mentioned a tension with foster care, in that some did not feel part of the family, if they were excluded from family occasions. This feeling of a lack of connection to foster families affected their ability to communicate with foster carers (Mullan et al. 2007). Lack of staff in residential care was also cited as problematic in terms of developing relationships (Mullan et al. 2007). Thus, it appears that professionals' role identity may impact on the development of relationships and communication with looked after young people.

This recognition of the impact of role identity led to the identification of a number of circumstantial factors that are unique to the populations, settings and context of the current study. These factors are what makes the current study different to those discussed in the literature review and were informed by this literature and the gaps identified in these studies. While professional role identity is the most obvious, due to the populations included in the study, there are a number of others which are also considered to be important to the current study: digital media use; the need to examine alcohol, tobacco and drug use together; the settings of foster and residential care; the need to

examine communication within the context of connectedness; and the importance of examining how communication occurs within these settings. Each of these factors will be discussed in turn, with an exploration as to why they were deemed important to consider in the current study.

Professional role identity

There is evidence that connectedness, general and substance use specific communication are important within mainstream populations, as well as some evidence that connectedness and general communication are important for looked after young people. However, for looked after young people, those providing this connectedness and communication are not their parents. For these young people, the context in which the protective factors of connectedness and communication occur is disrupted and often the parental role is assumed by someone other than the biological parents. In some cases, they are cared for by someone known to the child such as a family member but in other cases, by strangers such as foster carers, residential care staff and social workers; in the current study the latter groups were included. Gaining an understanding of connectedness and communication in this population is critical, as it presents a potential route for interventions to reduce the risky behaviours of this group of vulnerable young people. Also, previous research was based within a family setting, be it with biological parents, adoptive or foster families. With a move towards making residential care more homely, with care based more on family like relationships (Kendrick, 2013), the existing evidence may be applicable to residential care. However, professional role identity raises challenges for how carers build relationships and communicate with young people, both in foster and residential care.

As suggested by the young people in Mullan and colleagues' study, professionals' roles and responsibilities may affect their ability to develop relationships with looked after young people (Mullan et al. 2007). In Scotland, the recent introduction of the concept of corporate parenting by the Scottish Government has meant considerable changes in the role of those working with looked after young people. Essentially, corporate parents are those who

are accountable for the outcomes of those in their care and include local authority social work, education and fostering services, the NHS, Police and elected members (Bradbury, 2006; Who Cares? Scotland, 2014). Corporate parenting reflects a move away from the responsibility being on one individual, such as a social worker or teacher, to all those involved in the lives of looked after children and young people being responsible for their wellbeing. It is expected that all corporate parents will aim to improve the lives of children and young people in care, prioritise their needs and provide support and encouragement in the same way that a good parent would do for their own children (Scottish Government, 2008b). Corporate parenting is about doing more for looked after children and young people than expected from traditional professional roles and statutory responsibilities (Scottish Government, 2008b; Who Cares? Scotland, 2014).

Foster care has gone through a dramatic change in the last 40 years, moving away from a voluntary to a more professional service (Delfabbro et al. 2002; Hutchinson, Asquith and Simmonds, 2003; Kjeldsen and Kjeldsen, 2010; Schofield et al. 2013). This move towards professionalisation has occurred due to foster care requiring more administrative duties and paperwork (Delfabbro et al. 2002); the increase in children and young people with complex needs and challenging behaviours (Delfabbro et al. 2002; Schofield et al. 2013); the payment of fees to carers (Hutchinson et al. 2003; Kjeldsen and Kjeldsen, 2010; Schofield et al. 2013); and the provision of training, qualifications and accreditation for foster carers (Delfabbro et al. 2002; Hutchinson et al. 2003; Schofield et al. 2013).

There appears to be a tension for foster carers between being a professional and being a parent. Foster carers may view themselves as parents, professionals or a hybrid of the two (Kirton, 2001; Schofield et al. 2013). Foster carers have a desire to be a family and treat the children in their care as their own (Blythe et al. 2013; Broady, Stoyles, McMullan, Caputi and Crittenden, 2010; Riggs, Delfabbro and Augoustinos, 2009), although they are also expected to be more than parents, taking on tasks that are normally expected of professionals (Rhodes, Orme and McSurdy, 2003). They also

desire to be treated as professionals, having the same status and respect as social workers, due to their high level of knowledge and skills (Hollin and Larkin, 2011; Kirton et al. 2007; Wilson and Evetts, 2006). It appears that foster carers' motivations and length of placements impact upon their role identity; those who become foster carers to help children and those providing long term placements view themselves as parents, while those providing short term placements and those with motivations based on skills and expertise tend to view themselves as carers, or professionals (Blythe et al. 2012, 2013; Schofield et al. 2013).

Knorth, Harder, Huyghen, Kalverboer and Zandberg (2010) note that residential care workers are one of the most influential staff groups in residential child care. They create relationships with the young people for whom they care and spend a great deal of time with them (Knorth et al. 2010; Moses, 2000). However, staff in a study by Milligan et al. (2004) in Scotland reported that they wanted to be more involved in young peoples' care and spend more time with them, but felt unable to, due to pressure on resources and high number of young people in the residential units. Residential care workers have been found to have high job satisfaction, are motivated to working with vulnerable and challenging young people (Milligan et al. 2004; Moses, 2000).

However, they also lack long term commitment to their role, due to a lack of recognition for the work they do and a lack of long term job security (Knorth et al. 2010; Milligan et al. 2004; Moses, 2000). High staff turnover appears to be particularly problematic in residential care settings, with many authors discussing the reasons for problems in recruitment and retention (Cameron, Mooney and Moss, 2002; Colton and Roberts, 2007; Holland, Faulkner and Perez-del-Aguila, 2005; Milligan et al. 2004; Smith, 2005). Authors have argued that residential care staff are lacking a strong professional identity (Johnson, Dunn and Coldron, 2005; Knorth et al. 2010; Milligan et al. 2004). This identity may be strengthened through training, accreditation and improving the image of residential care as a whole, from one which is rather

negative, to a sector which has a clear role in improving the lives of looked after children and young people (Knorth et al. 2010).

Social workers have not traditionally been in a direct caring role, instead coordinating the care of children and young people in the care system. Hollin and Larkin (2011) used discourse analysis to compare social workers' accounts with a Government paper, 'Care Matters'. Within the Government paper, social workers were expected to take on a parenting role, by becoming good parents and putting the needs of children and young people first. However, social workers' discourses suggested that they did not see themselves in parental role, although they did discuss their role in terms of attachments and bonds. Social workers viewed themselves as having relationships with the children and young people in their care, but more as 'customers' and 'services providers', than as parents and children (Hollin and Larkin, 2011). The findings of this study suggest that social workers view themselves as having a key role in developing emotional attachments and bonds with looked after young people, but this role is entirely different to that of a parent. Leeson (2010) found that social workers experience discord between different parts of their role: between assessment and care planning and the need to build relationships with children and young people. They also reported that they need to feel that they have a role in the decision making processes when working with looked after children and young people. These challenges to their role identity can lead to social workers feeling distress, anxiety and inadequacy, affecting their performance (Leeson, 2010).

These studies suggest that professional role identity may impact upon relationships with young people in care. These carers will have statutory duties and responsibilities that they must fulfil, potentially influenced by their professional role identity. They also have the added influence of corporate parenting and the additional duties that this involves, with professionals taking on a more parenting role than they have previously. Thus, some professionals may have conflicting identities, acting in professional and parental roles to these young people. Professional role identity may influence the extent to which carers engage and communicate with these young

people. For some, they may see it as part of their professional role, while for others, they would do so in a way similar to that of many parents. The theory of professional role identity, as described below, is particularly relevant to this area of work.

One theory of professional role identity was developed in a grounded theory study by Machin, Machin and Pearson (2012) in response to changes to the role of the health visitor, with data gathered over a period of six years using interviews and observations. Their theory is explained by four connected categories which highlight the key duties and responsibilities, interactions with peers and other colleagues, issues associated with the role and a strong sense of role identity. Essentially, changes to the health visiting role can challenge and unbalance health visitors' professional role identity, with social interactions with colleagues in professional settings as a way of rebalancing and providing a strong and stable identity. The authors recommended that health visitors use regular meetings and networking to stabilise their collective professional role identity (Machin et al. 2012). This emphasis on social interactions has been highlighted within the social work literature; social workers' identities are strengthened through interactions with fellow professionals and threatened in interactions with those in diverse roles, particularly in multidisciplinary settings (Hymans, 2008; Leslie and Cassano, 2003; Miehl and Moffatt, 2000; Oliver, 2013; Payne, 2006; Smith, 2003).

This theory has been applied to other professionals (Elliott, Kennedy and Raeside, 2013) and appears to be particularly salient to those working with looked after young people. These carers, will have statutory duties and responsibilities that they must fulfil, potentially influenced by their professional role identity. They also have the added influence of corporate parenting and the additional duties that this involves, with professionals being expected to take on a more parenting role than they have previously. Thus, some professionals may have conflicting identities, acting in professional and parental roles to these young people. Professional role identity may influence the extent to which carers engage and communicate with these young people about alcohol, tobacco and drug use. Also, it is likely that carers' professional

training will influence their communication with young people, as well as the organisational culture in which they are embedded. For these carers, communication may be viewed as part of their job, but also as something which is imposed by someone else, such as social work departments or fostering bodies. Therefore, substance use specific communication can become a lot more complicated than in mainstream family settings. For these reasons, professional role identity was chosen to be the second theoretical framework to be used in the study, in order to gain an understanding of how carers' role identities influence and shape their communication with young people about substance use.

Digital media use

In the integrative review, there was no evidence regarding the use of digital media in terms of communication, even though digital media use is widespread. Young people spend a great deal of their time using digital technology, such as computers, the internet and mobile phones; one author has describe them as "Generation @" (Feixa, 2011, p. 1641). The way in which families communicate is constantly changing due to increased use of mobile devices and social media; these media allow families to keep in touch, maintain relationships and exchange information (Devitt and Roker, 2009; Kennedy, Smith, Wells and Wellman, 2008; Rudi, Dworkin, Walker and Doty, 2014). Parents report using email, text messaging and social networking websites as ways of communicating with their children, particularly young people (Rudi et al. 2014).

Increased use of mobile phones (Koivusilta, Lintonen and Rimpelä, 2005; Sánchez-Martínez and Otero, 2009); computers and the internet (Busch, Manders and de Leeuw, 2013; Epstein, 2011) is associated with higher rates of substance use. There are associations between being a victim of cyberbullying and higher rates of substance use (Gámez-Guadix, Orue, Smith and Calvete, 2013; Litwiller and Brausch, 2013). Social networking websites, such as Facebook, Bebo and MySpace may be linked to alcohol use (Epstein, 2011); with images promoting use of alcohol as a normative behaviour (Griffiths & Casswell, 2010; Moreno, Briner, Williams, Walker and

Christakis, 2009; Moreno et al. 2010). There is also evidence of social networking websites being used to promote and sell prescription medication, targeting young people in particular (Mackey, Liang and Strathdee, 2013). The internet is a vast source of information about drugs, from prescription medications to legal highs, in terms of positive and negative side effects and also how and where to purchase them (Schepis, Marlowe and Forman, 2008; Vardakou, Pistos and Spiliopoulou, 2011). Young drug users use the internet to search for information and have changed their behaviour as a result of what they have read (Boyer, Shannon and Hibberd, 2005). Visiting pro-drug websites has been associated with higher rates of smoking (Kam and Lee, 2013).

There is some research which highlights the potential of digital media to either facilitate or restrict communication. Parents report using stories from the digital news media as well as web-based materials to convey information to young people (Bourdeau et al. 2012; Miller-Day and Dodd, 2004; Sherriff et al. 2008). However, no studies have explored parents' use of other forms of digital media such as mobile devices or social networking websites when communicating with young people about substance use. This may be due to the timescale in which these studies were conducted, when digital media were less prevalent than they are now. The use of digital media in substance use specific communication is an important area to study; these technologies dominate the lives of many families. It may be that digital media are used to facilitate, or that their use hampers, parent-child communication about substance use. However, the lack of research currently means it is difficult to know. Therefore, gaining an understanding of how digital media are used when carers and young people are having conversations about substance use can provide a contemporary view of this communication, as well as the potential to inform interventions using digital media to improve communication.

Considering alcohol, tobacco and drug use together

A common theme throughout the literature was that parents deal with alcohol, tobacco and drug use differently. Alcohol is viewed as a normal,

acceptable behaviour for adults, and to some extent young people, particularly in the UK. Alcohol, when used in moderation, is a normal part of life; parents reported trying to limit the types of alcohol young people could drink and the occasions and locations in which alcohol use was allowed (Sherriff et al. 2008). Parents attempt to negotiate boundaries around alcohol use and ensure that young people drink safely and in moderation, as well as providing information about the risks and harms (Hight, 2005). Smoking is often forbidden or opposed, even when parents themselves smoke (Kulbok et al. 2010; Levy et al. 2010), possibly due to the perceived health risks associated with smoking. Drugs are viewed as particularly harmful and, as a result, are often difficult to discuss. In one study, young people noted that their parents frequently discussed alcohol use, but rarely discussed cannabis use, with discussions only occurring after they had been caught using (Hight, 2005).

Thus, it appears that alcohol use is normal and inevitable, tobacco use is discouraged and drug use is forbidden and hidden. This is reflected in the focus of the studies included in the integrative review: of the 76 studies which reported substance use outcomes, 18 examined alcohol use, 20 smoking and 30 a range of substances, while only eight studies focused specifically on drug use. The stronger focus on alcohol and tobacco than drug use may be due to drugs being less acceptable to consume, talk about and therefore study. The limited number of studies about drug use may reflect the illicit nature of these substances; parents may feel more comfortable talking to young people about more normative behaviours of smoking and alcohol use (Hight, 2005). Examining alcohol, tobacco and drug use together in the integrative review provided a greater understanding of the complexities of communication about substance use. Permissive messages and inconsistent rules around alcohol use can be confusing and increase use (Koning et al. 2013; Reimuller et al. 2013), while forbidding the use of tobacco and drugs can also increase use (Chaplin et al. 2014; Huver et al. 2006; Kam, 2011). Therefore, in the current study, it is important to examine communication about alcohol, tobacco and drug use, rather than just focusing on one of these substances. As mentioned previously, young people often use more

than one substance at a time, so it is important to consider the entirety of young people's use of these substances. Carers and young people may use different approaches to talk about each individual substance, so examining alcohol, tobacco and drug use together may provide a more comprehensive understanding of the communication which occurs.

Setting: foster and residential care

Most of the studies mentioned in the integrative review which included looked after young people examined those who were adopted; a few examined foster care but no studies looked at the experiences of those in residential care. Young people in foster and residential care tend to experience greater difficulties than those who have been adopted (Dregan and Gulliford, 2012; Farruggia and Sorkin, 2009; von Borczyskowski et al. 2013), with those in residential care tending to be most at risk of adverse outcomes. In terms of communication, those in foster care tend to experience more difficulties in communicating with their carers than adopted young people (Lanz et al. 1999; Rosnati and Marta, 1997; Rosnati et al. 2007). Relationships between young people and residential care staff are deemed important but can be problematic, due to the complex nature of this care setting (Emond et al. 2014; Kendrick, 2013; Mason, 2008; Smith, 2009). As discussed previously, there are tensions in foster care to become more professional, and for residential care to become more like a home environment. These tensions may affect the way in which carers build relationships and communicate with young people in their care. Thus, it is important to consider both types of setting in the current study, as there may be critical similarities and differences in the ways that carers and young people communicate about substance use.

Examining connectedness and communication together

Previous reviews and studies have tended to examine connectedness and communication separately. By examining both factors across all three substance use behaviours in the integrative review, it was possible to explore the influence of both communication and connectedness on young people's substance use. Communication is most effective within the context of high

levels of connectedness (Ackard et al. 2006; Bandi et al. 2008; Carter et al. 2007; Guilamo-Ramos et al. 2008; Horton and Gil, 2008; Kulbok et al. 2010; Razzino et al. 2004). Young people are more likely to display open communication with their parents about general topics when they have high connectedness (Luk et al. 2010). Connectedness appears to facilitate open communication about substance use; parents are more likely to have the opportunity to have frequent conversations and set rules effectively when connectedness is high (Cleveland et al. 2005; Guilamo-Ramos et al. 2008; Harakeh et al. 2010; Koning et al. 2014; Maggi et al. 2014). When connectedness is low, substance use may be viewed as an act of rebellion, which may increase their motivation to start (Maggi et al. 2014; Peterson, 2010). Thus, high connectedness is effective in reducing substance use behaviours and that young people's fear of disappointment may be particularly motivating.

As discussed in Chapter 1, it is important to enable looked after young people to build good, stable relationships and high quality communication with their carers. However, doing so can prove particularly problematic, on account of young people's negative experiences in relationships and other adverse events affecting their ability to form relationships and participate in conversations. Their status as looked after can also affect their relationships and subsequent communication: they are being cared for by people who are not their parents. In residential care, they are part of a unit, with other young people and staff who work shifts. In foster care, they are entering someone's home, joining a family but only to a limited extent. The studies in the review highlight the difficulties that carers and looked after young people might experience in terms of communication, which may be due to relationships with carers. Again, this highlights the need to consider connectedness and communication together and the usefulness of including connectedness as one of the theoretical concepts used in the current study.

Examining how communication occurs

Previous studies have examined the factors involved in effective communication about substance use. However, no research has examined

whether these conversations occur in circumstances different to those in a family home; how these conversations occur; or whether particular factors influence the context in which these conversations might occur. As mentioned previously, for looked after young people, communication and relationships with adults can be particularly challenging, suggesting that there may also be challenges in having conversations about substance use. In the abovementioned studies, parents talked about the difficulties they experience in communicating with their own children. Given that these conversations are difficult to have in families where relationships are good, it is likely that these conversations may be even more difficult, or simply do not occur when they are between carers and looked after young people. Therefore, gaining an understanding of these challenges and how communication occurs is vitally important to ensuring looked after young people do not experience such vulnerability in terms of substance use and misuse.

Aims and objectives of the study

Connectedness and communication are two factors which have been proposed to delay and reduce young people's alcohol, tobacco and drug use. However, there is no evidence regarding substance use specific communication between looked after young people and their carers. Much of the literature has been conducted with adoptive families, with limited understanding of those in foster care; no studies have been conducted with those in residential care. There is an impetus to make residential care more family-like, so gaining an understanding of communication within this setting is particularly relevant to current practice and policy.

There is a great deal of evidence regarding the protective nature of substance use specific communication, but all of the studies were conducted in mainstream families. Gaining an understanding of how such conversations occur within a family-like setting, with carers who are acting like parents but are not the parents is crucial, in order to develop interventions to delay and reduce looked after young people's substance use. This is particularly important as the outcomes for looked after young people regarding substance use tend to be worse than their peers. The professional role

identity of social workers, residential care staff and foster carers may impact on how they care for looked after young people. Whether they perceive their role to be that of parent, professional or a mix of the two, may affect the way in which they work with young people in their care. In particular, their role identity may impact on their connectedness and the way in which they communicate with looked after young people, specifically about substance use.

The purpose of this study is to gain an understanding of substance use specific communication between looked after young people and their carers. The next chapter will introduce the methods used in the study. Qualitative methods, which are useful when the research is exploratory, were used in the current study, to address the following research questions:

1. How do carers and looked after young people in foster and residential care communicate about alcohol, tobacco and drugs?
2. Which factors shape this communication?
3. To what extent do digital media play a part in this communication?

This chapter has provided the findings of an integrative review, which aimed to examine the available literature regarding the protective effects of connectedness, general and substance use specific communication. Bringing together this evidence and examining the gaps in the literature, as well as identifying the unique circumstantial factors, led to the formulation of the study rationale and research questions. The next chapter will detail the methodology used in the study, the recruitment process, data collection and transcription and data analysis, as well as addressing particular challenges associated with conducting qualitative research.

Chapter 3: Methodology

The aim of this chapter is to describe the research methods used in the study, as well as the rationale for using such methods to answer the research questions (see page 78). The need for qualitative methodology is introduced, along with the key concepts associated with this methodology, and a rationale as to why individual interviews were deemed most suitable. The benefits and challenges of conducting qualitative research with looked after young people are considered. The research process, including identification of participants, ethical approval, sampling, recruitment and the interview process are described. The analytical process used to code, interpret and generate meaning from the data will also be described. I also describe the reflexive work I undertook throughout the study, the challenges I faced and how I attempted to address these. Being transparent about the research process and the experience of the researcher is viewed as a crucial way of enhancing quality and rigour in qualitative research (Finlay, 2002a; Hand, 2003; Horsburgh, 2003). Throughout this chapter, I have aimed to be as open and honest about my experiences as possible, providing a clear audit trail regarding the decisions I made and the actions I took, throughout the research process. The chapter ends with a detailed description of how the themes will be presented in Chapters 4-6.

Qualitative methodology

Qualitative methodology, the approach used in this study, is ideally suited to research which is exploratory in nature and aims to gain a greater understanding of the social world and the experiences and perceptions of those in it (Green and Thorogood, 2014; Ormston, Spencer, Barnard and Snape, 2014), using methods that are flexible and consider the social context in which they are used (Mason, 2002). Epistemology refers to theories of knowledge, that is “how we come to know the world and have faith in the truth or validity of that knowledge” (Green and Thorogood, 2014, p. 11). Essentially, epistemology is concerned with how we know and learn about the world. In social science, there are two distinct epistemological stances:

positivism and interpretivism. Positivist researchers assume that reality is objective and stable, that human characteristics can be measured in a neutral, quantifiable manner and that research can be replicable, using validated tools and experimentation (Charmaz, 2003; Green and Thorogood, 2014; Ormston et al. 2014). Positivist researchers use quantitative methodology, such as experiments and surveys, to generate data and focus on criteria such as internal and external validity, reliability and objectivity (Denzin and Lincoln, 2005). At the other end of the spectrum, is qualitative research, which is underpinned by an interpretivist philosophical position. Interpretivist researchers are concerned with knowledge that is produced through the exploration of the social world (Mason, 2002; Ormston et al. 2014). They view people and their interactions as data sources and are concerned with understanding how people interpret the world and its reality (Green and Thorogood, 2014; Mason, 2002; Vasilachis de Gialdino, 2009).

Qualitative researchers are positioned to study and make sense of the world using naturalistic, interpretive approaches (Denzin and Lincoln, 2013). A range of methods are utilised to generate data, requiring flexible and active engagement on behalf of the researcher. These methods aim to produce detailed understandings of phenomena which are grounded in the interpretations of the research participants (Mason, 2002; Ormston et al. 2014). The data generated by such methods are rich and detailed, with analysis providing a deep and complex understanding of a phenomenon (Holloway and Wheeler, 2010; Mason, 2002). Qualitative research is often criticised for being unscientific and unable to contribute knowledge that is relevant to policy and practice (Green and Thorogood, 2014). However, there are a number of approaches which can strengthen the rigour and trustworthiness of findings; these approaches are detailed later in this chapter. While, theoretical assumptions are critical in all forms of research, they tend to be more explicit in qualitative research due to the history of the discipline. They also shape the entire research process, from the types of questions asked, the approaches used and the interpretation of and arguments around findings (Green and Thorogood, 2014; Mason, 2002).

Social constructionism is one such theoretical assumption or approach that is often drawn on in qualitative research. While no single definition of social constructionism exists (Burr, 2003), the term is often used to refer to an approach which views phenomena, reality and understandings as being constructed by social processes and interaction between people (Barbour, 2014; Burr, 2003; Seale, 2012). Barbour (2014) recommends that a broadly social constructionist position should be assumed in research as it can effectively provide an understanding of the interaction between individuals in the social, economic, political and policy context in which the data originated. Gaining an understanding of these individual interactions and the contexts in which they occur offers interpretations of wider social occurrences (Barbour, 2014).

A broadly social constructionist approach was adopted as the main theoretical assumption for this research study. Its application is particularly useful for this study, in helping to understand complex interactions within an important policy context, where a number of changes are influencing how looked after young people are cared for. Using a broadly social constructionist approach also allows for a flexible approach to research. This approach was used to guide the research design, analysis, interpretation of findings and implications. For example, interviews are an appropriate method of data collection due to the similarities with everyday conversations and the importance placed on the interactions between two people (Kvale & Brinkmann, 2009), which is in-keeping with social constructionism. Data were analysed using thematic analysis, a flexible approach to analysis which can be used across a range of theoretical approaches, including social constructionism (Braun and Clarke, 2006, n.d.). Using thematic analysis enabled participants' language to be considered, reflecting a broadly social constructionist approach. The findings and associated implications reveal participants' experiences within the broader policy context in which the research was conducted.

As emphasised in Chapter 2, nothing is known regarding how carers communicate with looked after young people about substance use.

Qualitative methods are particularly suited to research which is exploratory in nature, as a tool to gain an understanding of people's feelings, perceptions and experiences. As qualitative research is concerned with exploring, interpreting and understanding people's experiences, the use of these methods may provide a deeper insight into participants' experiences of substance use specific communication than quantitative methods could. Therefore, I judged that qualitative methods were well suited to the aims of the study, to explore young people and carers' experiences of communication about substance use. I then had to make a decision regarding which method would be most appropriate.

Rationale for choice of research methods

Silverman (2010) suggests that your chosen research method should be appropriate to your topic and your overall research strategy. With this in mind, I carefully considered the available methods to ensure that the one I chose was most appropriate to my research questions and population. After much consideration, engagement with the literature and discussions with my supervisory team, I decided that individual interviews with young people and carers would be the most suitable method to explore participants' experiences of communicating about substance use. Individual interviews would enable a deep understanding of their individual experiences, meanings and perspectives of communication (Johnson, 2001; Warren, 2001) in a way that other methods may not.

Individual interviews are one of the most powerful means of understanding people (Fontana and Frey, 2005). Punch (2002a) notes that some young people, particularly those in residential care, may prefer to participate in individual interviews, rather than group interviews, due to concerns about confidentiality. Interviews are one of the most frequently used techniques in research with looked after children and young people (Holland, 2009). It is purported that they enjoy participating in interviews and the experience can be beneficial, improving their sense of worth and enabling them to feel appreciated (Munro, Holmes and Ward, 2005; Murray, 2005). It was anticipated that interviewing young people on a one-to-one basis would

enable them to talk openly about a potentially sensitive topic, without fear of reprisal from peers. Interviews are also a useful way of exploring emergent themes in more detail and explore participants' personal thoughts and experiences (Punch, 2002a).

After deciding to use individual interviews with carers and young people, steps were taken to develop the research process, in terms of identifying the study site; negotiating access to participants; identifying potential participants and the sampling framework; and ethical considerations.

The research process

Identifying the study site and negotiating access to participants

I approached the City of Edinburgh Council to access young people and carers, because with 1419 children and young people (Scottish Government, 2016a), they have the second highest number of looked after children and young people in Scotland (Scottish Government, 2016b). In Edinburgh there are seven residential units which provide full-time care to up to 48 young people (City of Edinburgh Council, 2012); those in residential care tend to be of secondary school age (Scottish Government, 2015b). Foster care services are provided to children and young people, on a respite or permanent basis (City of Edinburgh Council, 2015). They also have foster carers who provide specialist foster care to children and young people with more complex needs and to those with disabilities (City of Edinburgh Council, 2015). Foster care can also be provided by a number of independent fostering organisations in Scotland.

The next step was to determine how to gain access to these young people and carers. Gaining access to looked after young people care is one of the most widely discussed issues in the literature (Gilbertson and Barber, 2002; Hayes, 2005; Heptinstall, 2000; Munro et al. 2005; Murray, 2005; Powell and Smith, 2009; Thomas and O'Kane, 1998). Often access is prevented by gatekeepers, who are legally accountable for the safety and wellbeing of these children and young people (Heptinstall, 2000; Murray, 2005). It is

understandable that these gatekeepers wish to protect looked after children and young people, whose past adverse experiences can make them particularly vulnerable. However, this stance can prevent them from participating in an important opportunity to voice their opinions about matters which affect them (Powell and Smith, 2009). In order to overcome these challenges, it is recommended that the research process should be carefully planned, with particular attention paid to potential problems that might arise (Berrick, Frasci and Fox, 2000; Munro et al. 2005). Taking time to build good, collaborative relationships with gatekeepers is also key in overcoming barriers to access (Murray, 2005; Thomas and O’Kane, 1998). Munro et al. (2005) also recommend having someone to act as a conduit between the researcher and the agencies involved.

I was able to identify a senior manager in Children and Families Services at City of Edinburgh Council. In May 2014 I sent him an email, introducing myself and my research, and asking to arrange a meeting to discuss it further. We met on 27th June 2014 and discussed my research topic and the types of individuals I would like to speak to. He agreed to support my research and felt that it would be a useful topic to explore, as substance use can be a problematic issue. We had further discussions in September and December 2014. During these meetings, we discussed my research aims, the potential number of participants I could recruit, the current situation of foster and residential care in Edinburgh and the services from which I could recruit young people. These meetings were a useful way of discussing my research methods; for example, I made my decision to use individual interviews after a discussion about the difficulties of using focus groups. As much of the foster care provided in Edinburgh is by independent organisations, I also decided to contact local fostering charity organisations. I was also informed that I would initially be put in touch with residential units, social workers in foster care and a supported accommodation unit, with further access to be negotiated over time.

Identifying potential participants for the research

After identifying that participants would be recruited from City of Edinburgh Council and fostering organisations, I next had to develop a sampling framework. This involved determining which young people and carers should be invited to participate. Firstly, the decisions regarding young people will be illustrated, followed by carers.

Current views of childhood and adolescence, which in the academic literature have been principally influenced by the United Nations Convention on the Rights of the Child (Fargas-Malet, McSherry, Larkin and Robinson, 2010; Lightfoot and Sloper, 2003; Moore, Saunders and McArthur, 2010; Powell, Fitzgerald, Taylor and Graham, 2012), view children and young people as active social agents, who are capable of expressing their views and being active participants in their social world, albeit with different experiences and knowledge than adults (Kirk, 2007; Powell et al. 2012). Therefore, it is essential to involve young people in research which aims to gain an understanding of the processes which involve and affect them directly. Being given an opportunity to participate in research and express views and opinions can be a valuable experience (Kendrick, Steckley and Lerpiniere, 2008; Munro et al. 2005; Powell and Smith, 2009).

Gilbertson and Barber (2002) note that including these looked after young people in research can be particularly important for them, by valuing their rights, supporting their recovery from adversity and supporting their development. They are likely to have different perspectives to those of caregivers, practitioners and policy makers; their reality can only be appreciated by directly involving them (Holland, 2009; Kendrick et al. 2008). A quote from a participant in a study by Warming (2006 p.38) sums up this point succinctly: "it's about time that somebody listens to us. We're the ones who know what it's like". However, often these voices are not heard, particularly when the research concerns sensitive topics (Powell and Smith, 2009). Thus, I considered it crucial to include young people in my study; their experiences of communicating about substance use may be different to

those of their carers, so it is important to gain an understanding from both groups.

In determining which young people should be included in the study, I had to consider a number of factors, including age, placement types and experiences of substance use. I decided to recruit young people who were aged between 12-19 years. The minimum age range reflected the age at which many young people in Scotland start to experiment with substances, with one fifth of young people reporting starting smoking or experiencing alcohol use before the age of 13 (Currie et al. 2012). Meltzer et al. (2004) found that 12% of looked after children had started drinking and 27% of smokers had started smoking before the age of 10 years, suggesting that substance use can begin at an earlier age than in the general population. However, due to ethical concerns, it was deemed inappropriate to include those under the age of 12 years. The maximum age of 19 years reflected the upper age at which looked after young people received support at the time of the study (Duncalf, Hill and McGhee, 2013; Scottish Government, 2015b); this age has now increased to 21 years (Scottish Government, 2015c). Including young people aged 12-19 years ensured that a wide range of views and experiences could be captured, from those who had little or no experience of substance use to those who had used substances for a while. The inclusion and exclusion criteria can be found in Appendix 4.

The majority of children and young people in care in Scotland, 36%, are in foster care, followed by kinship care (27%) and those living at home with parents (25%) (Scottish Government, 2016a). Young people in residential care comprise only ten percent of the population, with the majority living in local authority residential units (Scottish Government, 2016a). However, a decision was made to focus on foster and residential care, for two reasons. Firstly, because I was interested in gaining an understanding of communication between carers and young people, within the context of connectedness and professional role identity, as detailed in Chapters 1 and 2, I decided to include young people who are being looked after by those in more formal caring roles, such as those in foster and residential care. As

mentioned previously, those in residential care tend to have the poorest outcomes, followed by those in foster care, so they are likely to be at most risk of using substances. Secondly, I was informed that access to those being looked after at home by their parents, or by friends and family in kinship care would not be granted. Therefore, I excluded these young people and their carers.

I decided to exclude those in secure care, because it would be inappropriate to include them, given their small numbers and highly complex levels of risk and needs. Looked after young people are placed in secure accommodation when they are at high risk to themselves and others, with complex needs, including mental health problems, learning disabilities, sexually harmful behaviour, sexual offences and violence (Scottish Government, 2012). There were a total of 82 looked after children in secure accommodation in Scotland in 2014 (Scottish Government, 2015a), 12 of whom are placed in Edinburgh.

My next decision regarding participants was related to learning disabilities, mental health and behavioural problems. In Scotland, 45% of looked after children and young people are estimated to have a mental disorder, the majority of whom have conduct disorders (Meltzer et al. 2004). As consent is based on competency, I decided to exclude any young people with learning disabilities or mental health problems which would prevent them from understanding the research process, and therefore giving informed consent. However, the presence of a mental health problem or learning disability does not automatically exclude someone from participating so I decided to include young people if they could understand the research process, decide for themselves whether they wished to participate or not, and were able to provide verbal or written consent. Young people in care are a particularly vulnerable population; they have often had incredibly challenging childhoods and experienced traumatic events, both prior to entering and whilst in the care system (Jones et al. 2011). It was important to work closely with gatekeepers to ensure that they identified young people they believed were suitable to participate, with those they deemed too vulnerable being excluded.

Finally, I had to make a decision regarding whether to include young people based on their substance use. I considered it important to include young people who were using substances as well as those who were not. There is evidence that parents should have conversations with their children before they start using substances; if they wait to have conversations after they've started, it might be too late and have detrimental effects (Harakeh et al. 2005; Velleman, 2009). Therefore, it was important to include young people who did not use alcohol, tobacco or drugs and those who do, as well as young people who had experience of more problematic substance use, if their carers felt that it was appropriate for them to participate. As described in Chapter 5, accessing those with more problematic substance use was not possible.

In total, I aimed to recruit a total of twelve young people, half of whom would be in foster care and half in residential care, with equal proportions of males and females in each setting, as well as equal numbers of substance users and non-users. Table 1 shows the purposive sampling framework for the recruitment of young people.

Table 1. Purposive sampling framework for young people

	Foster Care	Residential Care
Male	3	3
Female	3	3
TOTAL	6	6

The term 'corporate parent' can refer to a range of professionals, including those involved in the day-to-day care of looked after young people, as well as teachers, social workers and NHS staff (Who Cares? Scotland, 2014). While I could have chosen to speak to any number of these professionals, I decided to choose three particular groups, to ensure that my PhD study was manageable. As previously mentioned, the focus and strength of this study is on professional role identity in the engagement of young people in communication about substance use. I wanted to include professionals who are involved in the direct care of these young people, so I decided to include social workers, foster carers and residential care workers. Biological parents

and kinship carers who are looking after the children of their friends and relatives were excluded. The carers that I aimed to recruit all had legal responsibility for looked after children and young people, providing care to them on a daily basis. Including a range of carers would provide insight into the types of interactions they have with young people, within different relationships. The inclusion and exclusion criteria are presented in Appendix 5.

I aimed to recruit a total of 16 carers: six foster carers, six residential care staff and four social workers. Again, I aimed to include equal numbers of males and females. Table 2 shows the purposive sampling framework for the recruitment of carers.

Table 2. Purposive sampling framework for carers

	Foster carers	Residential care staff	Social workers
Male	3	3	2
Female	3	3	2
TOTAL	6	6	4

In total, my purposive sampling frameworks provided a sample size of 28 participants. In qualitative research, there is much debate regarding what is an appropriate sample size for a study; often the decision is based on a number of factors, including the theoretical underpinnings; the research question; time and resources available; and the population being studied (Baker and Edwards, 2012; Francis et al. 2010; Guest, Bunce and Johnson, 2006). Therefore, my decision about sample size was based on my use of a broadly social constructionist approach, which enabled a larger sample size than other types of qualitative methodology. I also wanted to ensure depth in my population, to be able to interview a range of young people and professionals, whilst also ensuring that my data would be manageable in the limited amount of time I had to conduct the study. I recognised that there would likely be challenges in recruiting looked after young people to the study, based on anecdotal stories from other researchers and in the literature (Gilbertson and Barber, 2002; Heptinstall, 2000; Munro et al. 2005). Therefore, I needed to ensure that I could recruit enough young people so

that I could achieve diversity in terms of their views and experiences (Mason, 2010).

I deemed 28 participants to be adequate for achieving a diverse sample, which was also manageable, and fitted with recommendations of a number of experts, of around 28-40 participants for qualitative doctoral theses (Baker and Edwards, 2012). As well as sample size, it is essential to consider saturation and how this is achieved; this will be discussed in a later section.

Ethical considerations

In order to conduct the study, ethical approval was required from Edinburgh Napier University's Faculty of Health, Life and Social Sciences (FHLSS) Research Ethics and Governance Committee and the City of Edinburgh Council's Children and Families department. In September 2014 I submitted my application to the FHLSS committee, with approval being granted three weeks later. After being granted ethical approval from the FHLSS ethics committee, I submitted an application to the City of Edinburgh Council, with approval being granted in October 2014. I also ensured that I had an up-to-date PVG Scheme membership, as evidence of my suitability to work with vulnerable young people.

There are a number of issues which arise in all types of research with all participants, which are certainly not exclusive to conducting research with young people; specifically power, informed consent and confidentiality (Kirk, 2007; Oakley, 1994). These issues can be particularly salient when conducting research with young people, due to their different experiences, understandings and communication styles (Kirk, 2007), as well as due to their position in society as of a lower standing than adults (Punch, 2002b). These issues are particularly important and often particularly challenging, when conducting research with looked after young people. Each of these issues will be addressed in turn.

Power imbalances

Power imbalances are often manifest during the process of gaining informed consent (Kendrick et al. 2008; Powell and Smith, 2009) so it is vital that young people are provided with the opportunity to make decisions regarding whether or not they wish to participate. In research, issues of power are often highlighted as concerns about whether young people feel that they can refuse to participate and withdraw during the study, as well as the potential of experiencing harm or distress as a result of the research (Kirk, 2007; Morrow and Richards, 1996). Therefore, it is the responsibility of the researcher to ensure that children do not experience undue harm or distress, whilst also ensuring that they benefit from the research (Kirk, 2007; Powell et al. 2012). Power is a particularly important concept to consider when conducting research with looked after young people, as they often feel powerless within the care system. Professionals make decisions on their behalf and young people feel they can be excluded from decisions affecting their lives (Mason, 2008; Munro, 2001).

As I was unable to recruit young people myself, my access to participants was reliant on gatekeepers' ability to identify and recruit young people. At times, I felt particularly powerless to this situation, as I had to wait for residential care staff and social workers to identify and make contact with young people. It was the responsibility of these carers to ensure that participants who met the inclusion criteria were invited to participate in an interview. These gatekeepers may have prevented particular young people from participating because they deemed them too vulnerable, without giving them a chance to make a decision for themselves. Whilst this is understandable, it may have meant that particular young people have been excluded from the study, who may have wished to participate and had valuable experiences to share. For example, as I will discuss in Chapter 5, I had particular difficulty in accessing drug using young people and felt that the young people who did participate were likely to have had different experiences than those who were excluded, particularly in terms of communication about drug use. Critically reflecting on how one's role and assumptions affects the research process is essential as a way of addressing

power imbalances (Jasper, 2005; Ortlipp, 2008). Throughout the research process, I kept a reflexive diary and I will discuss the challenges I experienced in a later section. Limitations in terms of sampling will also be discussed in Chapter 7.

Informed consent

Informed consent is of significant importance in all research, particularly with young people due to the aforementioned issues with power relations (Gallagher, 2009). In Scotland, the ability of research participants to provide informed consent is based on their competence to do so, rather than their chronological age; thus, those under the age of 16 can give informed consent to participate in research, without the requirement of first obtaining parental consent or assent (Scottish Children's Research Network, 2012). However, to be able to give informed consent, potential participants must understand what participation will entail, what is being asked of them, that the research is unlikely to have direct benefits to them and then make an informed decision on the basis of this information (Fargas-Malet et al. 2010; Kirk, 2007; Morrow and Richards, 1996). Gallagher (2009) notes that there are four key features of informed consent: consent comprises an explicit act, such as spoken or written agreement; consent can only arise when participants are given information about and comprehend key aspects of what the research will entail and the expected outcomes; consent must always be given voluntarily; and must be open-ended, so that participants can withdraw at any time during the research process. Thus, informed consent in research is an ongoing process, which is much more than simply completing forms (Turner-Henson, 2005); researchers must constantly ensure that participants wish to continue (Kirk, 2007).

Consent is gained first by informing potential participants about the research; this is often achieved through the use of information sheets or leaflets. In research with children and young people, it is vital that these information sheets are appropriate to the developmental and chronological age of participants, by using simple language, diagrams, speech bubbles and a question and answer format (Fargas-Malet et al. 2010). The participant

information sheet (Appendix 6) used in the study was based on the suggestions by Fargas-Malet et al. (2010) and examples provided by other researchers, which have been used successfully in research with children and young people. I also ensured that I took the time to explain the information and answered any questions, as recommended by Gallagher (2009). Gaining informed consent can be especially complicated when conducting research with looked after young people, due to their perceived vulnerability (Thomas and O’Kane, 1998). In research with this population, who provides consent is a controversial matter; it is often required from participants themselves, parents or carers, professionals and organisations (Powell and Smith, 2009). It can be inappropriate to ask for parental consent for those in care (Kendrick et al. 2008).

In line with recommendations from the FHLSS ethics committee, gatekeepers’ consent was sought for those under the age of 16 years (Appendix 7). I felt that it was important for young people to give informed consent themselves, rather than relying on gatekeepers to provide it on their behalf. Therefore, all participants, carers and young people alike, were asked to give written informed consent at the start of the interview (Appendix 8 and 9). As consent is an ongoing process, I constantly ensured that participants knew they could stop the interview at any time. In reality, this meant that the interviews were sometimes stopped and started again as required, such as to use the toilet, answer the telephone, get a drink of water, deal with dinner and answer the door. At no point did any participant ask to stop the interview early. When gaining informed consent from my participants, I ensured that they were able to understand the information; could understand what the interview would entail and the potential consequences; to weigh up the information; and finally come to a decision regarding whether or not they wished to participate. This process was first done by the carers before I was able to access the young people and again prior to the interview, when I would explain the study and allow young people to ask questions. The same process was also followed for carers, prior to the interview.

Confidentiality and disclosures

Morrow and Richards (1996) assert that the extent of privacy and confidentiality given to young people in research studies should be equal to that given to adults. However, there are often limits to confidentiality in research, particularly in terms of disclosures of harm. Complete confidentiality cannot be promised in research with young people, as researchers are obligated to report disclosures of harm (Fargas-Malet et al. 2010; Kirk, 2007). It is important to clearly state these limits to confidentiality as well as when and how a researcher would deal with disclosures of harm in information sheets given to participants (Kirk, 2007). Participants need to understand that researchers may break confidentiality, and when and why this may be done, as some children and young people may see such an act as a breach of their trust (Gallagher, 2009). Confidentiality can be a source of concern when conducting research with looked after young people due to their perceived vulnerability, particularly those in residential care (Kendrick et al. 2008; Thomas and O’Kane, 1998).

Researchers need to be prepared to deal with disclosures of harm that young people make about themselves or others; it is important to be clear about confidentiality during research and particularly the limits of this confidentiality (Kendrick et al. 2008; Munro et al. 2005). There is a general consensus among researchers that when conducting research with looked after young people, one should explain that all information will be confidential unless the participant discloses information that suggests harm to themselves or another child or young person. If such disclosures occur, researchers are required to tell someone about the information, with the consent of the child or young person (Berrick et al. 2000; Kendrick et al. 2008; Munro et al. 2005; Thomas and O’Kane, 1998).

Privacy and confidentiality was conveyed to all participants throughout the study. Before each interview with a young person, I explained the limits of confidentiality, informing them that everything they said during the interview would be kept confidential, unless they made a disclosure of harm, or potential harm, to themselves or another young person. In this case, I would

be obliged to tell a professional about the disclosures. I then planned to discuss such disclosures with my supervision team. The process of dealing with disclosures is presented in Appendix 10. During the interviews, none of the young people made any such disclosures. With carers, there was also a legal obligation to inform someone if disclosures were made relating to harm to children or young people; there was no such obligation relating to carers themselves or other adults. In such cases, carers would be provided with information regarding support services and would be encouraged to talk to colleagues or a social worker. Again, no such disclosures were made.

Recruitment

Recruitment began after ethical approval had been granted and I received contact details for relevant professionals, occurring between December 2014 and October 2015. First I will explain the process of recruiting young people before moving onto detail the process with carers.

Recruitment of young people

The process of identifying and recruiting young people in residential care was lengthy, taking place over a period of ten months, involving contact with numerous people and organisations and frequent emails and telephone calls. Recruitment of those in residential care began in December 2014, when I made contact with two residential units and a supported living unit; I was informed by my contact in the Council that there would likely be a few young people willing to participate. The managers of these units agreed to identify and ask young people if they would like to participate in the study. These managers were provided with the inclusion and exclusion criteria (Appendix 4), to identify appropriate young people; and information sheets (Appendix 6), which they were asked to use when speaking to young people about the study. This process resulted in four young people being identified, three of whom were interviewed.

I contacted Who Cares? Scotland, a voluntary organisation for young people in care, in January 2015, to find out if they were able to help with the recruitment of young people in residential care. I was informed that they

would be willing to help, but most of the young people they work with have already left care. They identified a worker, who would speak to young people in the residential units in Edinburgh on my behalf, and I sent my study documents to her. Unfortunately, the majority of young people she approached refused to participate, all saying that they were not interested or did not have the time. Three were identified and initially agreed to participate; however, two were outwith the study age range and the other subsequently declined to participate. In June 2015, one of the unit managers passed on the contact details of five residential units; I made contact with these units and two agreed to help with identifying young people. This resulted in another six young people being identified, three of whom participated in an interview. A final sample of six young people participated in an interview. Recruitment was most successful when young people were identified and approached by residential unit managers and care staff. Once young people had agreed to participate in an interview, I arranged a suitable time and date with staff at the unit; as I was unable to contact young people directly, I had to rely on staff arranging these interviews on my behalf, which they did with little difficulty.

As with the recruitment of young people in residential care, recruiting young people in foster care was also a long, arduous process. In January 2015 I made contact with five independent fostering organisations, three of whom agreed to be involved in the study and help recruit young people in foster care. One organisation informed me that they had no direct contact with young people so would be unable to assist. I was only able to recruit young people through one foster organisation, with all five young people who were approached agreeing to participate in an interview. A social worker from City of Edinburgh Council's fostering team was able to identify and recruit a further two young people. Recruitment was most successful when young people were identified and approached by the independent fostering organisation's social worker, who they knew. Again, when the young people had agreed to participate, I arranged a suitable time and date for an interview with their foster carers, as I was unable to contact them directly myself. Table 3 shows the recruitment strategies used for foster and residential care. Table

4 shows the final sample of young people; brackets denote the number specified in the sampling framework.

Table 3. Recruitment strategies for young people

	Identified	Contacted	Interviewed
CEC residential units (n=7)	10	8	6
CEC-funded supported living unit	5	0	0
CEC Children's Rights Officer	Unknown	0	0
Who Cares? Scotland	3	1	0
CEC specialist fostering team social worker	2	2	2
CEC fostering team	Unknown	0	0
Fostering organisation A	5	5	5
Fostering organisation B	Unknown	0	0
Fostering organisation C	Unknown	0	0
Other organisations	Unknown	0	0
TOTAL	N/A	16	13

Table 4. Final sample of young people

	Foster Care	Residential Care
Male	2 (3)	2 (3)
Female	5 (3)	4 (3)
TOTAL	7 (6)	6 (6)

Recruitment of carers

Staff in residential units, social workers and foster carers were recruited generally in the same way as young people, although recruitment was slightly easier. I contacted the manager of each of the residential units that agreed to help me recruit young people and asked if there were staff who would also like to participate in the study. A total of ten residential care staff were identified and agreed to participate; one of these was not currently working in residential care but had worked as a unit manager for a number of years. Two social workers were identified through my contact in the Council, both of whom agreed to participate. They also passed the details of my study onto their colleagues, although no one contacted me to participate. Three foster carers were identified through a social worker in the fostering team and four were identified through the fostering organisation. Information about the study was emailed to the unit managers and social workers, who circulated this to potential participants, including permission to be contacted by me. Once carers gave permission for me to contact them, I telephoned or emailed

them to arrange a date and time to conduct the interviews. A total of 18 carers agreed to participate; only one, a foster carer, declined to participate, stating that she was too busy. Table 5 shows the final sample.

Table 5. Final sample of carers

Foster carers	6 (6)
Residential care staff	10 (6)
Social workers	2 (4)
TOTAL	18 (16)

Conducting the interviews

Data collection was conducted between January and October 2015. I will now describe the data collection process, in terms of how the interviews were conducted.

Young people

After being recruited to the study, I made arrangements to meet each individual and conduct the interview. All of the interviews were conducted in the residential unit or home in which they lived, at a time that was deemed suitable for them. The majority of interviews were conducted in the late afternoon or early evening, when the young people had arrived home from school or work. At the beginning of each interview, participants were provided with an information sheet (Appendix 6), explaining the rationale for the study and the interview process, and were asked to read through it. I also explained the study information in more detail, covering the use of the audio recorder, what would happen to the data and when confidentiality would be broken. I informed each participant that all names and places would be changed and asked if they would like to choose their own pseudonym; only one participant chose their own pseudonym, with the remainder allowing me to choose one for them. After explaining the research process, I asked if they had any questions about the research or wanted more information. None of the participants had any questions they wanted answered. I then asked if they wanted to continue and take part in the interview. All of the young people agreed and were asked to complete a consent form (Appendix 8).

After completing the consent forms, I checked again that the participants would like to continue and participate in the interview.

All of the interviews were recorded using a small digital audio recorder, which was placed, within easy reach, on a table or chair near to where we were sitting. Thomas and O’Kane (1998) note that a simple way of attempting to address the power imbalance during the research process is by giving young people control over the audio recording device, allowing them to turn it off if they wish. I explained to the participants that they could turn off the recorder at any point, by pressing a specific button, although none turned off the recorder during the interview. The interviews were varied in length, ranging from just over four minutes to over an hour. Three interviews lasted less than 10 minutes, as these participants felt that no one had communicated with them about substance use, so they had very little to say. They were also very shy and reserved, saying very little during the interviews. After reflecting on these interviews and going through the transcripts, I identified a number of potential prompts that I was able to use in future interviews with young people, in an attempt to build rapport and encourage young people to talk. These prompts are included at the bottom of the interview schedule in Appendix 11. I also decided to try to recruit more young people who had experience of substance use, particularly drug use, because it was apparent that non-users had little experience of communication and therefore much less to say during their interviews.

The interview schedule (Appendix 11) was developed through engagement with the literature and in discussions with my supervision team. As the study was exploratory in nature, I tried to make the interview schedule as broad as possible, with a list of questions I wanted to cover during the interview. The interview schedule was revised during the data collection process, adding relevant questions as topics were raised in the interviews with participants. Participants were asked questions relating to their experience of their current placement, relationships with carers, communication about general topics, conversations about alcohol, tobacco and drug use and the use of digital media in these conversations.

A number of authors have highlighted the difficulties in building rapport with young people during the research process (Fargas-Malet et al. 2010; Kendrick et al. 2008; Kirk, 2007; Punch, 2002b). Each interview began by asking young people about their current placement, previous care experiences and about whether they were at school, college or working. I felt that asking these questions helped put participants at ease, and also enabled me to gain an understanding of their care experiences and what it is like to be a looked after child. I felt that it was inappropriate to ask too many questions regarding why they had become looked after; some young people talked in more detail about their care experiences than others. After talking about their current placements and relationships with carers, the remainder of the interview was focused on communication about substance use, and their experiences of this. Using an iterative process during the research meant that topics and prompts were added to the interview schedule, which allowed me to explore emergent themes and ideas in more depth.

At the end of each interview, I thanked each participant and gave them a debrief sheet (Appendix 12), which included my contact details and details of support services. I also explained that I would provide them with a summary of my findings, at the end of the study (Appendix 13). Many of the young people were keen to leave as soon after the interview as possible. After each interview I wrote detailed notes on the experience, describing how I felt the interview had gone, my perceptions of the young people and any thoughts or feelings I felt were relevant. Often these notes were written in the car before I left, or later that day when I returned home.

Carers

After being recruited to the study, I contacted each individual and made arrangements to meet them to conduct the interview. The interviews were conducted in Council offices, residential units or in participants' homes, at a time and date that was suitable. At the beginning of each interview, participants were provided with an information sheet (Appendix 14), explaining the rationale for the study and the interview process, and were asked to read through it. I also explained the study information in more detail,

covering the use of the audio recorder, what would happen to the data and when confidentiality would be broken. I informed each participant that all names and places would be changed and asked if they would like to choose their own pseudonym; four participants chose their own pseudonym, with the remainder allowing me to choose one for them. After explaining the research process, I answered any questions about the research. I then asked if they wanted to continue and take part in the interview. All of the carers agreed and were asked to complete a consent form (Appendix 9).

After completing the consent forms, I again checked that the participants would like to continue and participate in the interview. All of the interviews were recorded using a small digital audio recorder, which was placed, within easy reach, on a table or chair near to where we were sitting. The interviews were varied in length, ranging from 25 to 90 minutes. All but one of the interviews were conducted individually; two foster carers explained that they would like to participate in the interview together, as they approached fostering “as a team”, and felt that doing separate interviews would be repetitive. Of the foster carers interviewed, two were single parents and the other couple were interviewed individually. I wanted to gain an understanding of their own individual experiences of communicating with young people, which is why the other foster carer couple was interviewed one at a time.

The interview schedule (Appendix 15) was developed through engagement with the literature and in discussions with my supervision team. Again, I tried to make the interview schedule as broad as possible, with a list of questions I wanted to cover. The interview schedule was revised during the data collection process, adding relevant questions as topics were raised in the interviews with participants, such as exploring ways in which connectedness is developed, instances of shared doing and discussion of the ways in which communication occurs. Participants were asked questions relating to their experience of being a social worker, residential care staff member or foster carer, communication about general topics, conversations about alcohol, tobacco and drug use and the use of digital media in these conversations. Using an iterative process during the research meant that topics and prompts

were added to the interview schedule, which allowed me to explore emergent themes and ideas in more depth; these prompts and new questions are at the bottom of the interview schedule in Appendix 15. At the end of each interview, I thanked each participant and gave them a debrief sheet (Appendix 16), which included my contact details and details of support services. I also explained that I would provide them with a summary of my findings, at the end of the study (Appendix 17). Again, detailed notes were written soon after the interview, in terms of my experience of the interview, my perceptions of the participants and any thoughts or feelings I deemed relevant.

As I was following an iterative process throughout the research, I conducted data analysis throughout the data collection phase. After I had conducted interviews with seven of the staff in residential care, I reflected on the interviews and felt that they had not spoken in much detail about how they had conversations with young people about substance use. In discussions with my supervisory team, I decided to contact these staff members again, asking if they would participate in a short follow up interview, to gain a greater understanding of these conversations. Four of the seven staff agreed to participate in a follow up interview, which all took place in May and June 2015. Before the interview, I asked participants to think of a recent conversation they had had with a young person. In these interviews, staff described why the conversation occurred, what they said and felt and how the young person responded. These interviews lasted between 10 and 25 minutes. In future interviews with foster carers and residential care staff, I ensured that I explored their experience of these conversations in more detail, asking similar questions to those asked in these follow up interviews.

Reflecting on the interview process

Reflexivity, an important but much debated issue within qualitative research, is described as “the impact which the researcher has on the data elicited and the impact of the research process on the researcher” (Barbour, 2014, p. 109). The researcher influences the entire research process, deciding what to research, how to collect and analyse data; thus, it is impossible to

separate the two (Finlay, 2002a; Hand, 2003; Horsburgh, 2003; Malterud, 2001; Ormston et al. 2014; Pillow, 2003; Watt, 2007). Within a broadly social constructionist framework, reflexivity is used as a way of exploring how individuals make sense of their social world, and as a way of understanding the relationship between researcher and participants (Finlay, 2002b). Each researcher will approach a research topic differently, having different motivations and backgrounds, reacting differently, asking different questions and having different experiences of the process (Finlay, 2002b; Malterud, 2001). As qualitative research is such a subjective experience, reflexivity plays an important role in increasing the transparency of the process, enhancing rigour and acting as a type of audit trail, with the researcher describing and justifying each step in the research process (Finlay, 2002a; Hand, 2003; Horsburgh, 2003; Jasper, 2005; Mays and Pope, 2000).

A researcher's background, culture, upbringing and experiences will also affect the research process, so it is important to consider the effect of these (Finlay, 2002a; Kuper, Reeves and Levinson, 2008; Malterud, 2001; Mays and Pope, 2000). Reflexivity can also involve analysing the dynamics of the relationship with participants, particularly in terms of power, as well as exploring participants' own cultures, backgrounds and experiences on the research and the data (Finlay, 2002a, 2002b; Mays and Pope, 2000; Pillow, 2003). Social constructionists are open about the tensions that emerge during the research which are a result of the researcher's and participants' social positions (Finlay, 2002a).

While reflexivity seems to be a rather straightforward concept, the process of engaging in reflexivity is often viewed as vague and challenging (Dowling, 2006; Finlay, 2002b). Much of the literature about reflexivity explores the concept and the importance of being reflexive when conducting research, but less is written in terms of practical advice regarding how to be reflexive. There are two methods that researchers can adopt to enable and enhance reflexivity in their research, both of which I have adopted in my study: writing about your experiences, thoughts, ideas and decisions, in field notes and a research diary (Dowling, 2006; Finlay, 2002b; Jasper, 2005; Watt, 2007), and

writing in the first person (Horsburgh, 2003; Jasper, 2005). I found that keeping detailed notes regarding the decisions I made during the research process, as well as writing about my experiences of the interviews, were useful ways of exploring the impact I might have on the research process, and the process on me. My field notes from an interview with a young person can be found as Appendix 18, and with a carer as Appendix 19.

Throughout my study, I tried to remain aware of how my personal appearance and characteristics might affect how participants, and other professionals, might view me. At the time of collecting the data for this study, I was a 28 year old, white, middle class woman, with no children of my own. My upbringing was comfortable, with loving parents; thus, my childhood experiences were very different from those of the young people I interviewed. The lives and experiences of looked after children and young people were almost alien to me; before starting my field work I had never been to a residential unit, or conducted research with young people, although I had experience of working with young people as a sports coach, and felt that this experience would give me some help when interviewing young people. However, throughout the interviews, I definitely felt like I struggled to engage with some of the young people, in building rapport and getting them to open up and talk to me. As a result, some of the interviews were very short. After these interviews, I would doubt my ability as a researcher and felt that these interviews were short because I was poor at interviewing.

Expressing my frustrations in my field notes (Appendix 18) allowed me to consider my own teenage self, other teenagers I have met and the experiences of the population I was researching. I was painfully shy as a teenager, and I'm sure that if I had to speak to a researcher, I would have struggled, like some of the participants in my study. I was aware, through conversations with staff in the field, that some of these young people can be shy and have severe trust issues, being unable to talk to staff they have known for months. For them, talking to a stranger, someone they had just met, was incredibly difficult. In future interviews, I tried to make the young people as comfortable as possible and reminded myself that while they may

have little to say, their contributions were still valuable. These issues will be discussed again in Chapter 7, when reflecting on the findings of the study.

One's physical appearance and its effect on the research process is often considered as crucial in ethnographic research, but I felt that it was important to consider my appearance in my study. A number of researchers have discussed their clothing choices as part of the research process, carefully considering what identity they wanted to portray to their participants (Allen, 2004; Lewis, 2008; Morris, Woodward and Peters, 1998; Nixon, 2014; Williams, 2011). This is something that I considered when conducting my interviews, especially those with young people. I felt that it would be inappropriate for me to wear clothing that was too professional, I wanted them to feel that I was approachable and not another authority figure. I chose to wear casual clothing, usually jeans, to each interview. I'm unsure as to whether my choice of clothing had any effect on how responsive the young people were towards me. Interestingly, my 'best' interview with a young person, who was very responsive and talkative, was conducted after I had attended a symposium, so I was wearing smarter, more professional attire. I noticed that most of the staff in the residential units I visited dressed very casually too.

At times, however, I did feel that my appearance had a negative effect on how I was perceived by staff, particularly gatekeepers, when I was trying to negotiate access to young people. Despite being 28 years of age, I am often told that I look much younger than this. On more than one occasion when talking to carers, I was referred to as the 'student' or asked what university course I was studying, which I took to imply that they thought I was an undergraduate student. Roesch-Marsh et al. (2012) reported experiencing similar difficulties, with the 'student' identity lacking power over negotiations about access to research participants. I felt, at times, that my lack of authority meant that professionals did not take my research seriously, which may have affected recruitment of participants.

My professional identity, as a researcher from a university, may have also had an effect on how participants viewed me and therefore the data collected. Participants were aware before the interviews that I was a researcher from a university, which they may have perceived as a place of authority. Participants were also aware that I came from the School of Nursing, Midwifery and Social Care, so they may have rightly assumed that I am not a social worker. My professional identity, as an academic not a social worker meant that I was an 'outsider', someone who came from outwith the social work field and did not have much understanding of, or experience with, the care system. While I cannot say whether participants held these particular views of me, it is possible that their perceptions may have influenced their answers.

Within a broadly social constructionist framework, it is important to consider that participants might be attempting to present themselves in a particular manner (Finlay, 2002b). They may have felt that they needed to present themselves in a favourable light and give socially desirable answers, rather than those which reflected their experiences or views (Collins, Shattell and Thomas, 2005; Krefting, 1991). Collins et al. (2005) note that participants may make particular efforts to present themselves in a favourable light when the interview concerns disclosures of unethical or illegal behaviours. Thus, participants may have given the answers that they deemed acceptable, because they wanted to make a particular impression. For young people, this may have been not wanting to disclose substance use; for carers, they may have said they were communicating about substance use more than they do, because they did not want to be seen as being a poor carer or not doing their job. Again, this will be discussed in more detail in Chapter 7.

Rigour

When considering reflexivity within a qualitative study, it is also crucial to examine rigour (Jasper, 2005). In qualitative research, rigour is a measure of the quality of a study, a way of ensuring that it has been conducted systematically and that the findings are trustworthy (Jasper, 2005; Mays and Pope, 1995). There are a number of ways to enhance rigour, which were

implemented in the current study. Firstly, a clear sampling framework was developed and purposive sampling was used (Mays and Pope, 1995; Tuckett, 2004). This approach to sampling ensures that participants are carefully selected to ensure that they are relevant to the study and will have experience of the phenomenon being studied (Ritchie, Lewis, Elam, Tennant and Rahim, 2014). Secondly, being reflexive throughout the whole research process adds to the rigour of the study. Jasper (2005) argues that rigour is improved when researchers can identify how their own experiences, behaviours and preconceptions can influence the research; she suggests that through reflexive writing, researchers are contributing another data source to their study.

My own reflexive writing has been described above, and will be detailed again in Chapter 7, in relation to the findings. Providing a clear audit trail, as I have done throughout this chapter, also enhances the rigour of a study (Jasper, 2005; Mays and Pope, 2000). Another method, triangulation, was achieved in this study by conducting interviews with both young people and carers; doing so ensured a more comprehensive, in-depth understanding of how communication occurs (Mays and Pope, 2000; Tobin and Begley, 2004). Examination of deviant cases, which was performed as part of the analysis and will be described below, also enhances rigour, through refinement of the analysis (Mays & Pope, 2000). Finally, the reliability of the analysis was ensured by keeping concise records of the interviews, detailing all of the steps taken during analysis and independent assessment of the coding framework (Mays and Pope, 1995). After I had developed my initial coding framework, I shared this with another PhD student, along with a small selection of interview transcripts, and asked her to assess whether the coding framework fitted with the data. We then came together to discuss her assessment: we were generally in agreement and no major changes were made. A similar, albeit less detailed process was also followed during discussions with my supervision team, ensuring that the analysis was reliable and that the findings reflected the raw data. Thus, the steps taking during the research design, data collection, analysis, interpretation and reporting of findings provide evidence of a rigorous and systematically conducted study.

Data saturation

As with sample size, there is much debate regarding data saturation in qualitative research, with few guidelines regarding how saturation is achieved in reality (Baker and Edwards, 2012; Francis et al. 2010; Guest et al. 2006). Often saturation is deemed to have been achieved when no new insights would be obtained from conducting further interviews (Francis et al. 2010; Kuper et al. 2008; Ritchie et al. 2014), or as Kuper, Lingard and Levinson (2008, para. 4) suggest “when a thorough understanding of the phenomenon under study has been reached”. I interviewed a total of 31 people, three more than my anticipated sample size of 28. Initially I had anticipated that I would interview four social workers, however, I was unable to recruit any other social workers after interviewing two. I also felt that the interviews with foster carers and residential care staff were more relevant, because they were with the young people on a daily basis, so had more opportunities for communication about substance use. Therefore, I decided to interview more residential care workers than first anticipated. I also wanted to interview residential care workers from a variety of residential units, to gain a diverse range of experiences. A couple of the interviews in one of the units were quite short, so I then interviewed another two staff from two different units. After conducting these final two interviews with residential care staff, I believed that I had reached data saturation, as no new themes were emerging, and I felt that conducting additional interviews would not be of value.

With the young people, I felt that I had almost reached data saturation after 11 interviews, but I was keen to try to recruit another two young people, one in foster care and one in residential care, who had used drugs, in order to gain an understanding of their experiences in relation to communication about drug use. This proved to be very difficult, and in the end, only one of these young people reported that they had used drugs. After conducting these final two interviews, I felt that collecting additional data would not shed any more light on the topic. It had also become difficult to recruit any more young people and after a discussion with my supervision team, I decided to stop recruitment after 31 interviews. Data saturation will be discussed again

in Chapter 7, in my reflections on conducting qualitative research within this population.

Data analysis

Data were gathered from a total of 13 interviews with young people, four males and nine females, aged 12-19 years. Seven were in foster care and six in residential care. Table 6 shows the characteristics of these young people.

Table 6. Participant characteristics – young people

Name	Age	Gender	Care type	Current placement	Reported substance use
Skylar	17	Female	Residential	2 years	Tobacco
Michael	14	Male	Residential	1 month	Tobacco, alcohol, NPS
Kate	13	Female	Residential	6 weeks	None
Joseph	13	Male	Residential	3 months	None
Hayley	14	Female	Residential	6 weeks	Alcohol
Megan	16	Female	Residential	3 years	Alcohol, tobacco
Sophie	15	Female	Foster care	1 year	Alcohol
Josh	12	Male	Foster care	9 months	None
Rachel	15	Female	Foster care	3 years	Alcohol
Beth	14	Female	Foster care	10 months	None
Craig	16	Male	Foster care	2.5 years	None
Kirsty	19	Female	Foster care	3 years	Alcohol, tobacco
Zoe	16	Female	Foster care	1 year	Alcohol, tobacco, cannabis

Twenty-one interviews were conducted with 18 carers; this was because I interviewed two foster carers together, and I carried out four follow up interviews with four residential care staff. Interviews were conducted with two social workers, 10 residential care staff and six foster carers. Table 7 shows the characteristics of these carers.

Table 7. Participant characteristics – carers

Name	Gender	Job title	Area	Experience
Michelle	Female	Social worker	Foster care	7 years
Hope	Female	Social worker	Foster care	6 years
Eric	Male	Ex-residential care staff	Residential care	25 years
James	Male	Residential care staff	Residential care (A)	5 years
Ashley	Female	Residential care staff	Residential care (A)	10.5 years
Jennifer	Female	Residential care staff	Residential care (A)	8 years
Diane	Female	Residential care staff	Residential care (B)	9 years
Angel	Female	Residential care staff	Residential care (B)	25 years
Marie	Female	Residential care staff	Residential care (B)	15 years
Julie	Female	Residential care staff	Residential care (B)	11 years
Ian	Male	Residential care staff	Residential care (C)	21 years
Sharon	Female	Residential care staff	Residential care (D)	15 years
Susan	Female	Foster carer	Foster care	11 years
Deborah	Female	Foster carer	Foster care	10 years
Tony	Male	Foster carer	Foster care	10 years
Sandra	Female	Foster carer	Foster care	3 years
Rob	Male	Foster carer	Foster care	3 years
Sarah	Female	Foster carer	Foster care	1 year

Analytic approach

These data were analysed using a thematic analysis approach, as described by Braun and Clarke (2006). Thematic analysis is a widely used approach in qualitative research, which is not attached to a specific discipline or theoretical paradigm (Bryman, 2012; Spencer, Ritchie, Ormston, O'Connor and Barnard, 2014). It is in keeping with a broadly social constructionist framework, whereby the underlying assumptions and ideas of participants' language can be analysed (Braun and Clarke, 2006). While some authors have argued that thematic analysis is more of a general analytic approach than a method in its own right (Spencer et al. 2014), Braun and Clarke (2006 p.78) disagree: they view it as a "flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of the data". While thematic analysis within a broadly social constructionist framework may involve a deductive rather than an inductive, approach, Braun and Clarke argue that researchers can be flexible in their approach, and that it is more important to explain what you have done and why, as well as producing consistent and coherent analysis, than following the method prescriptively

(Braun and Clarke, 2006). In keeping with this flexible approach, I examined my data both inductively and deductively, as well as being aware of participants' first hand experiences. I wanted to explore the data with an open mind, at the themes that were 'emerging' from the data, as well as considering my theoretical underpinnings and findings from the research, to help explain these data.

There are six key phases to conducting a thematic analysis, although the process is not linear and these phases should be repeated as necessary (Braun and Clarke, 2006). These phases are: becoming familiar with the data; generating initial codes; searching for themes; reviewing and refining themes; defining and naming themes; and reporting the final analysis (Braun and Clarke, 2006). The constant comparative method is a crucial part of thematic analysis (Thorne, 2000), whereby data are compared against one another (Pope, Ziebland and Mays, 2000). The identification of deviant cases is particularly important; instances of discourse or experiences are identified which appear to be contrary to the rest of the data (Green, 1998; Pope et al. 2000). Constant comparison within and between the data enables the researcher to identify and develop emergent themes and enhance the analysis (Charmaz, 2003; Mays and Pope, 2000). In the current study, data were compared within interviews, looking for similarities and differences, for instances in which participants may have contradicted a previous statement they made. Data were also compared between interviews, to examine the similarities and differences in terms of what carers and young people said, as well as what was said in each setting.

Thematic analysis is a flexible, accessible and relatively easy approach, which I have experience of using in previous research projects. It is also suited to research in which the results have potential to inform policy (Braun and Clarke, 2006) and it is anticipated that the findings of my study will have such outcomes. In the next section I will explain how I transcribed, coded and analysed my data.

Transcription of interviews

Transcription is more than just a process of transferring spoken language into written form; it is an excellent way for researchers to get to know their data, gain a deeper understanding of their participants, and to start thinking about analysis (Braun and Clarke, 2006; Howitt and Cramer, 2008). I felt that it was an important and useful first step in my data analysis to transcribe the interviews myself. All of the interviews were recorded using a handheld digital audio recorder. I transferred the audio files to my personal computer and the interviews were transcribed verbatim as soon as I could after each interview. Using an external microphone with the audio recorder meant that the quality of the recordings was good and transcription was generally straightforward, albeit time consuming. I tried to capture participants' language, dialects and pronunciations as well as possible, to avoid changing their meanings. I also underlined words, to capture occasions when participants had emphasised a particular word or phrase. All identifiable names and places were changed during transcription. In terms of choosing pseudonyms, I used an online baby name website, to choose a name that was suitable for their age and gender. The transcripts were checked for accuracy at least twice with the original audio recordings, a critical first step in generating a good thematic analysis and familiarising yourself with the data (Braun & Clarke, 2006). An extract from a transcript is provided as Appendix 20.

Coding and theme generation

The next step in thematic analysis is the generation of initial codes which appear to be most interesting and salient (Braun and Clarke, 2006), a process described as 'open coding' (Patton, 2002). I read through each of the transcripts, highlighting areas of text that I thought were interesting or important, writing short summaries, or codes, in the margin. These notes were words or short phrases that tried to summarise what I thought was being said in the text. Initially, I did this electronically, using Word, but I felt that I was not engaging fully with the data, so I decided to code each transcript manually, using highlighter pens. The process of coding was inductive, in that I identified themes that were emerging from the data, as well as deductive, by considering my theoretical underpinnings, findings from the

research and my own research questions, to help explain the data. Figure 1 below shows two examples of how transcripts were highlighted and coded. The right hand column shows the initial open codes, which are slightly longer summaries of the text. The left hand column details the more succinct codes, which were then sorted into themes, as detailed below. For ease of reporting, these examples have been taken from printed transcripts and entered into a table.

I then wrote a short memo for each interview, summarising the field notes and initial key codes that were emerging. An example of one of these memos is in Appendix 21. For Birks et al. (2008) memoing provides researchers with a way of extracting meaning from the data, to question what they are observing in the data and to aid with constant comparison. This act of coding and memoing was conducted throughout the data collection period, as I was following an iterative process. This meant that initial ideas and codes that were emerging from the data were asked about in subsequent interviews. At the outset, I wanted to write a short summary, or code, for each section of the transcript. However, when participants moved away from the topic and I felt that what they were saying was no longer relevant to the research, I chose not to code these sections. Morse and Field (1996) call these sections of an interview 'dross'; they are unusable sections of text that are unrelated to the topic (Burnard, 1991).

Figure 1. Examples of coding

Succinct codes	Transcript	Initial open codes
<p>Ways of building relationships</p> <p>Doing things together</p> <p>Shared doing - car</p> <p>Eye contact</p> <p>Choosing to have conversations</p>	<p>Hannah: mmhm and how d'you build up the relationships?</p> <p>Sharon: with with lots of talking and listening em...lots and lotsa talkin' and listenin' and doin' fun things and goin' for drives in the car [Hannah: okay]</p> <p>they're always drives in the car's always a <i>really</i> good way to talk to teenagers [Hannah: yeah] because they <i>don't</i> need to look at you [Hannah: yeah] so if there is topics that you need to discuss that's always a good way and they're more like they can't go anywhere if a car's movin' [Hannah: <i>laughs</i>] and they're so they're more likely to sit there you might not always get the information but it is a good a good place to start a conversation is in the car</p>	<p>Building relationships</p> <p>Doing fun things together</p> <p>Driving in car as good way of talking</p> <p>No eye contact</p> <p>Choosing to go for drive to talk</p> <p>Engagement</p> <p>Talk to you in car</p>
<p>Ways of building relationships</p> <p>Treated like own child</p> <p>Part of a family</p>	<p>Zoe: been really good em...just the way that they like they treat me em that they treat me as if I'm their own [Hannah: okay] so that's nice [<i>laughs</i>]</p> <p>Hannah: why d'you like that?</p> <p>Zoe: eh...I just like it cos I don't feel as if I'm like just a looked after child that I feel as if like they're my Mum and Dad so that's the way that they make me feel [Hannah: that's good] which is good [<i>laughs</i>]</p>	<p>Being treated as own child as good</p> <p>Doesn't feel like LAYP</p> <p>Feels like they're the parents</p>

After highlighting the transcripts and writing initial open codes and more succinct codes, I moved onto phase three, 'searching for themes'. This process involved sorting the codes into initial themes and collating all of the data extracts, or quotes, into each theme. For example, in the above extracts in Figure 1, these codes were sorted into the initial themes of 'shared doing' and 'building relationships'. I did this by sorting the data into tables for each theme and adding all of the corresponding data into the table, with a separate column to allow for a short explanation as to what I thought each participant was meaning, in order to provide a more interpretative lens to my analysis,

as well as to facilitate constant comparison. I also wrote a short summary of what I thought each initial theme was about. An extract of one of these theme tables is provided as Appendix 22, in relation to a sub-theme of 'shared doing in the car'. At the end of this phase I was left with a number of themes and sub-themes, which needed further refinement. These themes and sub-themes became my initial coding framework.

Phase four involved reviewing and refining these themes and sub-themes. It became apparent that some of the initial sub-themes did not have sufficient data to support them, so were either removed or formed part of another sub-theme, if relevant. For example, the sub-theme mentioned above, 'shared doing in the car', became part of the final sub-theme of 'a less intense approach to communication'. I found it helpful to draw a diagram of the themes and sub-themes (Appendix 23) and map how each related to each other and to the research questions. This provided an opportunity to determine whether I had collected sufficient data to answer the research questions I set out to answer. This was an important process, in case it revealed that further interviews with young people or carers were required. Secondly, by mapping the themes onto my research questions, I was able to collate all of the data to make it more manageable for writing up. This process highlighted how the initial themes and sub-themes might be used to address the three research questions.

The penultimate stage of thematic analysis was to define and name the themes. By the end of phase four, I had a number of sub-themes across three major themes. This stage involved making refinements to the themes, capturing the "essence" of the themes (Braun & Clarke, 2006, p. 92) and to organise data extracts into a coherent narrative which explained the theme in full. Braun & Clarke (2006) recommend writing a detailed story about each theme as phase five of thematic analysis. The process of writing the narrative involved examining the data extracts again, in relation to the thematic map and sub-themes, and writing a detailed description of the theme. My first attempt at this process was rather descriptive, with the description of the themes being rather simple. I initially struggled to be interpretative in my

analysis, finding it difficult to move beyond the surface of the data. Braun and Clarke (2006) recognise that interpretative analysis is difficult to define, stating that such analysis will vary across studies. After much discussion with my supervisors, I embarked upon the process again, this time delving deeper into the data, exploring participants' language and the underlying meaning to what they were saying.

Introduction to the themes

Thus, three narratives were produced, each telling a separate but interwoven story: '*the influence of connectedness and professional role identity*'; '*constraints, boundaries and rules*'; and '*doing communication*'. In order to write these stories, I examined the situations in which participants talked about relationships or connectedness, role identity and communication around substance use, as well as comparative analysis in terms of setting and population. Throughout the process, I used a constant comparative method to ensure that I was seeking similarities and differences in participants' accounts, looking for deviant cases which might highlight particularly important aspects of the data. I examined the perspectives of foster carers separately from residential care staff and social workers; those of young people from carers; and from young people in residential versus foster care. By examining the language that participants used to talk about their experiences, I could provide a deeper understanding of their underlying assumptions and constructions about their realities, in keeping with a broadly social constructionist approach.

Thus, by the end of phase five I had three concise narratives which detailed my themes. These stories were further refined, leading to phase six of analysis, in which the analysis is written up in full. This stage involved refinement, choosing particular data extracts, in the form of quotes from participants' transcripts, to augment the stories, providing a rich and detailed description of the themes. The writing up of qualitative findings provides an additional opportunity to finalise the analysis, to reassess themes and assemble them into a comprehensible and compelling story (Braun and Clarke, 2006; White, Woodfield and Ritchie, 2003). The purpose of writing up

your findings is to “tell a complicated story of your data in a way which convinces the reader of the merit and validity of your analysis” (Braun and Clarke, 2006, p. 93). Therefore, the aim of the three findings chapters is to provide a story of the themes, which are grounded in participants’ language, whilst addressing the three research questions set out in Chapter 2. These three themes and their sub-themes will be described in detail in the succeeding chapters.

It is important to note that these themes are presented in a different order to the way in which the research questions were ordered. The first research question addressed how carers and young people communicate about substance use, however, the theme of ‘doing communication’ will be presented last. I decided to present the findings in relation to the factors which shape communication, namely connectedness and professional role identity first, because it became clear that relationships are essential, acting as the precursor to communication. While the focus of the study was on substance use specific communication, it was clear during the interviews and throughout analysis that general communication was an important part of these relationships and acted as a precursor to substance use specific communication: young people need to be able to talk to their carers generally before they can talk about substance use. Thus, presenting the themes in the order they are provides an in-depth understanding of how carers’ relationships with young people and the constraints and boundaries around their role identity shape their communication about substance use. Table 8 below shows these three themes and their associated sub-themes, in the order they will be presented.

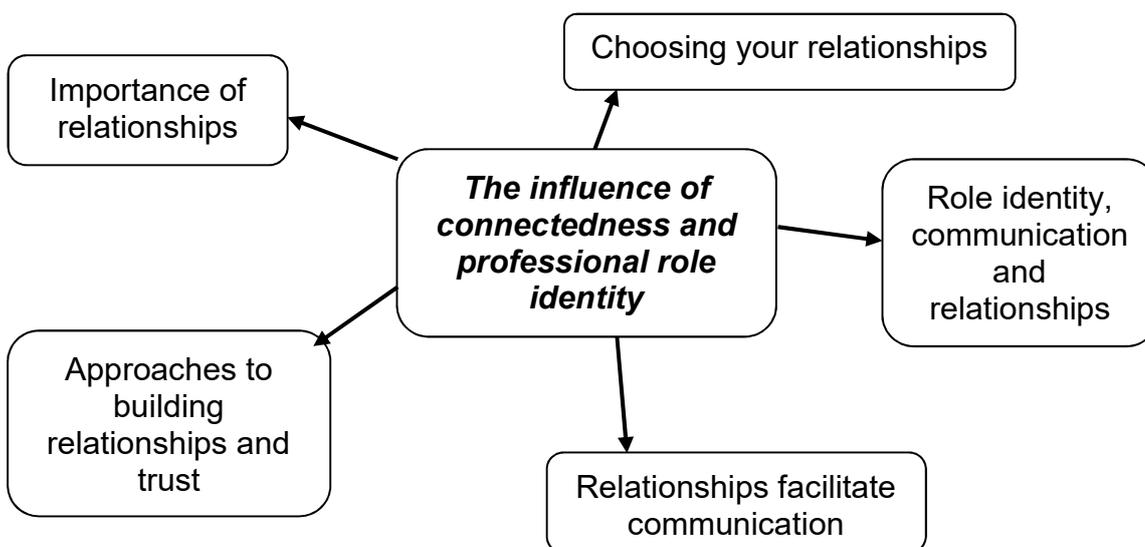
Table 8. Final themes and sub-themes

The influence of connectedness and professional role identity (Chapter 4)	Constraints, boundaries and rules (Chapter 5)	Doing communication (Chapter 6)
<i>The importance of relationships</i>	<i>Being open about yourself</i>	<i>A less intense approach to communication</i>
<i>Approaches to building relationships and trust</i>	<i>Conversations about your own substance use</i>	<i>Creating an environment</i>
<i>Relationships facilitate communication</i>	<i>Role identity, constraints and control</i>	<i>The importance of context: differences between foster and residential care</i>
<i>Choosing your relationships</i>	<i>Different rules for different substances</i>	<i>Young people's experiences of shared doing as communication</i>
<i>Role identity, communication and relationships</i>		<i>Digital media as (not) shared doing</i>
		<i>Shared doing and different substances</i>

Chapter 4: The influence of connectedness and professional role identity

This chapter explores the theme of '*the influence of connectedness and professional role identity*'. Figure 2 below shows the theme and five sub-themes, which will each be discussed in depth.

Figure 2. Diagram of theme and sub-themes



Both connectedness and professional role identity influenced carers' and young people's experiences of relationships and communication. As described previously, connectedness refers to the relationships, the two-way bonds between young people and those in a parenting role; professional role identity refers to carers' perceived role in caring for young people, viewing themselves as parents, staff or something in between. Building relationships with young people was a vital part of caring for them; without these relationships, both general and substance use specific communication was unlikely to occur. Participants talked about different ways of building relationships, within the context of both foster and residential care, as well as in terms of relationships between young people and social workers. Young people's relationships with different carers influenced with whom they would

talk. Carers' role identity of parent versus staff member can be blurred, affecting their relationship and communication with young people.

The importance of relationships

Carers talked about the importance of developing relationships and trust with the young people for whom they care. There was a view that supporting young people to develop relationships with carers is crucial, to enable them to heal; to deal with negative past experiences and associated problems; and to develop trust.

“the biggest thing is having a relationship with that young person”

(Hope, social worker)

“our job is to be alongside the kids and...develop relationships with them and hopefully through that they will be in a position where they're able to manage what life throws at them” (James, residential care staff, Unit A)

Building these relationships was often perceived as difficult, because they would take time to develop and, in some cases, would not develop at all. Ashley (residential care staff, Unit A) described the process of developing relationships with young people as a “*challenge*”, while Ian (residential care staff, Unit C) talked about some of the abuse, both physical and verbal, that he experienced when trying to develop relationships with the young people in the residential unit. He talked about being spat on, kicked and verbally abused as:

“part of gettin' to know that young person and gettin' to know...who they are...goin' through the motions of that...they will see how I respond to that and then hopefully things will start to kinda work through from there” (Ian, residential care staff, Unit C)

Ian's experiences highlight the lengths that some carers may go to in order to develop relationships with young people, suggesting that he deems them

vitally important. Sharon (residential care staff, Unit D) talked about one young person in the unit with whom she, and other staff members, had not yet developed a relationship. She put the lack of relationship down to the fact that he's "*not allowing us*"; he was constantly out of the unit and not spending enough time there in order to get to know the staff and build a relationship with them. This view suggests the need to spend time together as a way of developing relationships, as well as a suggestion of the control young people may have over these relationships; this control will be discussed in a later section, in the sub-theme '*choosing your relationships*'.

Interestingly, none of the young people talked explicitly about the importance of having relationships with their carers. They talked about the ways they build relationships with carers and that such relationships facilitate communication, but they did not talk about why such relationships are important to them. Instead, carers talked about why they thought it was important to have relationships with young people. Young people may have articulated this importance differently to carers, stating their likes and dislikes, as well as their experiences of developing relationships. Young people also may not have felt comfortable talking to a stranger about why relationships are important for them; carers viewed relationships as important in order to enable young people to deal with negative past experiences and develop better relationships than those they had experienced in the past. These experiences would likely be sensitive and difficult for the young people to talk about, thus inhibiting them from talking about the importance of relationships within the interviews. For carers, however, building relationships with young people was crucial and did not appear to be affected by their role identity. Foster carers, social workers and residential care staff alike talked about the importance of developing relationships with this group of young people.

Approaches to building relationships and trust

Young people and carers talked about the various things they have done to build relationships with each other. For some of the young people, having carers who are nice and kind, who meet their physical needs was a first step in developing relationships. As the following quotes highlight, getting help

and support from carers seems to be an important way of building relationships with them:

“they are...nice to me hmm...and they always help me” (Joseph, age 13, residential care)

“they managed to get all my stuff from where I used to stay em they've opened a bank account and stuff for me and got me a new passport so and just general...day to day stuff so yeah that's what's helped me...settle in” (Zoe, age 16, foster care)

These simple tasks seemed to be important to these young people: they may be a way of testing the waters with carers, of discovering the extent to which they will provide help and support and also discovering whether they can be trusted and relied upon. In the case of foster care, young people may be testing the extent to which they are allowed to be part of the family and home, with young people talking about practical support, such as accessing bank accounts and decorating bedrooms. Thus, it seems that in order to build a relationship with a young person when they are new to a placement, you need to be kind and provide practical support. There was also a sense that allowing young people to have their own room, with their own belongings, could be an initial step into developing relationships. Allowing young people to have a home, rather than a house to live in, seemed to be important: carers and young people in both care settings talked about creating a “*home*” environment for the young people. Carers talked about trying to create such an environment in the residential unit and treating the unit like a home:

“we do try and keep this place as homely as possible for the young people” (Jennifer, residential care staff, Unit A)

“this is their home” (Sharon, residential care staff, Unit D)

Susan’s discussion of her approach in foster care to making young people feel at home echoed these views from residential care staff. She wanted the

young people in her care to treat her house like a home, in the same way as her own children, rather than feeling like they did not belong there. She talked about ensuring her foster children had the same “*sense of entitlement*” as her own children to treat the house like their own home, so that these young people would not “*feel less than the...children in the house*”.

The simple tasks of welcoming young people into the foster home or residential unit, enabling them to have their own belongings and feel that they have a home, rather than a house, are vital in developing relationships with them. Carers also talked about routines and having dinner together as ways of creating this environment for young people in residential units, with sitting around a table stemming from carers’ own experiences and values of what constitutes home life. Thus, creating a home rather than just a place of living, appeared to be important for carers in both care settings, although more importance was placed in residential than foster care settings. This strong desire in residential care settings to create a homely environment may be due to the reality that a residential unit is very different to a family home. Creating a homely environment in foster care settings is likely to be easier, because a foster home is already a home to a family, with the young person fitting into this environment.

Another way of developing trust and relationships was by having things in common with each other. For some carers and young people, having similar backgrounds or interests was a key way to developing a relationship, providing a foundation on which to get to know someone better. Kirsty (age 19, foster care) talked about the fact that she immediately felt comfortable with her new foster carer and felt that they built a relationship together relatively quickly because they shared a hobby. She felt that she was able to build a relationship more quickly with her current foster carer than with previous foster carers because of this shared interest, stating “*it was quite fast...in other places it's like took [sic] years to build up a relationship*”. Michelle (social worker) also talked about a similar experience of trying to build a relationship with a young person in her care. She described him as a particularly difficult to engage young person with whom other social workers

had tried, and failed, to build a relationship. For her, talking about a shared interest in music helped to break down the barriers and helped to develop a relationship with this young person:

“we talked about a lot of different things he had posters on the wall about bands who I still knew...there are a lot of things that young people can know about myself where it doesn't matter if they tell it someone else you know...if I want to talk with this seventeen year old about his life” (Michelle, social worker)

Ian (residential care staff, Unit C) and Megan (age 16, residential care) also talked about the importance of sharing similar backgrounds and upbringings as a way of getting to know someone. Ian talked about his childhood experiences, which he described as being quite difficult, and he felt that sharing these experiences with young people in the unit was important; they could relate to his experiences and perhaps felt more comfortable with him than with someone who did not have such experiences. When asked about relationships with staff in the unit, Megan said she gets on better with her key worker than other staff because *“we're quite similar...brought up in the same area”*. Having a shared connection with someone and a sense of empathy appears to be key in developing relationships between looked after young people and carers. However, carers talked about constraints to sharing such information about themselves, as suggested in the above quote by Michelle (social worker). These constraints and boundaries will be discussed in detail in Chapter 5, in the sub-theme of *‘being open about yourself’*.

Being there for a young person and showing that you care for them were also important. Looked after young people may have been let down in the past, by parents, family members or by social workers and carers in previous placements, so providing care and support can be a critical first step in helping them to build trust and relationships with their carers. As Angel explained, showing you care is vital in developing a relationship with a young person:

“they don't think we care so we have to prove that we do care for them to then tell us well I care you care enough about me for me to tell you what's going on so it's that kind of how you get the the relationship with young people” (Angel, residential care staff, Unit B)

Beth (age 14, foster care), Megan (age 16, residential care), Sophie (age 15, foster care) and Zoe (age 16, foster care) all spoke about the importance of knowing that their carers are there for them if they need them. They mentioned the need for them to be available when they want to talk about any problems they might be experiencing. Zoe suggested that it is important for carers to be approachable, stating *“I wouldn't be scared just to talk to them about anythin' really”*. Carers talked about the importance of being there for young people through *“thick and thin”* (Ian, residential care staff, Unit C). However, these relationships are again constrained by boundaries: while carers talked about being there for young people, they can only do so within particular limitations. Residential care staff can only provide care when they are on shift, which is not all of the time. Also, when a young person leaves their placement, whether in foster or residential care, their relationships with carers will likely end. These boundaries will also be discussed in Chapter 5.

Finally, participants talked about the importance of openness and honesty when developing relationships. As Sandra and Sharon explained, their viewpoint was that if they are open and honest with young people, the young people will hopefully be open and honest with them:

“we've told them we'll never lie to them so they shouldnae need to lie tae us” (Sandra, foster carer)

“it's just tryin' to be open open and honest wae them and hope that they'll be open and honest wae you” (Sharon, residential care staff, Unit D)

Kirsty (age 19, foster care) spoke emphatically about the importance of her current foster carer being honest with her and that her honesty was at the foundation of their relationship. Kirsty explained that in previous placements her foster carers had lied to her about the reason for her placement ending, which she felt was a betrayal of trust. Her current foster carer was always honest with her and would share the details of any conversations with social workers, which she felt was a crucial part of their relationship:

“we're both honest wae each...if she's talkin' to social work and they say somethin' she always tells me what they say because she thinks she thinks it's unfair that if you were to move this is what happened like in a few placements they'd say that the foster carer's not well or somethin' when they're actual fit and well they just don't want you” (Kirsty, age 19, foster care)

There were, however, limitations to carers' honesty: while they talked about the need to be open and honest with young people, there was a sense that this was within the boundaries of being a carer. As Kirsty's quote highlights, some foster carers may not be totally honest with the young people they are caring for.

The interviews with participants provided insight into the approaches or factors they felt were important in developing relationships: being nice and kind; being there for them and providing help and support; having things in common, such as backgrounds and interests; and being open and honest. The participants' description of these important features also hints at the constraints and boundaries faced by carers: there is a limit to how much they can tell young people about themselves and a limit to how long they can provide them with help and support. These boundaries are the focus of the next chapter.

Relationships facilitate communication

As the focus of this research was on communication, specifically about substance use, it is important to consider the role of connectedness and

relationships on such communication. Participants talked about communication, about general topics and substance use, within the context of relationships: when young people and carers have a good relationship, communication is more likely to occur and conversations are easier to have. Jennifer explained that she finds it easier to talk to young people when she has a good relationship with them:

“within the relationship...don't really think oh god I've got to talk to this person about that you just d'you know once you've sort of built that relationship...with the young people...they're a lot more relaxed around you and you're more relaxed around them and you can...broach the bigger subjects quite naturally in a relationship”
(Jennifer, residential care staff, Unit A)

Having conversations with someone when you have a good relationship appears to be easier than when the relationship is flawed or absent. When carers and young people have a good relationship, they feel comfortable with each other, giving them the opportunities and safety to have conversations, and to talk about subjects that might be difficult, like substance use. Diane felt that it is important for young people to have a relationship with their carer and be able to talk to them about sensitive topics, stating:

“it's building up trust and once you get to know them and when they feel they're at a point that they can sorta discuss that and talk to you about it you know...I think it's it's important for them...to be able to do that” (Diane, residential care staff, Unit B)

Rachel also echoed this point, explaining that looked after young people often struggle to talk to their carers, particularly about negative past experiences and sensitive topics. However, she said that building a relationship and being able to talk to her foster carers has had positive effects on her self-esteem:

“I think if you're new like in care or you don't have that relationship it's obviously harder tae talk tae like someone about your past...it will take time you'll need to build that relationship but once you have then you'll feel better about yourself” (Rachel, age 15, foster care)

Carers talked about the difficulties of trying to communicate with young people when the relationship is lacking, with Hope (social worker) stating *“you can talk until you're blue in the face if you have no relationship with that person that's not gonna sink in”*. Marie (residential care staff, Unit B) also explained that if you were to ask young people about sensitive topics like substance use on day one, they would *“laugh you out the car”*. Thus, relationships take time to build and communication with young people can only really occur when relationships have been developed and young people feel comfortable enough to talk to their carers. Josh (age 12, foster care) mentioned that he only felt comfortable talking to his social worker about sensitive topics, stating *“I trust her more because I've known her a long time”*; he did not feel he had yet developed a strong enough relationship with his foster carers to have such a conversation. This suggests an element of pacing: relationships are built up slowly over time, through spending time together.

Hayley (age 14, residential care) and Michael (age 14, residential care) spoke about the difficulties they have talking to their key workers and other residential care staff, simply because they do not yet feel they have a good enough relationship with them. Both had been in their residential units for six and 10 weeks, respectively, and it was quite obvious when talking to them that they disliked their current living situation. When asked if he talks to staff in the residential unit, including his key worker, Michael said *“I barely ever speak to them...I barely even come out my room [laughs] I only like some people the other ones are annoyin”*. Michael's lack of relationship with staff, his negative opinion of them and reluctance to engage limited his communication with staff in the unit. Hayley felt that she was pressured to talk to staff in the residential unit, stating:

“they’ll be like...you need to like open up or something or you need to talk to us about stuff but...they don’t ask you...they say that you have to talk to them” (Hayley, age 14, residential care)

Hayley described her key worker as ‘*annoying*’ and felt that she “*asks too many questions that she doesn’t need to know about*”. It seemed that the reason for Hayley’s reluctance to communicate with her carers was in part due to a lack of relationship with them, but also due to a lack of confidentiality within the residential unit. Staff are obliged to share information between themselves about young people, which Hayley felt was unnecessary and limited her communication with staff in the unit. When asked if she talks to her key worker she said “*no cos if you tell one of the staff then all of the staff know so... you can’t really... they just have to tell each other stuff*”. Again, constraints and boundaries surrounding carers’ roles can affect young people’s communication with them. Hayley may have felt comfortable talking to her key worker if she knew that what she told her would not be shared with the other staff in the residential unit. However, residential care workers have a duty to share information about young people.

Relationships between carers and young people are important, take time to develop and act as the precursor to general and substance use specific communication. However, carers’ role identity and the associated constraints can impact on the extent to which young people feel comfortable discussing particular topics with them.

Choosing your relationships

There was a sense that young people often had different relationships with different carers and would choose whether or not to talk to particular carers on the basis of these different relationships. While the sense of having different relationships was more common in residential care, due to a high number of staff, some of the young people in foster care also had different relationships with each of their foster carers, which affected their communication. As mentioned above, young people and carers talked about different ways of building up relationships with each other and particular

factors appeared to be important, such as openness and honesty, having similar interests and sharing similar backgrounds and experiences. Therefore, it seems likely that young people will get on better with some of their carers more than others; they will have better relationships with some and seek these people out in order to talk to them. As James explained, residential care can actually make it easier to have better relationships than in other care settings:

“we're a team of people...and to a degree that makes it a bit less intense for the kids that they can seek out people...kids can choose who they're comfortable speaking to...they won't build up the same level of relationship with every carer here...they will choose who it is that they're closest to and... who they will seek out for emotional support and who they'll seek out to maybe talk about particular things” (James, residential care staff, Unit A)

For some young people in residential care, their key worker is the person with whom they have the best relationship, but for others, it could be another member of staff. There was a sense of finding the “*right person*”, “*best person*” who is in the “*best position*” to be a “*good parent*” to these young people. Residential care staffs’ language suggested the need to find someone who is going to be able to work effectively with the young people, create good, long-lasting relationships and engage them in conversations in which they can be open and honest, rather than just finding anyone to step into that role. This suggests the importance of relationships within residential care and the need to have good relationships with young people before expecting them to be able to communicate about particular topics.

While young people had little choice over the foster carers they were placed with or their key worker, there was a sense that these young people had control over their relationships. They could choose whether or not to have a relationship with someone and also choose with whom they would talk. The following quote by Megan highlights her choice to only have conversations with her key worker, with whom she has a good relationship:

“aye some to a certain degree like the people that like ma key worker I obviously get on better wae than some other staff cos she's the one I speak to if I've got any problems” (Megan, age 16, residential care)

In residential care, young people had more of a choice over who they would talk to due to a vast number of staff; in foster care, young people could also choose to some extent, as will be discussed subsequently.

While it seems that having a choice of staff to build relationships with and talk to can be beneficial for young people, giving them the opportunity to find the person they feel most comfortable with, these different relationships can be problematic. The following quotes from Diane and Sharon provide insight into the potential problems of having close relationships with particular members of staff in residential care:

“they've obviously got better relationships with some staff than others and depending on who's about so that can maybe have quite a there's a lass you know...oh when's my key worker in I need to speak to her about something” (Diane, residential care staff, Unit B)

“she would only come and speak to me openly about it or one or two other so some of the guys she wouldnae talk tae so if...it's just mostly male staff that's in nobody's gonna speak to her about it cos...she definitely won't speak to anybody about it...that can be the problem” (Sharon, residential care staff, Unit D)

In residential care, despite the vast number of staff for young people to develop relationships with, there may only be one or two staff members with whom they feel comfortable enough to speak. When these staff members are not in the unit, because they have a day off, are on holiday, or off sick, young people may feel unable to have conversations with any of the other staff members. Thus, these young people may be missing out on vital

conversations. Ian (residential care staff, Unit C) talked about a similar experience in the unit in which he works, where some of the girls felt uncomfortable talking to the male staff members and would be unable to ask for help or support. For some carers, there was a sense that for some girls in care, there were particular difficulties around building relationships and feeling comfortable with male staff members, possibly due to past experiences of abuse by men. When there were only male staff members on shift, communication could be completely absent. Thus, it seems incredibly important to have a mix of male and female staff members during each shift to negate this problem, although in reality, this is not always possible.

Male and female foster carers appeared to play slightly different roles within the caring relationship. Two foster carer couples participated; two interviews were conducted separately with two of the carers and one interview was conducted jointly, with both carers participating. There was a sense from their interviews, and those with the young people they fostered, that each foster carer fitted into a particular, somewhat traditional, role in terms of communication. The male foster carers would talk to the girls but often only about general topics and would deal with boys' conversations about sensitive topics; the female foster carers would talk about sensitive topics with boys and girls, but particularly with girls. For example:

“she'll quite happily talk to me but obviously if it's more personal [she'll talk to Sandra]” (Rob, foster carer)

“yeah if it's girly stuff it's me” (Sandra, foster carer)

These distinct gender roles in communication potentially stem from societal gender roles, in which women are viewed as more nurturing and empathetic and as more caring in their communication styles than men. Women are also more likely to be involved in the care of looked after children and young people. In this study, female foster carers appear to play a greater role in communication than their husbands. Sophie (age 15, foster care) explained that she prefers to talk more to Deborah (foster carer) than Tony (foster

carer), due to her own feelings and experiences of communicating with her own parents:

“yeah I find well I usually it's more Deborah that I'll talk to and not Tony...I think I just find it easier to talk to like females...I get on with my Mum better than I do my Dad so I think that's like part of it...I'd rather speak to Deborah first and then even if I talk to Tony after with Deborah or somethin' I find it easier” (Sophie, age 15, foster care)

For Sophie, communicating with her female foster carer came more naturally than with her male foster carer because she was used to talking to her Mum more than her Dad. Thus, it appears that young people's experiences of relationships and subsequent communication with their carers can be influenced by their past experiences: of talking to their parents as well as experiences of abuse which affect whether or not they feel comfortable in talking to carers of a particular gender.

Role identity, communication and relationships

Foster carers, social workers and residential care staff communicated with young people in a variety of ways, and this communication seems to be underpinned, to some extent, by both connectedness and professional role identity. At the start of this research, I anticipated that foster carers would see themselves more as parents while residential care staff, and social workers, would see themselves as staff. However, the boundaries between parent and staff were blurred for all carers, with some staff talking about communication *“like a parent”* and some foster carers talking about the need to follow rules, guidelines and procedures, as you would do if fostering was a job. As Ashley and Angel explained, residential care staff are acting as parents to the young people in their care, providing parental guidance, support and care, as well as affecting how they communicate about and deal with substance use:

“you're obviously the parental guidance for them whilst they're here” (Ashley, residential care staff, Unit A)

“it's kinda checking like as a parent you would say to your child well if you're going to this party I'll pick you up and make sure you've had something to eat before you go and if you're gonna be drinking you need to be careful” (Angel, residential care staff, Unit B)

Being in this parental role affected young people's communication with residential care staff, particularly about substance use and other more sensitive topics. In some cases, young people may be happy to talk to their parents about substance use, while for some, such conversations are too embarrassing or sensitive. This difficulty reflects an almost universal view of adolescents, that talking to parents, or in this case, those in a parental role, about substances, particularly drugs, is a challenge, due to confusion, power imbalances and fear of punishment. As Marie explained, being viewed as someone in a parental role can make conversations about substance use difficult; some young people prefer to speak to an external person, and then come back to the unit for more parent-child activities like nurturing, care and support:

“we're almost like parents so they want to talk about stuff but they'll talk out there...with people about it and then they can kinda come home and be cared and nurtured and fed and watered and...have an argument about coming in times” (Marie, residential care staff, Unit B)

However, in residential care, there was a view that you were only acting as a parent when you were on shift, suggesting that parenting within the residential care setting is not a full time role, as it would be as a foster carer. As Julie (residential care staff, Unit B) explained, *“we're corporate parents when we're here [emphasis added]”*. Residential care staff talked about the nature of residential work in terms of shifts; working shifts and having a staff rota means that you are clearly staff members, that the residential unit is your workplace, not your home. Only acting in a parental role when you are on

shift suggests that there can be different relationships and dynamics between young people and staff members, as discussed above.

For young people in residential care, it seemed to be clear that staff were staff, not parents, which was different for those in foster care. Residential care is a very distinct set up, and as much as staff try to make units as homely as possible, they are clearly not family homes. The young people talked about “staff” in a rather general, depersonalised way, suggesting that they do not view the residential unit as their home but rather as somewhere in which they live. The way in which the young people in residential care talked about their carers was different to those in foster care: they talked about disliking the staff, being unable to talk to them and not trusting them, whereas those in foster care talked more positively about their carers, with some calling them ‘Mum’ and ‘Dad’. This difference may be due to care status, in that viewing carers as parents is more difficult in residential than foster care, due to the more obvious distinction between roles. It may also reflect the length of time that these young people had spent in the units. Of the six young people interviewed, four of them had only recently arrived in the unit within the last three months. It may be that these young people had not yet built up a good enough relationship with their carers to view them in a parenting role. Megan (age 16, residential care), who had been in the residential unit for a year and a half, explained that she gets on well with most of the staff in the unit. When asked about the staff being ‘staff’, she said that “*some of them are more than that*”, in that they are there for her when she needs them. Five of the seven young people in foster care had been in their current placements for over a year.

In foster care, there was a view that while foster carers were acting in a parenting role, and some saw themselves as the young person’s parent, they were still not the parents. They talked about the need to treat young people as part of their family, as though they were their own children, with a view that treating them differently would be unacceptable. As Rob explained, treating foster children as part of the family is particularly important for these young people because of their negative past experiences:

“if you can make somebody feel part of a family then you'll build trust and trust is everything especially to a looked after child in my view cos they've been let down before sometimes they can't actually accept it but it's one of these ones you...persevere with”
(Rob, foster carer)

Both Rachel (age 15, foster care) and Kirsty (age 19, foster care) had experienced foster care placements in which they were treated differently to foster carers' own children, which ultimately caused their placements to break down. They contrasted these experiences with their current foster carers, who treat them as part of their families and spoke positively about their carers and their experience of being fostered. Along with Zoe (age 16, foster care), they viewed their foster carers as parents more than carers, and felt that they could talk openly and honestly with them about a range of topics, including substance use.

As much as foster carers included young people in family life, there was still an impression that they were obviously not their parents, and never would be. For example, there was a need to follow rules and guidelines imposed by social work departments, as well as a view that fostering might not be something they would choose to do forever. To illustrate the difference between being a foster carer and a parent, Susan (foster carer) talked about how it would be *“inappropriate”* to have photographs of foster children on her walls as she does with her own children.

Sandra and her husband Rob (foster carer) talked about bending the rules slightly in terms of fostering Rachel (age 15, foster care), but it seemed that they could only do so with permission from the Panel members and Rachel's social worker. Thus, while they were able to treat Rachel in the same way as their own daughter, they were still conscious of the rules and regulations to which they were expected to adhere. Foster carers seem to make a deliberate effort to include these young people in their lives and treat them in the same way as their own children, but underlying these efforts is the awareness that their placement is time limited, the young people have

biological parents and foster carers are just that, they are carers. These challenges are described in more detail in the next chapter, in terms of boundaries and role identity.

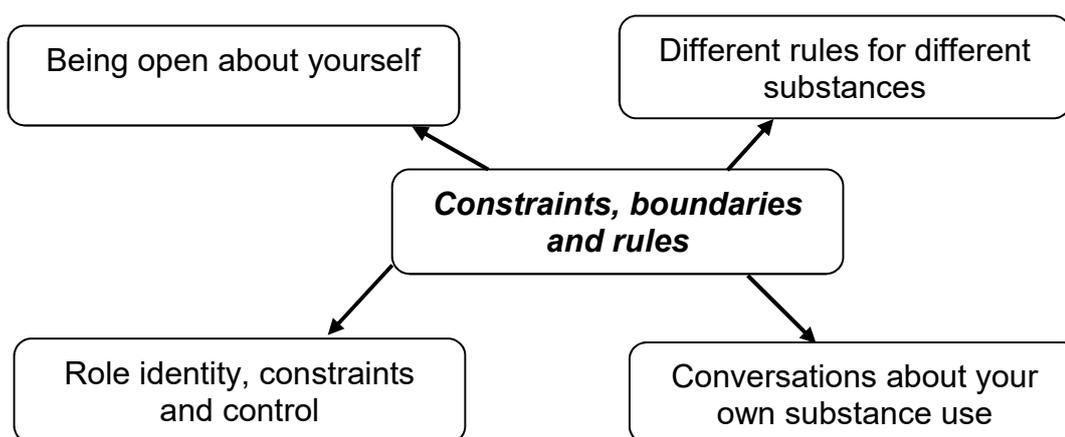
Summary of ‘the influence of connectedness and professional role identity’

Carers’ professional role identity influenced connectedness and communication with young people. Young people and carers talked about the different ways in which they built relationships with each other: through openness, honesty, shared interests and doing things together. These experiences enable young people to get to know their carers with whom they would spend a large amount of their time. However, carers experienced numerous boundaries around their role identity: although some talked about being like a parent to the young people in their care, there was a sense that they would never truly be their parents and that their caring was time limited. This was even the case in foster care: young people were treated as part of the family, they might call their foster carers ‘Mum’ and ‘Dad’ but there was a sense that they would never fully be parents to these young people. Thus, carers’ role identity has a wide influence on their experience of caring for, having relationships and communicating with these young people. In the next chapter, constraints, boundaries and rules will be discussed, in relation to carers’ role identity, communication, and substance use.

Chapter 5: Constraints, boundaries and rules

In this chapter, the theme of '*constraints, boundaries and rules*' will be explored. Figure 3 below shows the theme and four sub-themes, which will each be discussed in depth.

Figure 3. Diagram of theme and sub-themes



In Chapter 4, relationships between carers and young people were viewed as important, particularly in facilitating communication about general topics and substance use. However, these relationships were surrounded by boundaries and limitations; while carers tried to build relationships that were comparable to those between parents and children, these relationships were constrained by professional role identity and rules and regulations involved in being a carer rather than a parent. These rules and regulations were mostly discussed in terms of substance use, but also in terms of more general caring, including living conditions, health and safeguarding. There were boundaries around how much carers would disclose about themselves, around conversations about substance use and the extent to which carers have control over young people's behaviour. There were also boundaries, rules and constraints in terms of carers' approach to each substance, again influenced by their role identity.

Being open about yourself

Throughout the interviews with carers and young people, there was a sense that constraints and boundaries existed, potentially due to professional role identity, which influenced communication as well as rules around substance use. These constraints and boundaries related to regulations and rules implemented as part of the caring environment, as well as to carers' sense of parenting.

As described in Chapter 4, carers talked about the importance of being open and honest with the young people in their care. Openness and honesty seemed to be important for residential care staff, foster carers and social workers, alike. However, openness and honesty comes with particular constraints; carers talked about being restricted in terms of how much information about themselves they could share with young people. These constraints were particularly prevalent in residential care, possibly due to the nature of residential care and the care system, in which the differences between parent and staff are clearer. Conversely, foster carers may have more scope and opportunity to be open about themselves than residential care workers and social workers, due to the nature of the foster care setting.

While staff in residential care somewhat viewed themselves as parents, there was a view that they would only be able to share a certain amount of information about themselves with the young people. They might want to be open and honest with the young people, but felt constrained by the fact that they were in a job. As Jennifer explained, the young people feel they know a lot about her, but she has been cautious in terms of the personal details she has shared:

“the kids think they know a lot about you but it's all very carefully sort of planned stuff...I might say oh about my friends d'you know a little bit that but they wouldn't know any details of anything...they think they know so much about me...it's nothing d'you know too personal...it's that sort of balancing act” (Jennifer, residential care staff, Unit A)

Michelle (social worker) also shared this view, talking about the importance of being open and honest with young people, but also feeling that there were limitations in the extent to which she could tell them about herself. Like Jennifer, Michelle spoke about telling young people enough about her life so that they feel they know her, without sharing any specific details:

“you have to give something of course I would never share intimate details about me em you need to know where to draw the line but you need to be yourself you need to be credible and you need to bring something in” (Michelle, social worker)

Ian talked about the difficulties associated with being residential care staff and the negative impact that cuts and changes to the role can have on experiences at work and job satisfaction. He states that while young people are often aware when something is wrong, staff will lie and tell them everything is okay, suggesting a reluctance to opening up about their lives:

“there's been a lotta kinda talk about different changes there's cuts here and cuts there and that can have a profound effect on...on the services that that we give these young people em and it's no rea- it's no really what a discussion that we have wae the young people it's kinda mainly between ourselves...they'll ask questions ken if they see you're a bit down and everything and just say everythin's fine” (Ian, residential care staff, Unit C)

It seems that carers expect openness and honesty from young people, and for them to share details about their lives. In return, however, carers appear less willing to share the same level of detail about their own lives. These quotes highlight the differences between carers' roles in different care settings. In residential care and social work, there are more structured boundaries to relationships, and it is more obvious that care is being provided as part of a job. In foster care, however, young people are integrated into a family, foster carers act more like parents and the boundaries are more blurred. Some talked about being quite open with the young people about

their lives: Deborah (foster carer) shared information about her siblings' mental health problems, Sarah (foster carer) talked to her foster child about her son's cannabis use, and Susan (foster carer) has opened up to a young person about her experiences with her alcoholic ex-husband. Having a clearer professional role identity, of a residential care worker or social worker, is likely to have more clear boundaries as to what behaviours are deemed appropriate; being a foster carer may mean these boundaries are less distinct, because the young person is living in their home. Thus, the foster carers in the current study may have felt that they could be more open about their own lives, particularly when placements were long term, because they felt like parents to these young people.

Thus, it appears that while carers promote openness and honesty with young people and highlight these factors as key to building and maintaining relationships, there can be a reluctance on their part to share particular details about their lives. Carers' role identity may influence how much they share about themselves: if they see themselves as a parent to the young people, they may be more open about their lives and experiences than if they view themselves as a paid carer. While carers can limit what they tell young people about themselves, young people may not be afforded the same opportunity and instead be expected to tell carers whatever they want to know. This reluctance suggests a power imbalance between young people and their carers, which carers themselves have hinted at. In the previous chapter, a quote from Hayley (age 14, residential care) alluded to this power imbalance: she felt almost forced by staff to talk, stating that they “*make*” her talk to them. Young people, like Hayley, may be reluctant to talk to their carers if they feel forced to do so, or feel that information sharing is one sided. Addressing these power imbalances may be an important way of encouraging more communication between young people and their carers.

Conversations about your own substance use

Along with a reluctance to share information about their personal lives, carers also spoke of a reluctance to talk about their own substance use, particularly

within residential care, as the following quotes from Angel and James indicate:

“don't talk about smoking we don't we don't promote it in any way around young people...and even if they say do you smoke?...I'm not sharing that with you” (Angel, residential care staff, Unit B)

“it makes it into sometimes a bit more taboo than it needs to be because I think staff are maybe a bit wary of discussing their alcohol consumption so it's generally that stock fairly safe answer yeah I'll have I'll have a drink if it's a party but obviously just rather than maybe a bit more realistic” (James, residential care staff, Unit A)

Angel would not share her smoking status with the young people, because smoking in the residential unit was forbidden and she felt that by doing so might encourage smoking, stating *“we don't promote it”*. However, other residential care workers have talked about staff smoking being relatively obvious in residential care, because workers have to leave the building to smoke in the same way that young people have to. Thus, carers may not be able to hide their smoking status but may not want to talk about it. James' quote suggests that staff face difficulties in talking about their own alcohol use. Carers might talk generally about their own alcohol use, without giving much detail, which he sees as unrealistic. He said that residential care staff will often give a *“fairly safe answer”* to questions around their own drinking, rather than sharing details of their actual alcohol use. James also talked about the difficulties of talking about drug use: sharing details of your own drug use, he says, *“can be quite useful”* but he is clear that because drug use might be a criminal offence, staff are unwilling to talk about it, in case they were to be penalised and lose their job. Carers felt that there can be real difficulties in talking about their own substance use, due to concerns about promoting such use or that staff will be reprimanded for their honesty.

Some residential care staff, on the other hand, felt that talking about their own alcohol and tobacco use was important as it provides a more realistic view of substance use. Jennifer would use her own experiences, and regrets, of being a smoker, as well as opportunities to have conversations when young people bring up other staff members' smoking. She says:

“smoking is a really hard one cos we do have a few members of staff that smoke...there's ex-smokers me being one of them that say it's actually one of the biggest regrets in my life ever startin' smoking...bein' able to reflect on and actually acknowledge that you're doin' something that's not very good choice and d'you know some staff will quite openly say I wish I could stop...it's really hard don't start” (Jennifer, residential care staff, Unit A)

Jennifer and other staff felt that it was important to have conversations about their own smoking status as a way of discouraging young people from starting smoking themselves. Sharon also used conversations about her own current and past drinking to highlight the negative effects of drinking too much and encouraging more sensible alcohol use:

“she's like I bet you were drunk on your holidays I'll say...yeah I did have a few drinks on ma holidays because I was on ma holidays...but I know when to stop cos...I've been where you've been...they need to know we were teenagers...I was actually a teenager too and I made the mistakes and that's okay cos we all learn...I've told these kids...I was fourteen and I drank too much cider and got really sick...they need to know we're human beings as well” (Sharon, residential care staff, Unit D)

In residential care there was a sense that sharing details of your own substance use could be a helpful way of enabling young people to develop a more realistic view of alcohol, tobacco and drug use. However, for some, sharing details of such use was problematic: details of their own substance use could encourage young people to use substances as they might be

viewed as a normal part of life. Carers' reluctance to disclose details of their own substance use may be due to concerns about encouraging and normalising substance use, as well as concerns about being reprimanded themselves. However, there was also a sense that in having these conversations, young people would gain a more realistic view of substance use and may be discouraged from smoking, drinking too much and using drugs. Carers' reluctance may be influenced by their professional role identity: if they view themselves strictly as staff, they may be reluctant to talk about their own use and feel that doing so is inappropriate. Those who view themselves in more of a parental role may feel that talking about their own experiences of substance use is natural and something they would do with their own children. Careful consideration by carers is needed to ensure they are providing the right message when they choose to talk about their own substance use.

In foster care, there was a slightly different approach, potentially due to the nature of the care context, in which carers' smoking and alcohol use might be more obvious. Young people are living in their home so will be aware if they are smoking and drinking. Young people and carers talked about disclosures of current and past smoking as a way of discouraging tobacco use. Deborah, like Jennifer above, would tell young people about her experiences of stopping smoking and how challenging it was:

"I'll tell them how you know how I did it when I gave up smoking how hard it was...I say oh god it is it's really hard...I say to them you know what I did was you know you can do things like saving your money and then you can actually see what you're spending"
(Deborah, foster carer)

Thus, these disclosures were used to try to discourage young people from starting smoking and to encourage them to stop smoking when they are young, by highlighting how difficult they found quitting and the negative effects of smoking. Similar disclosures about alcohol use were also used to highlight the negatives associated with excessive use and, as Hope

explained, being realistic about alcohol use within the context of Scottish culture. She talked about the importance of being honest with young people if they ask her about alcohol use, stressing the need to be realistic:

“it's kinda like oh yeah that's you saying it but actually you're probably down at the pub at five o'clock on a Friday out all night...they'll say to you oh so what you've never had a drink in your life or you've never been drunk? and you're like oh no...it's pointless and it's one thing about saying well actually I have but you know what I was over eighteen” (Hope, social worker)

Hope talked about an underlying lesson in her disclosure: that she has been drunk before, but she was over the legal age to drink. She also goes on to say that when drinking, she was with friends she could rely on, thus making an attempt to discourage young people from getting drunk and encourage more sensible alcohol use. Rachel also talked about her foster carers telling her about their experiences of drinking too much as a way of discouraging her from doing the same, stating:

“they kinda give you like experiences of their own [drinking] well you don't wanta be like that and I'm like oh no [laughs] I don't”
(Rachel, age 15, foster care)

Rachel's foster carer Rob echoes her experience of conversations about substance use. Rob talked about using his own experiences of being drunk as well as the experiences of Rachel's friends and the negative effects that alcohol has had on them. It seems that Rob feels that such an approach is effective in explaining the negative effects of too much alcohol and the need to encourage more sensible use:

“when it comes to alcohol you need to use your own experiences and experiences of other people...you also need to be able to use the experiences of their...pals and the states that they've got in”
(Rob, foster carer)

For alcohol use, there is a sense that carers need to be open and honest about their own use, which appears to be easier in a foster than residential care setting. There was a sense from both foster carers and social workers that by being honest about your own alcohol and tobacco use, you could discourage young people from smoking and drinking too much. As with residential care, drug use, however, was more hidden. Only one carer talked about their own experiences with drugs; however, it was clear that he had not shared such information with his own or foster children. Rob (foster carer) states *"I'm a hypocrite if I turn round and say don't do it but I mean it's the right thing to say"*, suggesting that while he has used drugs in the past, he would never encourage it. Rob later talked about the hope that young people would respect his and his wife's opinions about and experiences of using substances. He then states *"what they don't know is I've done it ten times worse"*, suggesting that he would share certain information about his own past use but would not disclose everything. This lack of disclosure could potentially be due to a concern about encouraging and normalising particular types of substance use.

Carers seemed somewhat reluctant to have conversations with young people about their own substance use, particularly within residential care. The context of residential care appeared to make such conversations and disclosures difficult: substance use is forbidden within residential care, so conversations about carers' own smoking and alcohol use are particularly challenging. Within foster care, such conversations appear to be easier: young people are living with foster carers, so will be aware if they smoke or drink alcohol, making disclosures about their own use less challenging. When carers do talk about their own substance use, either past or present, it appears that their anecdotes are used to discourage young people's substance use.

Role identity, constraints and control

Within foster and residential care, there were constraints around the extent to which carers treated young people like their own children and the extent to which they felt they had control over their behaviour. Foster and residential

care are distinct settings, which result in carers having different experiences of parenting and caring, although there are some similarities.

Within residential care, carers described themselves as ‘corporate parents’, whose job it was to guide, support, introduce rules and help young people make the right choices in life. Although some residential care workers talked about trying to create a homely environment for the young people in the unit, there was a clear sense that they were not the parents, they were staff who were only acting in a parenting role when they were at work. Residential care staffs’ ability to act as a parent to young people was time limited; they could only care for them when the young people were in residential care, or when they were at work.

“you're not a...family member... you're obviously the parental guidance for them whilst they're here” (Ashley, residential care staff, Unit A)

Carers also talked about rotas, shift work, staff training, being “*an experienced worker*”, and doing certain tasks that were “*part of the job*”, which highlighted the role of residential care workers as carers, not parents. As James explained, it is clear that residential care workers are staff due to their shift patterns:

“it's a lot clearer in residential care...it's very clear to the kids...you're not there all the time you're working shift patterns...so that idea of it being a job is very clear” (James, residential care staff, Unit A)

Thus, carers felt that they could act in a parental role only when they were in the unit; working shifts within the residential unit meant that their role was clear, as staff not parents. In addition to this, residential care workers often talked about their role and associated tasks in terms of “we”, rather than “I”, suggesting a collective identity, that of a team of staff working to look after young people. Residential care workers may have been attempting to portray

a collective identity within their interviews as a way of protecting their somewhat fragile role identity. For carers, using language suggestive of team work and collective identities may be a way of portraying a strong professional identity within residential care.

Interestingly, residential care workers also talked about a desire to treat the young people as if they were their own children, but within the context of residential care, where they were clearly not the parents, suggesting a conflict in their identity. For example:

“oh you speak to me like you’re my Mum yeah I do because I care...exactly the same approach wae the kids in here that I would have wae my girls at home” (Sharon, residential care staff, Unit D)

For Sharon, there was a need to treat the young people in the unit in the same way as she would her own children, in order to prove to them that she cared for them. Angel (residential care staff, Unit B) also echoes this desire to show young people that she cares by acting like a parent, stating *“we’re concerned because we’re worried as a parent we’re not your parent”*. However, there was a clear understanding that residential care staff are not the legal parents, which can affect the control they have over the young people in their care.

This lack of control seemed to be particularly relevant in terms of substance use. There was a sense that carers could inform and educate young people and introduce sanctions for breaking the rules, but they could not actually prevent young people’s substance use. Angel (residential care staff, Unit B) explained that if they know young people will be drinking at a party, they will encourage them to be careful, eat beforehand and arrange a time to pick them up, stating that they do so as a way of *“kinda checking like as a parent”*. She then goes onto say *“as a parent you wouldn’t be allowing your child to drink”*, highlighting the lack of control residential care workers have over young people’s substance use, because they are not the parents. Other residential care workers talked about the lack of control over young people’s

substance use, with Diane (residential care staff, Unit B) stating *“there's only so much you can say and do...before you get told to where to go”*. The following quote from Megan also highlights the lack of control that residential care staff have over her when she is not in the unit; when she is away at weekends, she can drink alcohol because staff have no influence over her behaviour, due to a lack of contact:

“they ken when I'm away at the weekends I drink they're no really fussed I'm no on an order I'm sixteen...if I want to drink I'll drink [laughs]...but I dae stay here then so if they dinnae know that I'm drinkin' cos I dae have any contact wae them over the weekend”
(Megan, age 16, residential care)

Ian talked in-depth about the boundaries around parenting and alcohol use within residential care. He was keen to treat the young people in the unit like his own children and this desire extended to alcohol use. Ian felt that the approach he used with his own daughter, buying her a limited amount of alcohol, was preferable to forbidding alcohol use altogether; but in the unit, alcohol use was completely forbidden:

“because we're in a job that we cannae like...I think if we'd went in and say right no you're not drinking...that just doesnae work but in this line of work we have to do that...we cannae be seen as givin' permission for young people...to then go and drink... I wish we could...we do say no but we also say look like I said these are all the kinda the areas that you need to be careful about” (Ian, residential care staff, Unit C)

Ian felt that his job compelled him to deny young people's alcohol use, even though he felt that such an approach might actually increase use. But biological parents' views and rights had to be considered and respected, so Ian's favoured approach to alcohol could not be implemented. James (residential care staff, Unit A) spoke of an incident which highlights these strict rules around use and carers' reluctance to have a more 'realistic'

approach: he and another staff member went to the pub with two young people, both of whom were over the age of 18 years and were no longer living in the unit, to watch football. Afterwards, one of the young people had told another worker that James had got him drunk, and the worker had spoken to James' manager about it. James reflected on the whole experience, stating "*that is the environment that we work in so that means that those kind of things we can't do and I do think to a degree that makes alcohol more taboo*". For James and Ian, alcohol can become a challenging and taboo subject within residential care because it is forbidden and young people cannot learn about alcohol in, what they term, a more "*realistic*" way, as might occur within a home environment.

Thus, in residential care, carers were concerned about boundaries around their professional role identity. Despite considering themselves as being in a parenting role, there were clear limitations in terms of the extent to which they could parent these young people. Being in a parental role within residential care is time limited: you can only act as one when you are at work or when the young people are in the unit. Outwith these circumstances, staff have no control over young people's behaviour or substance use. While carers wished to treat these young people as they would their own children, particularly in their approach to alcohol use, there was a view that this was unacceptable within a residential care setting, where alcohol is forbidden and parental rights are paramount.

Within foster care, carers talked about fostering within a continuum of parenting. Some foster carers will treat the young people in their care exactly like their own children and will implement their own rules; others will treat them somewhat like their own children, welcoming them into the family home, whilst also being bound by social work rules and regulations; other foster carers see the role as a job, more akin to residential care than a family home. While some of the young people reflected on past experiences of foster care in which they did not feel like part of the family, the foster carers in the study seemed to fall in between the former two sections of the continuum, treating the young people as close to their own children as they could, within the

context of rules and regulations. Treating fostering like a job was perceived negatively by carers and young people, particularly those young people who had experienced this type of fostering. Both Rachel and Kirsty talked about their negative past experiences of foster carers who did not treat them like part of the family:

“I've been in places that just...they don't they don't think of it as a family they just think it is a job...if you went into fostering think it is somethin' you want to do you wantae help somebody don't think of it as a job...goin' into someone's house and like stayin' there is not a job” (Kirsty, age 19, foster care)

“they don't see me as a foster child whereas my old carers were like they're my children and you're...but they don't like I'm kinda like I'm treated the same as her own children...they'll like fight for me...my last placement...we didn't have that like connection”
(Rachel, age 15, foster care)

The final part of Kirsty's quote succinctly illustrates her, and others', viewpoint on fostering, that having young people live in your own house is unlike a job. As Rob explained, fostering is not a job because caring is continuous:

“with a job you clock in at eight o'clock and you finish at four o'clock and you forget about it till next morning no this is twenty-four seven so it's a...lifestyle choice” (Rob, foster carer)

These quotes provide an insight into the key differences between fostering and working in residential care: foster care entails more intense caring than residential care, with a perceived need to treat young people like your own children. As illustrated above, acting as a parent to these young people in residential care ended as soon as staff left the building; with fostering, however, they are acting as parents “*twenty-four seven*”. For the foster carers in this study, there was a desire to treat these young people as part of the

family, with a recognition that this could only be done within particular boundaries. As much as foster carers tried to treat the young people as their own children, there were particular differences. For Deborah (foster carer), she was aware that young people in foster care tended to have more challenging behaviour than her own children did, which meant she had to discuss a wide range of topics that she *“woulda never brought up with my own kids”*. For Sarah (foster carer), parenting your own children comes more naturally than it does for foster children, because *“cos they know like what kinda parent you are”*. Sarah talked about having less influence over her foster child’s behaviour because she did not know her as well as she would her own children. As Sandra explained, fostering can be difficult due to the need to follow rules and guidelines:

“it’s the legal side of that but bringing them up as kids it’s just the same as your own kids it’s just the legal requirements are a wee bit different...there’s guidelines that you’ve got to go by you know whereas parents we don’t...we’ve got our own guidelines but they’re not well if you do this you can get done for that or you know you’re no allowed to” (Sandra, foster carer)

Foster carers appear to have a strong desire to treat young people like part of the family, with many of the carers and young people talking about the importance of doing so. However, they were obliged to follow particular rules and guidelines, as highlighted above by Sandra. In terms of substance use, these rules extended to what young people could and could not do in terms of smoking and alcohol use. Foster carers and young people talked about being allowed to drink alcohol and smoke, within certain boundaries, which seemed to be determined by their foster carers’ own views and rules around such use. For example, some foster carers talked about allowing young people to drink alcohol within certain contexts, such as at home or during special occasions. However, they were adamant that they would not purchase alcohol for them, as doing so would be against the law:

“I wouldnae obviously outside because it's against the law but...if we were maybe on holiday and she's sixteen and we can maybe have a wee...there's only like a very low alcohol in it...every context is different I would do it in that context but I wouldnae...get one out the bar for her and give it to her or anythin' like that...at Christmas and that she'll be able to have a glass of wine or champagne” (Sarah, foster carer)

“she just says will you buy me booze and I says I might allow you to drink it I says but I ain't buyin' it...I cannae buy it ye I says because it's illegal” (Rob, foster carer)

Sarah mentioned that she would allow her foster child to drink alcohol as long as she knew it was not too strong. Zoe's foster carers also allow her to drink alcohol at home because they know what she's drinking and can control the amount. When she is drinking with her friends, she is only allowed under the agreement that she will drink particular types of alcohol:

“I'm only allowed alcohol sometimes when it's at home or when I'm with friends that they know that they can trust me to be with when I've got drink...but I'm only allowed like so much...so I'd probably drink like Stella [lager] or something something like that with like juice in it like a shandy or something but not like big bottles of like stupid stuff like Strongbow [cider] and Buckfast [tonic wine]” (Zoe, age 16, foster care)

For these foster carers, alcohol could be consumed within particular contexts, which were influenced by their own practice as parents and the law. Foster carers may have considered the law around purchasing alcohol more carefully than they would if they were not foster carers, due to fostering regulations. Substance use was also dictated by social work rules: Kirsty (age 19, foster care) talked about being unable to smoke near the house; Zoe (age 16, foster care) was not allowed to get a vaporizer because she was under the age of 18; and Sophie (age 15, foster care) refused to tell her foster carer about her alcohol use as the information would be reported to her

social worker. Thus, it appears that both foster carers' own rules and regulations, as well as those enforced by social workers, influence their approach to alcohol and tobacco use. As discussed previously, Sandra and Rob (foster carers) were able to bend the social work rules to fit their own, but only after much discussion with social workers and Panel members. For Rob, their approach to alcohol with Rachel was the same as for their own daughter, and was an important way of ensuring Rachel felt included in their family, ensuring there was consistency in their approach.

Thus, in foster care, the rules and boundaries surrounding substance use, particularly alcohol use, are blurred more than in residential care. Foster carers may bend the rules slightly, incorporating their own rules around alcohol use, but only within the context of the law: they may allow their foster children to drink alcohol within certain contexts, but will not buy alcohol for them. For carers, their professional role identity appears to have an effect on the extent to which they have control over young people's behaviour and their rules around substance use. In residential care, the role of caring, as professional rather than parent, is relatively clear; you cannot promote or give permission to use substances; and parental permission is necessary. In foster care, however, the boundaries between parent and carer are blurred; where fostering should be viewed more like parenting than a job. Carers seem to use their own judgements and experiences as a parent to influence their approach to substance use, but within the context of social work guidelines and the law.

Different rules for different substances

Carers' role identity influenced the extent to which they could be open with young people about themselves and their own substance use, as well as their control over young people's behaviour. Their identity, and the associated rules, boundaries and constraints, also influenced their approach to alcohol, tobacco and drug use: each substance had different rules and approaches. In Chapter 1, it was argued that while alcohol, tobacco and drugs are diverse in terms of the associated risks, the way they are used and their legal status, it is important to examine all three substances together as

some young people use more than one substance at a time. In this study, carers had to deal with young people's alcohol, tobacco and drug use; however, they tended to respond to and communicate about alcohol, tobacco and drug use in different ways, highlighting different rules, meanings and approaches to each substance. Generally, carers' approach to the three different substances reflected cultural views around substance use, with alcohol being viewed as a normal part of life, smoking as an unhealthy but generally accepted habit, and drug use as forbidden. Carers' different approaches to communication will be discussed in a Chapter 6, in the theme 'doing communication'. In this sub-theme, the differences in carers' approaches to alcohol, tobacco and drug use will be discussed in relation to their professional role identity and rules around use.

Alcohol use was considered by carers and young people as a normal part of life, as something that is likely to start during adolescence and continue into adulthood. For example:

"the culture that we live in...young people will dabble a bit wae...booze" (Jennifer, residential care staff, Unit A)

"obviously at ma age like fifteen sixteen you're gonna be you're at like parties...they've said from the start like...when I started going to parties" (Rachel, age 15, foster care)

Carers and young people held the view that responsible drinking should be encouraged, with drunkenness discouraged. Responsible alcohol use was viewed in terms of consuming particular drinks; knowing the effect of alcohol on your body; your limits; responsibilities; where you are drinking; and the negative effects of drinking too much. Beth (age 14, foster care) explained what she was told by her foster carer about drinking alcohol sensibly, about not just getting drunk because you can but instead knowing how much you can tolerate. Hope talked about the approach she promoted with her foster carers, in order to teach a young person about responsible drinking:

“you need to teach him how to drink responsibly and you need to take away the myth...you can give him a taste of it...he can taste a bit of wine see what it tastes like and then you can explain kinda what comes with it what's the responsibilities around it and just you know casually go into it...teaching how to drink responsibly than having bingeing...coming in everyday just completely hammered” (Hope, social worker)

Carers used various methods for teaching responsible drinking: communication around alcohol, monitoring, role modelling, and rules. As mentioned previously, carers disclosures of their own alcohol use and the extent to which they would allow young people to try alcohol varied by care context: in residential care, alcohol was forbidden so carers were reluctant to discuss their own use in detail and would never be able to allow young people to try alcohol. As James' (residential care staff, Unit A) aforementioned experience highlights, even buying a pint for a care leaver who was over the age of 18 years was met with criticism and disapproval. In foster care, however, carers and young people talked about allowing young people to try alcohol within the home, at special occasions and on holiday. Alcohol use was carefully considered, with young people only being allowed alcohol when they reached a particular age and then they could only consume particular drinks. Some foster carers talked about drinking alcohol in front of young people, viewing it as a useful way of encouraging sensible drinking, by showing them the positive, social effects of alcohol consumption in contrast to their experiences of more harmful drinking by parents, family members and peers.

Carers and young people talked in depth about the rules around alcohol consumption; carers wished to discourage alcohol use but recognised that forbidding young people from drinking was difficult, so rules were implemented to encourage more sensible drinking. Although discussed in residential care, rules appeared to be implemented more in foster care, whereby alcohol use was approached differently; rules were implemented to forbid use, whereas in foster care, rules were around safe use. For some

young people the rules they experienced centred on particular circumstances, drinks and amounts: they were allowed to drink alcohol with certain people, in particular places and could only have a certain amount of a particular type of alcohol. For example, Kirsty (age 19, foster care), she was only allowed to drink certain amounts, and would be told “*you can't have too much*”; Rachel’s foster carers would encourage her to keep them informed about where she was and how much she was drinking. As mentioned previously, Zoe talked about only drinking with friends or at home and was only allowed certain types of alcohol, and would ensure she did not drink too much by diluting her drinks.

Thus, foster carers attempt to control young people’s alcohol use by allowing them to drink within certain boundaries. Although foster carers are bound by social work rules and guidelines, they seem to use their own judgement as parents and allow the young people to consume alcohol if they deem it appropriate, using the same approaches as they might with their own children. There was also a sense that such an approach would only be appropriate for young people of a particular age. For example, Deborah (foster carer) talked about allowing Sophie (age 15, foster care) to drink champagne at Christmas, but not Josh (age 12, foster care), due to their respective ages of 15 and 12 years. Sarah (foster carer) shared a similar view, stating she would not let Beth (age 14, foster care) have a cocktail for her 15th birthday, but would have a different view if she was 16 years of age, stating “*I explained to her I said no because...you're just too young for that just now know what I mean I would I would if she was sixteen*”. Such an approach cannot occur in residential care, where alcohol is forbidden, meaning that the rules are focused on consuming no alcohol and sanctions for being caught. For example, as Ian explained:

“we have to follow protocol so the council's protocol no drugs no alcohol but we know it happens and it's about how we balance that out to support these young people...we supervise their pocket money if they come in drunk” (Ian, residential care staff, Unit C)

Carers' attitude and approach to young people's and their own alcohol use and communication around such use appears to be influenced by their professional role identity and the rules surrounding these roles. In residential care, alcohol use is forbidden, own use is rarely discussed in depth and young people's use is discouraged, although there is some consideration regarding whether preventing use altogether is possible. For some carers, there was a view that having a more realistic approach to alcohol use, as is observed in family homes and in foster care, would be beneficial, providing opportunities for better discussion regarding use. However, such an approach is not possible, due to regulations enforced by the units and the local authority. In foster care, a more parent-oriented approach was used, whereby alcohol use occurred in the family home, was supervised and monitored, influenced by rules around type, quantity and locations. However, foster carers were still bound by social work rules, highlighting the complexity of acting in a parental role without the full parenting rights.

Unlike alcohol use, which was often discussed even if young people were not drinkers, conversations about smoking tended to only occur with smokers, and when they did occur, were focused on rules and encouragement to stop smoking. These differences between conversations around smoking and drinking reflect wider cultural views, in which alcohol use is seen as common and normal and smoking as unhealthy and stigmatised. While alcohol use may be encouraged in particular contexts, smoking was discouraged, cessation encouraged and young people were forbidden from smoking in or anywhere near residential units and foster homes.

According to the carers, smoking is very common among looked after young people, but particularly problematic in residential care, with a number of carers reflecting on the vast numbers of young people who smoke. Deborah (foster carer) alludes to the likely reason for the high rates of smoking and the difficulty of encouraging them to stop: young people start smoking at a young age and sometimes their parents continue to encourage their smoking. Sharon highlights the extent of smoking within residential care:

“smoking's probably the biggest conversation...because all of our kids smoke...mostly all of our kids we've got new kids in that don't smoke just now...the longer they're here they will because they will smoke to fit in wae the kids that're already here...unfortunately ...we'll be lucky if we get one kid that walks out of here...a non-smoker” (Sharon, residential care staff, Unit D)

Thus, carers perceived smoking to be problematic within care settings, particularly residential care. Residential care staff in particular talked about regularly having conversations with young people about smoking, often on a daily basis because smoking is common, and obvious, as young people can be seen going out of the building to smoke. Diane (residential care staff, Unit B) described conversations about smoking as a “*constant reminder*” about the rules around smoking and stated that conversations occur “*sorta day to day*” because staff are always trying to discourage young people from smoking.

Rules around smoking were also common, like they were for alcohol use. However, for smoking, rules did not focus on encouraging sensible use of tobacco, but on the law around smoking in public places. Young people were forbidden from smoking in buildings and were urged to smoke as far away from buildings as possible so their smoking could not be observed by staff and members of the public. Such rules were applicable in residential care as well as foster care. For example:

“he's got very strict rules around you can't smoke in the house...if you wanna do it when you walk the dog fine” (Hope, Social Worker)

“I keep gettin' caught like I'm no meant to smoke like if I want like to smoke a fag I've to go to the back but I always go to the front and like when staff come up in their car I dinnae realise it's them and they always catch me” (Michael, age 14, residential care)

Thus, rules around smoking were to prevent young people from smoking within homes and residential units, and to prevent them from being seen to be smoking. Some of the carers and young people talked about punishments for breaking these rules, such as limiting pocket money, but there seemed to be little effect of these rules and sanctions influencing young people's smoking behaviour.

Carers, particularly in residential care, also talked about encouraging young people to stop smoking and encouraging particular smoking cessation aids, such as patches, e-cigarettes, visits from the smoking cessation nurse or GP, and sessions on smoking during development days:

"we get the information and the nurse comes out...they do try the patches and the chewing gum and things" (Sharon, residential care staff, Unit D)

"if they wanted to stop we'd help them...if they want to stop they can they'll get support to do it" (Tony, foster carer)

However, none of the young people who smoked expressed a desire to stop smoking. Michael (age 14, residential care) said that residential care staff had tried to persuade him to stop smoking without having provided him with information about how to actually do so. Skylar (age 16, residential care) also talked about trying to stop smoking in the past, although her attempts only lasted a few hours; she talked about now having no desire to stop smoking and would not take on board any information from residential care workers. Megan (age 16, residential care) talked about being given leaflets about stopping smoking and noted that the residential care workers wanted her to stop but reflected that *"if I wanna that's my choice"*. Zoe (age 16, foster care) said that she currently smokes, but only socially, so it's *"not a big thing"*. She spoke of her foster carers' preference that she did not smoke, but also stated *"they said that they can't really do that much about it"*. The quotes from Megan and Zoe suggest a lack of control over their smoking, with carers viewing tobacco use as a choice made by the young people.

Carers' approach to smoking differs from their approach to alcohol use: conversations occur on a daily basis when young people smoke, to remind them not to smoke within residential units and foster homes. Conversations about smoking occur less frequently, if at all, for those who do not smoke, suggesting they are not used as a preventative approach, but rather to discourage current smoking in smokers. Carers talked about encouraging access to smoking cessation, however, young people talked less about wanting to stop smoking and about being provided with resources to do so. They also talked about being told that smoking is their own choice, which is suggestive of a lack of control over their behaviour. Unlike with alcohol, carers' role identity did not appear to influence their approach to smoking. Carers were bound by policy and guidelines enforced not only by social work departments, local authorities, but also by the law, whereby smoking in residential units and foster homes is forbidden. While alcohol use was discouraged, there was a view that monitoring sensible use was unproblematic, although the extent to which carers were able to advocate such an approach varied by care setting. Thus, it seems that while boundaries and rules affect both substances, role identity influenced carers' approach to alcohol use more than smoking.

Drugs were discussed in rather negative terms, by both carers and young people. There was a sense that drug use was a very damaging activity with serious consequences, including death. Of the young people interviewed, Zoe (age 16, foster care) had used cannabis and Michael (age 14, residential care) had used NPS, experiencing extremely negative side effects. Five of the young people mentioned their experiences with parental drug use; the following quotes from Beth and Megan allude to the reasons for their negative views of drug use and the devastating effects on their family:

"my Dad took drugs so I'm gonna learn from him cos he died...don't take them... you're no just doin' harm to yourself...hurtin' other people as well cos it killed you cos you're done somethin' stupid" (Beth, age 14, foster care)

“when I was younger like ma Mum took drugs but I'm just against them dinnae like them never have willnae and they ruin people's lives” (Megan, age 16, residential care)

Although some of the young people had experienced parental alcohol misuse, there was not the same sense of disgust and disapproval as there was in terms of drug use. Both Sophie (age 15, foster care) and Zoe (age 16, foster care) talk about their own experiences with parental alcohol problems, but did not have the same reaction as Beth (age 14, foster care), Megan (age 16, residential care) and Rachel (age 15, foster care) towards parental drug problems. Sophie and Zoe would still drink alcohol despite their experiences, although they did mention being more aware of the effects than their peers; Beth, Megan and Rachel were completely against drug use and would never consider using drugs. These contrasting views of these substances may be due to cultural perceptions of drug use and drug users. Of the thirteen young people interviewed, two reported experiences with drugs, with these experiences being one-offs. I experienced a great deal of difficulty in recruiting young people who had experienced drug use; gatekeepers had explicitly said that these young people would not engage, and that staff struggle to communicate with them. This difficulty will be discussed in more detail in Chapter 7. Thus, the view of drugs within the study was slightly one-sided, with a view that drugs are dangerous, cause huge problems to the user and their families and often lead to death. Carers' role identity, as with smoking, did not seem to influence their approach to drugs: the majority of carers held the view that drugs were dangerous and should not be encouraged, which appears to have been influenced by cultural views and the law.

There was a sense that drug use was unfamiliar territory; carers felt comfortable talking about and dealing with alcohol and tobacco use, because they had their own experiences with these substances. Drug use, however, was more alien, difficult to deal with and understand. For example:

“the whole drug thing's just like I understand it and I understand what's going on but it's really hard to work with it's really difficult”

(Angel, residential care staff, Unit B)

“it's illegal there's no way you're ever gonna have foster carers role modelling...it just makes it a whole lot more complicated”

(Hope, social worker)

Carers' lack of understanding around drug use may be due to their own experiences: they can deal with and talk about alcohol and tobacco because they are likely to have had personal experiences with these substances. As drug use tends to be less common than alcohol and tobacco use, carers may have little or no experience with drugs, making their use much harder to understand.

Even when carers held less negative or anxious views of drug use, they would never encourage such use or allow it, in the same way as they might with alcohol use. For example, both Jennifer (residential care staff, Unit A) and Ian (residential care staff, Unit C) talked about alcohol and tobacco use being more damaging to health than drugs, with Jennifer stating that while she holds this view of drugs, she would never promote drug use:

“alcohol and...cigarettes are probably the bigger killers than a lot of drugs...society goes oh my god drugs...I'm not promoting that we should obviously [laughs]” (Jennifer, residential care staff, Unit

A)

The legal status of alcohol and tobacco compared to drugs may also have influenced carers' concerns around use and their inability to promote safer use. Drugs are illegal substances so carers would never be able to use the same approaches as they might with alcohol use, of allowing use in certain circumstances and role modelling sensible use.

There was particular concern and confusion around NPS, with use being described as a “*big concern*”, as “*scary*” and “*terrifying*”, as “*unknown*” and a “*challenge*”. Carers felt that because these substances were new, changed so frequently and the side effects were not as straightforward to deal with as with alcohol or street drugs, they felt ill-prepared to deal with them. For example:

“the legal highs stuff...because of the nature of it and how quickly it changes and that...is really difficult...the moment you've got your head half way around what the current trend is it's gone...you're then dealing with something else...the kids obviously know more about it much more about it than we do so when you try to speak about it you just sound stupid” (James, residential care staff, Unit A)

“I don't know about the drugs nowadays that my lack of knowledge about legal highs and all these different things out there...that's where my confidence just dives...I don't know the effects I don't know how to manage that if a kid comes back and says I took a legal high what legal high? cos I have no idea” (Sharon, residential care staff, Unit D)

Many carers reported that they lacked knowledge on such substances. Although some, particularly those in residential care, had attended training sessions on NPS, others felt that such training was viewed as crucial to increasing their understanding and keeping up-to-date with these ever-changing substances.

Interestingly, a number of carers talked about having gained knowledge and information about NPS from young people themselves. Such an approach was not used in terms of alcohol and tobacco use, whereby carers themselves would provide the information and knowledge to young people. There was a sense that in terms of alcohol and tobacco, carers are likely to know more than young people. However, with NPS, carers felt that they were

lacking in knowledge and viewed young people as more knowledgeable than them. As James' quote above suggests, you would come across as "*stupid*" if you tried to talk to young people about a subject that they knew more about, like NPS. For example:

"we spoke about legal highs...I was actually getting some education...there's been things that we've spoken about with kids and they've actually been able to say well it is actually this and I'm like oh right aye you know cos sometimes they have...slang terms for things...so in a sense they are educating you" (Deborah, foster carer)

Thus, carers' lack of knowledge and experience of NPS compelled them to use young people as sources of information, as experts who can inform carers about these substances. With alcohol, tobacco and street drug use, carers view themselves as having a role in informing and educating young people about these substances. However, when it comes to NPS, carers view themselves as having limited knowledge and young people as being the experts. Treating young people as experts suggests a slight, albeit temporary role reversal in which young people are educating carers.

It appears that while the focus of this study was on substance use as a whole, encompassing alcohol, tobacco and drug use, carers deal with each substance in different ways, influenced by their professional role identity and the care context. It seems important that although each substance is dealt with separately, carers need to be aware that some young people will be using more than one substance at a time. By dealing with each substance in a different way, young people may be exposed to mixed messages and contrasting rules.

Summary of 'constraints, boundaries and rules'

Boundaries around role identity were particularly pronounced in residential care, where the distinctions between parent and staff were much clearer. These boundaries influenced carers' approach to substance use and

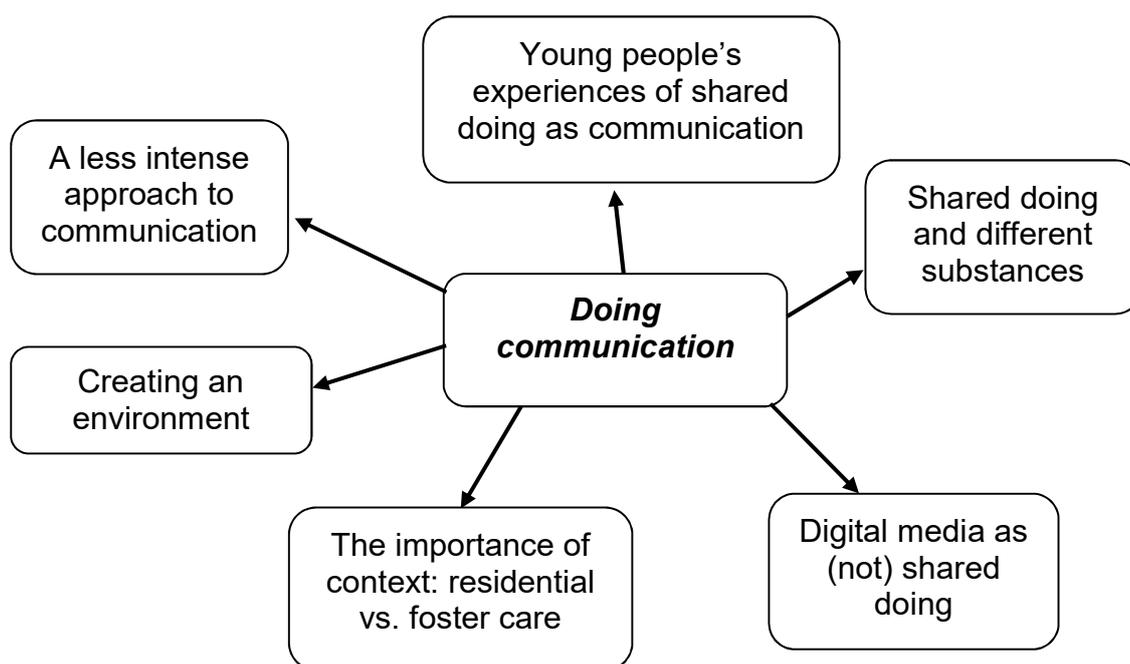
communication about it. In foster care, the rules around alcohol use were more relaxed, with carers using a similar approach as they would with their own children: allowing moderate alcohol use within particular contexts. In residential care, such an approach was inappropriate as alcohol use was forbidden. The boundaries experienced around caring also influenced carers' perceived control over young people's behaviour, with such control being limited when carers are not parents.

Carers and young people talked about different approaches and rules around alcohol, tobacco and drug use. Alcohol use was somewhat discouraged but also moderated, with responsible drinking tolerated. Tobacco use was disfavoured, and rules centred on the locations in which young people could and could not smoke, due to the laws surrounding smoking in council buildings. Drugs were met with negativity and revulsion; NPS were viewed as confusing by both carers and young people, but carers also viewed young people as experts on these substances, providing a temporary role reversal. Thus, carers' role identity has a wide influence on their experience of caring for these young people and their approaches to substance use. The next chapter will look in depth at the ways in which carers and young people communicate about substance use.

Chapter 6: Doing communication

This chapter explores the theme of '*doing communication*', describing the ways in which carers and young people communicate about substance use. Figure 4 below shows the theme and six sub-themes, which will each be discussed in detail.

Figure 4. Diagram of theme and sub-themes



First, the concept of shared doing is introduced, to provide context to the theme of 'doing communication'. Shared doing provided a way in which carers and young people could build relationships and have conversations about substance use in a less intense, more natural way, where eye contact is minimised. It also created an environment in which these conversations could occur, in a way that was different to conversations in other settings. Communication which occurs within the context of shared doing is in contrast with more formal types of communication, which focus on information giving. Differences exist in terms of how shared doing occurs within foster and residential care, suggesting different requirements for this type of communication. Young people's experiences of shared doing were different to those of carers; they tended to talk about more formal types of

communication. Digital media were discussed rather negatively, with few carers using them to communicate, but rather to gain information for themselves; however, potential benefits are discussed. Finally, as mentioned in Chapter 5, different substances were approached in different ways, affecting the way in which carers and young people communicated about them. Shared doing tended to be used more often for communication about alcohol and drugs than tobacco, suggesting different environments may be needed depending on the substance being discussed.

An introduction to the concept of 'shared doing'

Participants, particularly carers, talked about doing things together, as a way of developing connectedness and communicating about general topics and substance use. These shared activities, or 'shared doing' as they will be termed in this thesis, were described as particular activities that carers and young people would do together, such as having dinner together; going for a walk; driving in the car; doing activities in the kitchen, such as cooking or doing the dishes; and watching TV together. The purpose of shared doing appeared to be twofold: spending time together and creating an environment in which communication could be facilitated.

Participants talked about shared doing as a way of getting to know each other and building relationships. Activities such as eating dinner together, going for a walk, playing football, going shopping and sharing hobbies, were discussed as ways of developing relationships, building trust and facilitating communication. For example:

"we always set the table we always sat down...and ate...there's a whole lot of research around this now about the importance of sitting down having a family meal turning the telly off and just chatting about your day" (Eric, former residential care staff)

"hmmm...I went to [town] for a weekend it was quite fun...fishing playing football" (Joseph, age 13, residential care)

"I'll sometimes like walk the dogs...normally I would be walkin' the dogs with David [foster carer] just now...I started doin' that and then that's what made us...like talkin' and actually gettin' to know each other...with Christine [foster carer] I just like help her with stuff...if I was goin' out shoppin' for clothes then Amy [foster carers' daughter] would be the one that would take me so I got to know her from doin' that" (Zoe, age 16, foster care)

These activities were highlighted as opportunities in which carers and young people could spend time together. Interestingly, these environments differ somewhat to those discussed in terms of communication. These activities may serve a different purpose to those discussed in terms of shared doing and communication; they may be used solely for the purpose of developing relationships and having general conversations, whereas other environments are used to facilitate communication about substance use. Shared doing within the context of substance use specific communication is the main focus of this theme and the associated sub-themes, providing an understanding of how carers and young people communicate about alcohol, tobacco and drug use.

A less intense approach to communication

Participants talked about the importance of shared doing when communicating about substance use, particularly in terms of the lack of eye contact, which gave the impression of the communication being less intense. Having conversations about sensitive topics like substance use can be quite daunting for both carers and young people. Shared doing allowed conversations to take place in a less intimidating and intense way. A number of carers said that they found that face-to-face conversations do not work; young people find such situations uncomfortable. Providing an opportunity for communication when eye contact is minimised may be a particularly useful approach when young people are lacking trust and relationships with their carers. This type of communication is in contrast with more formal types of communication, in which carer and young person may sit across from each other, and eye contact would be maximised, occurring for potentially lengthy

periods. This more formal communication will be discussed in a later section. A number of carers talked about how difficult these types of conversations can be, with a recognition that looked after young people really struggle with making eye contact; one young person, Sophie (age 15, foster care) talked about eye contact as making her feel uncomfortable, so she was able to have more sensitive or intimate conversations about alcohol in the car when her foster carer was driving her to school.

Having conversations when you are doing something together was felt to be a more natural approach, making both carer and young person feel more comfortable. Talking about substance use in the car, in the kitchen while cooking or cleaning, when watching TV or when going for a walk all suggest the need for both carer and young person to be front facing, rather than looking at each other, and for something else to be happening at the same time as having a conversation. Jennifer and Sophie talk about the importance of having conversations about substance use when eye contact is minimised:

“quite often take them drive in the car and they don't once there's no eye contact there's just it's the best they just chat away”
(Jennifer, residential care staff, Unit A)

“there's somethin' about...easier being in the car cos you're not like...I don't like eye contact with people...I have a 'hing with eye contact...it's easier in the car but as well I think yeah” (Sophie, age 15, foster care)

James and Michelle talk about the challenges of trying to have conversations with young people in a more formal manner, whereby both are sitting facing each other and it is obvious that the purpose of the conversation is to talk about substance use:

“it's that care environment...there is a difference between...addressing issues...and identifying this is an issue for this kid so let's sit them down and talk about it...a lotta kids don't learn that way a lotta kids aren't gonna respond to that” (James, residential care staff, Unit A)

“very often I find that sitting in a room like we having our conversation is something that is really hard for young people I found that often it works much easier if you do something together” (Michelle, social worker)

There appeared to be an obvious decision for carers to find other methods of communicating with young people that may be more effective in getting them to engage and talk. Shared doing appears to be the most favoured method, given the different locations and providing carers and young people the opportunity to spend time together, having conversations that may not occur, or occur differently, if they were to happen in the unit or foster home.

Participating in an activity whilst talking also appeared to make the communication feel more natural and unplanned, as though the topic of substance use had just arisen spontaneously. Conversations seemed to occur more naturally and more difficult topics could be discussed, because instead of the focus being on the young person, it was on something else. The pressure was off and young people, and possibly the carers, may feel that they could relax. Natural, unplanned conversations were viewed more favourably than planned conversations; shared doing provided a way of having such conversations about substance use. The following quotes by Michelle and Sharon highlight the importance of finding an activity that allows for naturally occurring conversations about difficult topics:

“I said to someone we could try to have a running club... I did that with some young people we went running walking running and that was usually when they started talking because you did something you didn't need to talk you meant to run by accident you would talk alongside her...those things would work” (Michelle, social worker)

“goin' for a drive in the car...that's the ultimate top one for me...cos kids don't have to do the eye-to-eye contact when you're driving you can't...they'll quite happily chat away” (Sharon, residential care staff, Unit D)

While carers spoke of shared doing as a natural approach to communication, it appeared that these naturally occurring activities may have been somewhat intentional. As the following quote from Marie suggests, taking young people away for a drive in the car is a way of stimulating conversation, to talk about substance use in response to something happening, such as a young person being caught using substances, or if they just feel that certain conversations around substance use need to be had:

“they don't quite know how to ask they'll do it in the car...that's always quite a good tool if you know somebody's kinda wanting to speak about something let's go along to [town] [laughs] let's go a wee trip in the car...and then you can kind of very subtly ask or let them kinda just...spew it out” (Marie, residential care staff, Unit B)

Hope (social worker) also talked about taking a young person for a walk along the beach as a way of getting them to talk, stating that in doing so, *“you can address what basically whatever you want”*. Thus, some conversations within the context of shared doing may occur spontaneously, while others are planned, contrived conversations, which are made to feel natural through the very environment in which they occur. Carers appear to have learned through natural, spontaneous conversations about substance use in particular environments that the approach works, so they then use shared doing as a method for future communication about substance use. Others do appear to

occur naturally, depending on the situation and the environment. It appears that the crucial part of shared doing is to make the conversations feel natural to the young people, even if the conversations are planned.

Creating an environment

On the surface, shared doing appears to facilitate communication through the lack of eye contact and the desire to make conversations about substance use appear more natural. However, there seems to be more to shared doing than just a lack of eye contact and the informal nature of the conversations. Such activities may be carefully planned by carers as a way of creating an environment in order to make it easier for young people to talk. Going for a drive in the car or for a walk along the beach may act as a prompt for the young person: they may learn that being in such an environment means that they are allowed to talk about substance use, that they are in control of the situation and are not being forced to communicate. The environments in which carers and young people have these conversations are often shaped by time, space and context: they occur in particular settings and often for short time periods.

The carers recognised that having formal sit-down conversations with young people rarely works, that such conversations make them feel uncomfortable. However, doing activities together and having conversations that are perceived as natural and informal, might encourage young people to feel more comfortable, by letting them “*take the lead*” as suggested by Marie (residential care staff, Unit B). For example, Angel talks about having a conversation with a young person in the car about her alcohol use, which was worrying staff in the unit. She mentioned that the young person was talking openly and that she did not need to prompt the conversation; being in the car encouraged the young person to talk on her own terms, rather than feeling that she was being forced to talk:

“she kinda just chatted away quite openly... she was talking em I wasn't kinda prompting it” (Angel, residential care staff, Unit B)

Carers felt that young people were more open when they had conversations in these environments. Diane also talked about her experiences of being in a car with a young person, and having conversations that were prompted by a specific event: being arrested for drinking too much. She explained that being in the car with this young person had allowed more honest dialogue about alcohol use, perhaps talking in more detail than they might if they were in a different environment, one that did not involve shared doing:

“I...took her over to the hospital cos she'd got arrested and everything...away from this environment out and about in the car...chatting away and she kinda opened up a wee bit more and told me the story exactly what had happened the previous night...talked me through it and I was asking questions and she was quite open” (Diane, residential care staff, Unit B)

Susan (foster carer) talked about walking her dogs with foster children as providing an environment in which you can *“talk about anything and everything”*; Deborah (foster carer) also talked about watching the TV together as a way of communicating about substance use, because the topic *“just kinda comes up”*. These quotes suggest that carers use shared doing, in its various guises, as a way of creating an environment in which communication about substance use occurs freely, as a topic that might come up in conversations, rather than it being expected or necessary.

In the same way that carers might have learned that particular environments were conducive to effective conversations, young people might have learned that these environments were safe spaces in which to have conversations with their carers about substance use. Sophie (age 15, foster care) talks openly about her experiences of having conversations in the car with her foster carer, stating that they would talk about *“everything”*, but particularly about alcohol use. She seemed to have felt comfortable having these conversations and her use of language suggests she felt that she was contributing equally: she says *“we'd just talk”* rather than suggesting that her foster carer did all of the talking. Thus, Sophie may have learned that in order

to have conversations about alcohol use in a constructive, non-lecturing way, she would have these conversations when they were driving in the car. This way, she would have control over the situation, without experiencing any power imbalances.

Being in the car seemed to provide young people with the opportunity to have difficult conversations. These car journeys, and therefore the conversations which occurred during them, were time limited: when the journey was over, the conversation would also stop. Thus, conversations about substance use could occur for short periods of time, giving young people control over how much they could and would reveal in a limited period of time. However, while it appears that young people had an influence over such communication, most of the time carers seemed to initiate the conversations, rather than the young people themselves. Thus, young people might feel that they are in control of the conversations, but rather they are carefully planned by carers as a way of encouraging young people to talk about substance use.

The environments mentioned previously are suggestive of the need for carers to take advantage of the space in which they are in, the context and the time available in which to have these conversations. Being away from the residential unit, or being alone with a young person appeared to facilitate communication about substance use more so than having conversations when other people were around; carers talked about the need to have 'quiet time' and being 'away from this environment'. These environments created spaces in which communication could occur because they were likely to enable carers and young people to feel comfortable: they were normal, homely or safe settings where conversations tended to occur more naturally. For example, having a conversation in a car or in the kitchen will feel different to conversations which occur in offices, at meetings or even in other areas of the residential units and foster homes. The following quote from Jennifer highlights these spaces as facilitating conversations about substance use:

“we’ve got a wee place we go a drive to...it’s just that it’s a space out we go a wee drive and we sit and we have a chat and reflect on what’s been going on...sort of mark it rather than formal”
(Jennifer, residential care staff, Unit A)

The time limited nature of these environments appears to be crucial: having a conversation in the car or when doing an activity such as washing the dishes means there is a clear end point: when the journey is finished or the dishes are washed and dried. For example, as mentioned previously, Sophie felt comfortable having conversations in the car on journeys to and from school; she was aware of how long these journeys, and therefore the conversations, would take. Thus, conversations can be short and provide carers and young people with the opportunity to end the conversations if they begin to feel uncomfortable.

Shared doing contrasts with other types of communication, which are more formal and forced, suggesting that different types of communication may be required and occur in relation to different circumstances. The language used by participants hints at the different experiences of communication within shared doing in contrast to more formal communication, which will be discussed later in this chapter. When talking about shared doing and the activities involved, participants used terms such as *“informal”*, *“exploring”*, *“open”*, *“chatting”*, *“natural”* and *“relaxed”*. As participants’ language suggests, shared doing was viewed as more a natural and informal approach to communication about substance use, as more of a chat than a formal conversation. This approach seemed to encourage young people to be more open in their communication, perhaps divulging information that they might not in a different environment.

“one of the things I really liked is...cooking with the kids in the kitchen so that you’re chatting away cos what you tend to find is if you’re not eye-balling each other...you’re maybe able to...unpick more and the children are able to say more” (Susan, foster carer)

Participants' talk of their experiences of shared doing also alludes to the shared nature of the communication, in which carer and young person could both participate, or that the young person was given more of an opportunity to talk than they would in a different environment. The above quote from Susan and the following quote from Marie highlight the ability of shared doing to encourage young people to be more talkative and forthcoming:

“kind of say what they need to say or ask what they need to ask”
(Marie, residential care staff, Unit B)

As mentioned previously, the language used by Sophie (age 15, foster care) about the conversations she had in the car with her foster carer about alcohol use are suggestive of them both contributing equally and being able to talk openly about “*everything*”. Sophie's ease at having conversations with her carer in the car may be suggestive of the relationship they have: they may have developed their relationship to the level that they both feel comfortable having certain conversations, they know each other well enough to both feel they can contribute particular stories about their experiences, but only within the safe environment of an hour long car journey.

The way in which participants spoke about other types of communication contrasts with their language in terms of shared doing. This communication tended to be more formal, which was particularly common in residential care through the use of development days and residents' meetings. Participants' language suggested a passive role of young people in this communication, in which they were “*given*” information, spoken “*to*”, and “*educated*”; this indicates a contrast with being spoken with. Carers talked about the importance of giving young people verbal and written information about substance use and about educating them. This education could be provided by staff through talking about the negative effects of drinking too much alcohol or the negative health effects of smoking; or using more formal approaches, such as development days, where young people might have a session on NPS by a local drugs organisation.

Leaflets were one such way of providing young people with information about substance use. There was a sense that leaflets were useful, providing young people with information without feeling pressurised to have a conversation; leaflets could be left lying around the residential unit or given to a young person specifically. However, the use of leaflets seems to be in stark contrast with examples of shared doing, in which communication is a collaborative activity. Their use is also in contrast to the 'homely' environment that residential care staff talked about creating in Chapter 4. There was a sense that such communication, unlike shared doing, was not influenced by carers' relationships with young people: anyone could provide information and education without the need for a good relationship. Thus, using leaflets as a means of communication could be useful when young people are unable or unwilling to engage with carers. However, the young people who mentioned being aware of such leaflets did not express a desire to read such materials.

Carers talked about the importance of not lecturing young people, as they felt that such an approach would cause them to ignore the information, or even encourage them to rebel against the messages and use substances regardless of what had been said. Despite these concerns about lecturing, participants talked about teaching and educating young people, both of which are suggestive of a top-down approach to communication, in which the power lies with the carer. The following quote by Marie is suggestive of a power imbalance between carer and young person, in which young people are passive recipients:

"sometimes we'll say right this session's going to be on...drink or alcohol or substance misuse or whatever...so they do get it"

(Marie, residential care staff, Unit B)

Marie does go on to say *"but we try and not make that the...only way of doing things"*, suggesting that staff are aware that these more formal sessions may not necessarily be the best approach. Carers also seemed to be trying to equal the power imbalances in these more formal types of communication, by suggesting that young people have a choice about whether or not they

attend. As Angel and Ashley both suggest, young people's participation in these sessions appears to be voluntary:

"we'll bring them [specialist drugs information service] in here to speak to kids about it or we'll take them there for them to speak if they want to one-to-one or as a group we'll do that" (Angel, residential care staff, Unit B)

"we did some group work with the local community police they used to come sort of once a month and do stuff...the dangers of that and personal safety and stuff as well...that was obviously a choice thing for the young people if they wanted to be involved in that or not" (Ashley, residential care staff, Unit A)

Of the six young people in residential care who were interviewed, only one mentioned that they had been involved in these formal types of communication. Skylar (age 15, residential care) had recently attended a development day on NPS at a local drugs information organisation, which she said she found interesting. It is difficult to tell whether her participation in this session was voluntary or not. She states that *"for our last development day they took us to...[specialist drugs information service]"*; her use of language, stating that *"they took us"* could imply a lack of control, that participation was not, in fact voluntary, as the carers suggest. However, the lack of explicit statements from Skylar and other young people, mean that such conclusions cannot be drawn.

Shared doing created an environment in which to have more effective, natural, realistic conversations, in which young people participated, were open and honest and talked about their own use rather than just discussing substances more generally and being provided with information. There was a sense that shared doing provided a method of communication that was mutual, it was not forced or imposed. Conversely, formal communication, through information giving, was something that was required, part of carers' roles as corporate parents. This type of communication was perceived as

something that was done by carers because it was expected of them; part of their role was to talk to young people about alcohol, tobacco and drug use. As corporate parents there are certain expectations placed on them and there was a sense that communication about substance use was one such task, although participants did not explicitly state this. Participants talked about this communication in terms of “*need*”, “*got to*”, “*should*” and “*have to*”; on more than one occasion Angel (residential care staff, Unit B) mentioned that by having conversations with, and giving information to, young people, she had “*done her job*”. The following quote from Hope highlights the sense that communication was something that needed to occur:

“obviously you talk about it [alcohol]...I think you should always talk about it demystifies the taboo around it...you need to talk about it you need to say what it is and what it isn't” (Hope, social worker)

Interestingly, carers talked about using a planned approach to have natural conversations with young people, which are, in fact, not as naturally occurring as they might seem. As communication about substance use appears to be part of their jobs, carers are looking for opportunities in which to have these conversations. They are choosing instances in which to have conversations in a way that young people might be more responsive and engaged. The following quote from James illustrates the planned approach to natural conversations:

“you're going in a situation you're gonna be around the kids you're looking for opportunities to maybe do certain things in like a natural...” (James, residential care staff, Unit A)

Both Deborah (foster carer) and Susan (foster carer) also spoke of using such an approach in foster care, suggesting that they too feel the need to have these conversations. They spoke of the need to “*choose the moment*” to have conversations, planning to do so when it was appropriate and when it “*feels natural*”. Thus, it seems that natural conversations may actually have

more intention behind them than carers and young people perceive. These natural conversations appear to be influenced by the need for carers, in both settings, to have particular conversations with young people in order to fulfil their caring duties and create an environment to facilitate this communication.

The importance of context: differences between foster and residential care

Instances of shared doing, in which carers and young people had conversations about substance use whilst partaking in particular activities, occurred within residential and foster care settings. Both foster carers and residential care staff talked about having conversations in the car, in the kitchen, going for a walk and whilst watching TV. More than half of the participants who mentioned shared doing were in residential care, suggesting that there were differences in the use of shared doing as a method of communication between care settings. Foster and residential care are distinct settings, with differences in terms of how carers communicate with young people about substance use.

Shared doing in foster care

As mentioned in Chapter 4, in foster care, young people are joining a family environment, sometimes with foster carers' own biological children. In some cases, foster children are seen as part of the family, they are treated the same as foster carers' own children and might eventually call their foster carers 'Mum' and 'Dad'. As discussed in Chapter 5, the boundaries between parent and carer are somewhat blurred, which may affect the way in which communication occurs. In foster care settings, shared doing occurred in situations in which family-based communication might naturally occur: driving to school, cooking, walking dogs and watching TV. The environment in which these activities occur may be created by foster carers as a way of including young people into family life, to help them feel like part of the family and to build relationships; they are also created to facilitate communication about substance use. Foster carers talked about treating their foster children in the same way as they would their own children, but there was also a tension due to the rules and boundaries that they would have to follow in relation to

fostering. Susan (foster carer) and Deborah (foster carer) both spoke about including young people in their family and treating them as their own, but did not talk about having such conversations about substance use with their own children.

Susan talked about going for walks as a useful opportunity in which to have conversations about substance use. She mentioned that the purpose of going for a walk with the dogs was not to have conversations, but the topic might come up if it was appropriate:

“walkin’ the dogs was a great thing cos you’re both front facing...you’re sorta tied up with apparently...walking the dogs and throwing balls for the dogs and within all that you can talk about anything and everything...but did I ever walk out the door and say and today we’re raising the subject of substance misuse? it wasn’t it would be if it was...easy to bring up and it seemed appropriate” (Susan, foster carer)

As this quote illustrates, walking the dogs was used almost a guise for having conversations about substance use: her use of “*apparently*” suggests that there is hidden element to the activity. Young people thought they were simply walking the dogs, but often difficult conversations could be had. She suggested that young people were not pre-warned about the conversation, but she would often talk about substance use, if it was “*easy to bring up*” and “*seemed appropriate*”. Susan’s language hints to the planned nature of shared doing, doing a seemingly irrelevant task as a way of having somewhat difficult conversations about substance use.

The way in which Sophie (age 15, foster care) talked about her experiences of shared doing, having conversations in the car with her foster carer on the way to school, is suggestive of the blurred boundaries between fostering and parenting and hint to the tensions that her foster carer experienced when talking to her about alcohol use. Her initial description of the event suggested that driving in the car was a way of getting to know her foster carer, of

building relationships and talking about “*everything*”, particularly sharing stories about their experiences of alcohol use. However, she then goes onto say:

“she said she can't condone it...she said everyone will at some point so it's just not gonna be like a surprise but then she would have to report it to social work if I had... I just thought well if I do then I probably won't say anything cos [laughs] it's easier just not to say anythin” (Sophie, age 15, foster care)

Instead of her foster carer treating the conversation as a way of educating Sophie, or dealing with the disclosure as a parent might, she made it clear that she would have to follow fostering guidelines and report any future alcohol use to social work. While foster carers talked about treating young people as part of the family, when it comes to substance use there were particular rules and regulations that were different to those in a ‘normal’ family, as explored in Chapter 4. Perhaps she felt that this was the correct thing to do, but as Sophie explained, this need to follow rules had a detrimental effect on her future communication about alcohol, that it would be easier for her to hide her alcohol use than to talk about it. Deborah, Sophie’s foster carer, might have created the environment of having conversations in the car as a way of having these difficult conversations about what would happen if Sophie disclosed use or was caught with alcohol. Such conversations may have felt inappropriate in a home setting, in which Deborah felt like a parent. In the car, she could perhaps feel more like a paid foster carer, who is bound by social work regulations. In the interview with Deborah, she mentioned having conversations about substance use, particularly alcohol, at home, in the living room or whilst watching TV. While she did not go into much depth, on the surface there seems to be a difference in the content of these conversations:

“we do tend to sit and chat and it can just follow on from it can be we could start off with nothing to do with that but then it just gets onto it you know that subject...it just kinda comes up” (Deborah, foster carer)

Deborah’s quote hints at a different type of conversation than would occur in car journeys with Sophie. Previously in her interview she talked about having conversations about alcohol at home because she will sometimes have a glass of wine in front of the young people. These conversations reflected a more laid-back, natural approach to communication, in which she would explore alcohol use with young people, explaining that alcohol can be used in a positive way, contrasting this with their past experiences of parental alcohol misuse. Her reflection on these conversations differs from Sophie’s, contrasting a natural, exploratory conversation with one which is centred on rules and regulations. These different conversations may be in response to different situations: she would talk casually at home about alcohol use with young people because they were not drinking or at risk of going out and getting drunk. Perhaps the conversations were in response to concerns around her alcohol use, as Sophie had admitted drinking a lot more before entering foster care.

It appears that foster carers may use shared doing in order to create environments in which to have conversations with young people about substance use. These activities are rather family-like, the types of activities that parents and children do together, like driving to school or walking the dogs. However, it appears that they are sometimes carefully thought out approaches in which to have conversations about a challenging topic. These conversations are also bound up by fostering rules and regulations which influence carers’ communication with young people, as detailed in Chapter 5.

Shared doing in residential care

Residential care is a very different setup to foster care. More formal methods of communication tended to occur: participants spoke of development days; residents’ meetings; outings to drugs organisations; and sessions with

healthcare workers and the Police. Such activities were never mentioned in foster care settings, suggesting different methods and approaches to communication. The use of leaflets was regularly mentioned by residential care staff as a useful way of conveying information about substance use to young people. In contrast, Rob (foster carer) highlights the fact that such an approach would be seen as inappropriate in foster care: *“to actually sit down and pull out a leaflet I think we'd just get slapped”*.

Shared doing appears to occur more frequently in residential care than foster care, suggesting potentially different reasons and needs for such approaches. On the surface, shared doing seems to be a way of building relationships, of having difficult conversations without eye contact and as a way of having more informal conversations. As mentioned in terms of foster care, these activities are also somewhat family-oriented, those that are likely to occur in a family home between parents and children. Thus, shared doing may be a way of creating a home environment for young people in a setting that is very clearly not a family home. As discussed previously in Chapter 4, residential care staff talked about the need to create a homely environment for young people, allowing them to decorate their rooms and view the unit as a safe and secure place. Watching TV together, washing the dishes and cooking together, as well as having dinner together, may be environments that are created to enable young people in residential care to experience family life. They are also situations in which staff can have conversations about substance use:

“if it comes up in conversation where it's on TV and stuff cos it's just there you're sitting watching and you can kinda from then”
(Ashley, residential care staff, Unit A)

There was a sense that conversations could occur when staff and young people were watching TV together, particularly if TV programmes acted as a prompt to such conversations. Ian talked about using TV programmes as a way of helping young people to reflect on their substance use behaviour:

“something on the telly and sayin' oh that's shockin'...you shouldnae be doin' that...we would say well ken this is somethin' that you've kinda experienced yourself and how did you feel about it when you were doin' that?...they try to reflect back to exactly what they done [sic] and say oh aye right enough cos if I'm sayin' that about what's happenin' on the telly I've been doin' the exact same so actually I shoulda been listenin' to what yous are sayin' to us” (Ian, residential care staff, Unit C)

Shared doing also appears to provide an opportunity to get away from the unit and to spend time together one-on-one. Residential care staff talked about driving in the car and spending time away from the unit, such as going for a walk, getting an ice cream or going for a spa day. These instances allude to a need to have conversations outwith the unit environment. Residential units are busy places, with numerous staff and young people. It may be that carers feel unable to have difficult conversations in a more formal environment in earshot of other staff and young people. Carers talked about using development days and other sessions to educate young people about substance use. It appears that these sessions provide an opportunity to have more general conversations about substance use, while more difficult, intense or personal conversations occur externally:

“drives in the car's always a really good way to talk to teenagers...so if there is topics that you need to discuss that's always a good way...they're more likely to sit there you might not always get the information but it is a good a good place to start a conversation” (Sharon, residential care staff, Unit D)

As the above quote from Sharon suggests, being away from the unit can be a particularly useful way of having difficult conversations; taking young people away from the unit for a drive in the car, particularly if there are conversations that need to occur. Staff are using shared doing to carefully create environments in which to have conversations with young people about

substance use, conversations that may not occur in other settings or when shared doing is not being utilised.

Young people's experiences of shared doing as communication

Interestingly, the only young person who mentioned instances of shared doing was Sophie (age 15, foster care). It may have been that the result of conversations that she had in the car with her foster carer had been memorable, that if she was found to be using alcohol, social work would be informed. For the other young people, such instances may be less memorable or may not have occurred. Young people in residential care spoke of having conversations during more formal sessions, such as development days. For example, Skylar talked about recently attending a development day about NPS at a local drugs organisation. This was the only communication that she talked about in depth. Kate (age 13, residential care) also mentioned that she was aware of such sessions but as she had only been in the residential unit for a month, she had not attended anything yet. According to Kate, she had not had any conversations with staff about substance use since arriving at the unit, because it was not something she was involved in. It may be that staff have not made it a priority to talk to her about substance use because she has informed them that she is not using alcohol, tobacco or drugs.

Eleven of the thirteen young people alluded somewhat to a lack of communication, either completely, or only having conversations about one particular substance. There was a sense that if they were not using substances, their carers did not need to have conversations with them about substance use. Craig (age 16, foster care), Hayley (age 13, residential care), Joseph (age 13, residential care), Josh (age 12, foster care) and Kate (age 13, residential care) all said that they had never had a conversation with foster carers or residential care staff about smoking, drinking or drug use. This may be due to their young ages: four out of the five were aged 12-14 years. It is unclear as to the reason for their perceived lack of communication: it could be that the conversations had occurred but were not memorable for them. Alternatively, these conversations may not have yet

occurred because their carers felt that conversations were not necessary because substance use was not an activity they engaged in or were interested in. This viewpoint is reflected in the following quotes by Deborah and Sarah:

“we have lots of these kinda talks...when they're needed...it's different Josh's young so we're not at these stages yet and Josh is a very young twelve so...we've not felt it kinda necessary to”
(Deborah, foster carer)

“I know she's she's no doin' any of that... it's just no on the agenda it's just no happenin' no doubt it will” (Sarah, foster carer)

It seemed that in foster care, conversations tended to occur only when deemed necessary, when young people are using substances. This may, in part, be due to foster carers' professional role identity, in that they view themselves more as a parent than a carer so feel that they should have conversations when they feel it is appropriate, rather than because they have to. They may be using their experiences as parents to determine when best to have such conversations, possibly around the same time as they might have had them with their own children. This approach to communication suggests a harm reduction approach, rather than a preventative approach, having conversations when young people have started using substances rather than prior to such use occurring.

In contrast, there was a sense that, in residential care, you need to inform young people about substances, even if they are not using them, taking a more preventative approach to communication:

“well some kids you can some kids...it's...not on their radar...but we always kinda have obviously keep them knowledgeable about like drugs and alcohol and smoking and whatever” (Diane, residential care staff, Unit B)

“the two wee lads we’ve got just now are not smokers or drinkers or drugs...they’re pretty young... it’s not that we don’t talk about it with them like I would still...it’s not off the cards but we obviously don’t talk about with them as often just cos it’s not...part of their sort of world” (Jennifer, residential care staff, Unit A)

Residential care workers may feel obligated to have these conversations with young people because it is part of their job, a task that they must do to fulfil the requirements of their post and the regulations in place in terms of caring for these young people. There is a sense in Diane’s quote that such communication is required, that it is something that residential care staff “have” to do. The requirement of residential care staff to talk to young people about substance use regardless of whether or not they use substances may be a due to their perceived vulnerability or due to specific requirements imposed on residential care units. That said, three of the five young people who reported no communication were in residential care. These conversations may not yet have occurred due to the short length of time they had been living in the unit, or staff had not yet organised development days on substance use.

For the young people who reported some experience of substance use specific communication, the conversations they had with their carers tended to focus on the particular substance, or substances, they used. Rachel and Sophie only drank alcohol so they explained that they did not have conversations about tobacco or drugs because it is not something that they need to discuss. They both explain that conversations about tobacco are irrelevant to them, as well as boring:

“we don’t actually have like conversations about cigarettes and all that cos I think if we were...I’d just be like [makes bored face] what’s the point in this?...I’d just get bored and I’d be like nah like I don’t smoke that’s it” (Rachel, age 15, foster care)

"I don't smoke or anythin'...it's not a worry cos they know I wouldn't...it's not been like a big...conversation or anything that we've had like a big topic that we discuss" (Sophie, age 15, foster care)

Michael (age 14, residential care) and Skylar (age 16, residential care) reported similar experiences in terms of conversations about smoking: they are smokers so they have had conversations about tobacco use but not alcohol or drug use. Megan (age 16, residential care) spoke of having conversations with staff about both alcohol and tobacco use and Zoe (age 16, foster care) reported having conversations about alcohol, tobacco and drugs because she currently uses or has previously used all three. These conversations about substance use tended to focus on the rules around such use.

Thus, it appears that many carers often only talk to young people about the substances that are relevant to them, or young people only take on board the messages that are particularly relevant to them. Rachel's quote highlights the potential negative attitude towards irrelevant conversations, which may be the reason why carers do not often talk about the substances that young people are not involved in. For two of the young people, conversations did occur about substances they were not using. Beth (age 14, foster care) said that she currently does not use any substances but has had limited communication with her foster carer about alcohol and tobacco use. It seems that these conversations stem more from her foster carer's own use, rather than in relation to Beth's future use. Thus Sarah, Beth's foster carer, may be trying to introduce the topic of substance use gently before Beth starts drinking or smoking, as a way of having conversations that are not too difficult. She may also be talking generally about these substances because she is aware that Beth is there when she is drinking or smoking. Kirsty (age 19, foster care) talked about having conversations with her foster carer about drugs, even though she has never used any drugs. These conversations seemed to involve warning messages about the damaging effects of drugs, using Kirsty's parents and siblings as examples. Thus, it may be that carers

try to have conversations that are relevant to the young people, in terms of their own and others' experiences.

Apart from Sophie (age 15, foster care), none of the young people talked about the environments in which conversations occurred. It may be that these conversations are not memorable; that because staff are hoping to have conversations that seem natural, the conversations are less poignant for the young people and thus did not talk about them during the interviews. When young people spoke of the types of communication they had experienced with their carers, the focus tended to be on general advice around alcohol and tobacco use, as well as rules. For example:

"all the risks and everythin' but I probably won't do it at all...it's a bad habit to get into...you shouldn't do it...I asked when I would be...allowed to... she says once you're over eighteen" (Craig, age 16, foster care)

"just know your limits...cos you're clever you ken when to stop...dinnae over drink like you used to cos you've got a job to think about...stuff like that" (Megan, age 16, residential care)

There were very few reported conversations about drug use, which is reflected in the fact that only two of the young people had experience of using drugs. There was also a general sense from the young people, which was echoed in the interviews with the carers, that substance use is something that cannot be prevented or really controlled:

"as much as you want to prevent it and try and stop it you it's about education...trying to educate the kids" (Julie, residential care staff, Unit B)

"I don't think you can ever say don't ever dae it" (Sarah, foster carer)

“[about cannabis] they said not to but if I did do it...it's ma own choice that they'd prefer that I shouldn't touch it but like if you smoke it the odd time then you smoke it but I'm not going to [laughs]” (Zoe, age 16, foster care)

Instead, carers' communication tended to cover three particular areas: providing information; setting rules and boundaries; and advising them not to use certain substances. Carers would provide information in terms of the negative effects of substances, and the potential consequences of use:

“she does say like if you ever do [start smoking]...I'd advise you not to like...it's bad for you your lungs blah blah blah...I'm like no I know” (Rachel, age 15, foster care)

“we'd mostly talk about...the health issues round drinking too much alcohol...the kids get how unsafe it can be how things can happen when you're drunk that you might not want to happen when you're sober but mostly my thing is about long term health issues that's what I speak to them about” (Sharon, residential care staff, Unit D)

As described in Chapter 5, these rules and boundaries around substance use were influenced by carers' professional role identity and the rules by which they were required to follow. There were also different rules around particular substances, with most conversations centring on tobacco and alcohol use, rather than drugs. There were strict rules around tobacco use, while with alcohol use, rules and boundaries tended to be around sensible drinking and preventing drunkenness. The following quotes from Eric and Megan highlight the types of rules and boundaries communicated to young people:

“we’ve noticed that the last four times you’ve come home from your pal’s...you’ve been a little funny or whatever...quite often start like that...it would be kind of exploratory but I guess in the long run we would be saying...you can’t keep going there if you’re gonna get drink you know you can’t keep coming back drunk... you can’t do that...that’s not acceptable in here...that kind of thing”
(Eric, former residential care staff)

“they said we werenae allowed to smoke like outside the door we had to go over the road if we wanted to have a fag and if we did if we smoked outside the door our money at the end of the week would be supervised” (Megan, age 16, residential care)

Young people would also be advised not to start using substances, particularly tobacco and drugs. Beth talked about her foster carer advising her not to start smoking due to the negative effects on your health, while Tony talked about discouraging cannabis use:

“Sarah used to smoke but she says it's not good for you...makes you like feel more older in the insides cos you know your body's under that stress and that pressure of what you're intaking” (Beth, age 14, foster care)

“I have talked about...marijuana use...that kinda came up with one of the young people we had where they'd been off and smoked marijuana...it was just...tryin' to explain to them look it's not the end of the world...but it's maybe not the the greatest thing to be doing because it can very quickly turn into a...like a lifestyle choice a habit that's not a good habit to have” (Tony, foster carer)

Of the thirteen young people interviewed, five spoke in detail in terms of the conversations they have had with carers about substance use. The remaining eight reported little or no communication, particularly in terms of the context in which communication occurred. Thus, it may have been that

these conversations occur in a way that means young people do not acknowledge them or that different carers use different approaches with different young people. Conversations within an environment of shared doing may only reflect more difficult discussions about substance use, in terms of dealing with problematic use or difficult topics, rather than more general use, which was reported by the young people who participated. The conversations that the young people spoke of were often in terms of general advice about alcohol use and encouragement to stop smoking. These conversations were perceived to relate to normal teenage behaviours of alcohol and tobacco use. It appears that young people and carers had somewhat different perceptions and experiences of communication about substance use.

Digital media use as (not) shared doing

Overall, digital media were rarely used to communicate about substance use and were viewed quite negatively by a number of carers. However, there was a suggestion that digital media had potential in terms of substance use specific communication. Participants talked about shared doing as a useful way of communicating with young people about substance use, due to the lack of eye contact and the focus being on the activity rather than on the young person. Therefore, one would assume that the use of digital media, particularly the use of computers, would provide the perfect opportunity for shared doing: carers and young people could sit at the computer together, side-by-side, and have discussions about substance use. Websites and videos could also provide a prompt to the discussion, providing young people and carers with information about alcohol, tobacco and drug use. Thus, digital media have the potential to be a potentially useful way of communicating with young people about substance use; however, this was not necessarily the case in the current study. Marie, and other carers talked about the usefulness of such an approach:

“you're kind of both facing the screen so although you're talking about stuff it's not as intense cos you're not looking at each other in the face you can kind of use that as a kind of buffer zone kind of look at the issues without being...kinda too personalised about it”

(Marie, residential care staff, Unit B)

As Marie suggested, having conversations whilst using the computer could provide a safe environment in which to talk about substance use; this type of shared doing acts as a ‘buffer zone’ and makes the conversations seem less personal. Eric (former residential care staff) describes websites as providing *“accessible...good information in a child friendly way...about drugs”*, with James (residential care staff, Unit A) also echoing this favourable stance. Sarah (foster carer) had not yet used such media in conversations with her foster child, but could see the benefits, stating that she would definitely use websites and social media. While some carers could see the potential benefits of using digital media, Marie (residential care staff, Unit B) was the only carer who talked about using the computer to communicate with young people and access information. She appeared to be the only carer who could see the positives of such an approach. Others saw digital media as challenging:

“I've been very reluctant...because I think that it just...takes up too much of your time...I'm against it...yes [laughs]” (Deborah, foster carer)

“we have a difficult attitude to technology as well...I think we see some of the dangers in it more easily than the benefits” (Eric, former residential care staff)

Carers talked about using computers, particularly the internet, as a way of gaining information about substance use for themselves and for young people. There was a sense that the internet provided carers with up-to-date information about drugs, particularly NPS, and this seemed to be the extent of their digital media use. For example, Tony (foster carer) talked about

accessing information online about cannabis, which he said was “*for my own benefit to understand...what's goin' on with it*”. Julie talked about accessing information online regarding NPS as being particularly helpful due to their ever-changing nature:

“legal highs they change that regularly you have to keep in loop and we got a thing from [specialist drugs information service] when we were on the training day...they sent us a whole list of what the names were...current names that's probably changed now...there are websites you can go into and find out all what the legal highs are called now so you know what to look out for” (Julie, residential care staff, Unit B)

For Julie, Tony, and other carers, online information could provide evidence to back up their claims about the negative effects of substances when talking to young people, as well as a way to gauge young people's behaviour and determine if they were using substances. Carers also talked about the provision of online information to young people, as well as their ability to access such information themselves:

“obviously they can research things as well if they've got the internet...that's accessible for them...to get information...from the computer or the internet just about anything...they probably would do that they're on the computers a lot the young people obviously they've got their own computer room so you know they have got access to information via the internet” (Diane, residential care staff, Unit B)

While there was a sense from carers that young people could and would access information online about substance use, young people did not seem to share this experience. None of the young people had used any form of digital media as a way of communicating with their carers, except Rachel (age 15, foster care), who would use her mobile phone to text her foster carers when she was out drinking with friends. Few young people talked

about gaining information from websites: Kirsty (age 19, foster care) had been recommended by her doctor to have a look at a website about substance use, which she found useful; and Beth (age 14, foster care) had looked up information online about smoking as part of a school project. There was a sense that digital media use was not necessary and that their carers would instead have conversations with them about substance use.

Interestingly, Hayley talked about her desire to use online information over having conversations with residential care staff. Throughout the interview with Hayley, there was a sense that she did not like living in the residential unit and had not developed relationships with any of the staff in the two months she had lived there, as previously discussed in Chapter 4. She reported no communication with her carers about substance use since entering the unit, or in previous secure care and foster care settings. The following quote highlights her resistance to having conversations about substance use:

“I’d look it up online I wouldn’t speak to them...cos it’s just easier and I don’t like them...and if you ask them then everyone knows and then they’ll like think that I dunno you’ll just get in trouble...well like they’d become suspicious like somethin’ was happening” (Hayley, age 14, residential care)

Hayley’s quote suggests that her preference for digital media over conversations stems from a lack of connectedness with her carers. She viewed the staff in the unit as being suspicious of any mention of substance use, even if the conversations she is looking to have are more about general use and gaining information. Therefore, digital media may have potential in providing information and advice for young people if they feel unable to have conversations with their carers about substance use. Such an approach could almost be used as a way of building up to full-on conversations: first, young people could have a look at websites regarding substance use; they could then sit with their carers and build up to having conversations about the information they are looking at, in a safe environment, or as Marie (residential

care staff, Unit B) stated, a “*buffer zone*”. However, the lack of digital media use in residential and foster care by both carers and young people may reflect the negative views held by carers as well as the boundaries imposed by the care environment.

There was an overall sense from carers that digital media caused more harm than good, that they were challenging and surrounded by rules, boundaries and negativity. For some, digital media were viewed as problematic as they were associated with bullying and safety concerns. There was a sense that young people in care are vulnerable and in need of protection from outside sources:

“young people...their phones and Facebook's like their...right arm...all the time's there a lotta like bullying and a lotta underlying issues are going on...on Facebook that we find it difficult to get access to...we have got internet access in in the unit but again that's got to be quite closely monitored by staff to help protect them to a certain degree” (Diane, residential care staff, Unit B)

Hope (social worker) talked about her distrust and dislike of digital media and that she avoids using such methods with young people. In her experience, digital media use is fraught with anxieties, because the young people in her care are either not allowed to use it, due to safety concerns, or use computers and other digital media too often, in an unhealthy way. By limiting young people’s access to digital media, carers attempted to protect young people from harm. In residential care, boundaries were imposed around digital media use by limiting internet access to particular websites and blocking others. As discussed in Chapter 5, there were limitations to the extent to which carers could control young people’s behaviour; control over digital media use may be easier than controlling other aspects of their lives. Thus, limiting young people’s access to digital media may have been a way for carers to enforce rules and boundaries. However, as Ian points out, young people have unlimited access to their mobile phones, which affects the control carers can place on them:

“there's only certain amount of things that we can get here wae cos it's a Council [building]...a lotta things can get blocked but the kids will generally have their own phones wae internet access and they can go into everythin' ... the mobile phones is a huge thing at the moment for these young people especially Facebook” (Ian, residential care staff, Unit C)

As mentioned in Chapter 5, carers felt that they had little control over young people's behaviour, due to their role as staff rather than as parents. This lack of control extends to mobile phone use: carers are unable to confiscate phones or limit what young people do with them because they are not their parents. Thus, it may be easier to set boundaries around mobile phone use in foster than residential care.

In foster care, there was a sense that using digital media as part of substance use specific communication was unnecessary and that carers preferred to just talk to young people. Rob (foster carer), Sandra (foster carer) and Susan (foster carer) explained that they preferred to just have conversations with young people, with digital media being viewed as inappropriate. Rob and Sandra explained that they would not need to use digital media because they have open communication, stating *“we just talk to them”*. In the following quote, Susan explained her reasons for having conversations over using digital media:

“it would not be my first medium cos that means two of us would be sorta looking at a screen...what I'm aware of is information comes at them at all ways but that information doesn't care about them I do...I'm no sayin' an app's not got it's place but...I think in a home environment...you have to at every single point...show you care by taking the time to make sure that that dialogue feels natural” (Susan, foster carer)

Susan explained that digital media may be more useful in a school setting, as a way of encouraging young people to learn about substance use. In a home

environment, however, digital media might be inappropriate. She highlights the need to show young people that you care about them. Thus, carers' use of digital media may be influenced by their role identity and their relationships with young people: for those who view themselves as carers, digital media may provide a useful way of informing young people and having informal conversations about substance use. For those who view themselves more as parents, digital media use is presented as an inappropriate and almost uncaring way of having conversations about substance use.

Shared doing and different substances

Throughout the interviews with carers and young people, there was a sense that alcohol, tobacco and drugs have different meanings and rules attached to them which affected carers' communication about each substance. These differences in how substance use was approached were discussed in Chapter 5. However, it is important to consider these differences now, in the context of doing communication, and whether shared doing occurred for a particular substance more than the other two.

There was no clear pattern in terms of whether shared doing was used to have conversations about particular substances, but rather these conversations were responsive to young people's substance use and what was relevant to them at a particular time. Carers talked about experiences of conversations in the car about alcohol use; in the kitchen about cannabis use; and about smoking when walking the dogs. For example, Sharon and Susan shared experiences of talking about different substances in different locations. Susan also mentioned talking about smoking when walking the dogs.

"I would just talk to them about that goin' for a drive in the car and sayin'...so are you drinking this weekend?" (Sharon, residential care staff, Unit D)

“you're standing cookin'...havin' a conversation and you look as though you're talking about a third person rather than talking to them...you say d'you remember I was talking to you about such and such you know well I'm actually noticing...you know that you've got the munchies that you never had before...now if they had been experimenting then you would think how the hell does she know?” (Susan, foster carer)

Carers also talked more generally about having conversations about substance use in these environments, suggesting that shared doing provides an opportunity to talk about all three substances, depending on which is most applicable at that time.

Interestingly, conversations about smoking appeared to occur more frequently and in a potentially less planned way than communication about alcohol and drug use. In both foster and residential care settings, smoking is always forbidden, due to legislation around smoking in public places. Although Susan mentioned talking to young people about smoking when out for a walk with the dogs, this conversation would be in response to seeing young people smoke while walking. For the majority of conversations about smoking, carers raised the topic in response to young people's desire to have a cigarette, which they obviously could not do in the unit or foster home. As mentioned previously, conversations about smoking tended to be centred around rules, telling young people when and where they could and could not smoke. These conversations appeared to happen on a daily basis, because smoking would occur throughout the day and night, particularly in residential care:

“it's there daily cos they smoke and they go out and they...leave for a cigarette they're coming back in...it's around more often”
(Diane, residential care staff, Unit B)

Conversations about smoking might not occur within the context of shared doing because smoking is a more obvious behaviour than alcohol and drug

use, one which has many proven harms. It occurs on a daily basis, carers can see when young people are going outside to smoke and can smell smoke on them. Therefore, conversations about smoking are relatively easy to have. Drinking and drug use may be less likely to occur on a daily basis and young people are possibly more likely to hide their use. Thus, carers might need to use shared doing as a way of having conversations about alcohol and drug use more so than tobacco use, because alcohol and drugs require a different approach to communication. Conversations about smoking appeared to occur in potentially a more natural manner, in response to the young people going out to smoke; conversations about alcohol and drugs may be more suited to shared doing, providing an environment in which to have more difficult conversations.

Summary of 'doing communication'

The theme of '*doing communication*' explores the different environments in which carers attempt to have conversations with young people about alcohol, tobacco and drug use. Shared doing enables carers to create an environment in which communication about substance use is encouraged, for carers and young people to have difficult conversations that may not occur in other settings, such as in the foster home or residential unit. Shared doing, in contrast with other, more formal communication, is viewed as natural and informal; however, carers' language around these conversations suggests that in fact these apparently natural conversations involve a great deal of planning. There appear to be some differences between care settings: shared doing appears to occur more frequently in residential than foster care. This may be suggestive of a more challenging population or a greater need to have conversations in a particular environment, one which is safe, and without interruption. Young people's experiences of shared doing varied greatly from those of carers: only one young person talked about having conversations in particular environments. For the rest, communication about substance use did not seem to be as memorable and most conversations focused on rules around use.

Carers' conversations with young people again seemed to vary by care setting: foster carers seemed to have conversations in the same way as they might as parents to their own children, when the time felt appropriate. In residential care, however, there was a sense that young people needed to be informed about substance use, that it was part of carers' jobs. Digital media may be viewed as a key way of having conversations within the context of shared doing, but the majority of carers viewed such methods as dangerous and inappropriate. This view reflects two key factors: young people's vulnerable status as looked after young people; and carers' professional role identity as parents or staff. The lack of digital media use could also be linked to carers' need for relationships with young people and digital media being viewed as a barrier to such relationships. Finally, there was no clear pattern regarding whether shared doing varied by substance, although carers talked more about shared doing in terms of alcohol and drug use than smoking. As highlighted, smoking is a very obvious substance use behaviour, meaning conversations might be had more readily and more opportunistically than those about alcohol and drug use.

Chapter 7: Discussion

The purpose of this chapter is to discuss the key findings of the study in relation to the wider empirical evidence. First, a reminder of the study background and rationale will be provided, to contextualise the findings. Next, an overview of the main research findings will be provided, before discussing how these contribute to and extend the current empirical literature on looked after young people, relationships and communication about substance use. The strengths and limitations of the study will also be considered. The implications of these findings for policy, practice and research will then be discussed. Finally, the final conclusions which can be drawn from the findings will be presented.

Summary of the scientific rationale

Young people tend to start to use alcohol, tobacco and drugs during adolescence. Most do so without experiencing problems, but there is evidence that those who begin at an earlier age are more likely to use more frequently, report higher rates of use and develop subsequent problems (Bonomo and Proimos, 2005; Bremner et al. 2011; Currie et al. 2002; Feinstein et al. 2012; Mirza and Mirza, 2008). The findings of the integrative review in Chapter 2 were presented, demonstrating that parent-child connectedness, general and substance use specific communication were associated with lower rates of substance use. However, there is limited evidence regarding such processes in more vulnerable groups of young people, such as those looked after by the state. These young people tend to have experienced adverse life events, affecting their future relationships with caregivers (Jones et al. 2011). They are also more likely to use substances and develop subsequent problems. Their care is provided by someone who is acting in a parental role, but is not their biological parent; often these carers are strangers.

There is evidence that having good relationships with carers can protect these young people against substance use, and good general

communication can be beneficial. However, no studies have been conducted to examine substance use specific communication between looked after young people and carers. Thus, gaining an understanding of how such conversations occur, with carers who are acting like parents but are not the parents is crucial, in order to develop interventions to delay and reduce looked after young people's substance use. Carers' relationships with these young people, their professional role identity and use of digital media may influence the way in which they communicate about substance use.

The present study addressed the identified gaps in the literature on substance use specific communication between looked after young people and carers using qualitative methodology. The study aimed to examine how carers and young people communicate about alcohol, tobacco and drug use; the factors influencing this communication; and the use of digital media in relation to conversations about substance use.

Overview of the findings

The key findings from the study are presented below. These findings will subsequently be discussed in more detail, in relation to the research questions and the existing evidence.

- Shared doing provided a more natural, less intense method of having conversations about substance use in which eye contact was minimised. Often carers created these environments to facilitate conversations about substance use; these environments were shaped by space, time and the context in which they occurred
- Formal communication in residential care is an important way of providing young people with information about substance use. These sessions may be a way of providing more broad communication about substances similar to sessions provided in a school setting

- Young people's experiences of communication reflected their use of substances. Those who did not currently use substances reported little or no communication, whereas those who used alcohol, tobacco or drugs reported conversations relevant to their substance of choice
- Shared doing appeared to be used more often for conversations about alcohol and drugs than tobacco use, reflecting the use of shared doing as an approach for more difficult, complex conversations
- Relationships acted as the antecedent to communication in general and about substance use. Without relationships, young people were unlikely to be open to their carers about their substance use
- Carers' professional role identity also influenced their communication about substance use. For some, communication was part of their job while for others, it was an essential part of parenting these young people. However, many experienced tensions in caring for and communicating with a young person to whom they are not the parent
- The context in which communication occurred was also important. In foster care, shared doing reflected family-like activities; in residential care, shared doing provided an opportunity to get away from the unit. Formal communication was only used in residential care, reflecting the more institutionalised nature of residential units
- Context also influenced carers' professional role identity. Residential care staff experienced greater tensions in their role because they were acting as parents, whilst working in a role which involved rotas, shift work and institutionalised care

- Carers' knowledge of substances affected their communication: conversations about alcohol and tobacco use were easier than those about drugs, particularly novel psychoactive substances (NPS). Communication about NPS resulted in a novel approach to communication: using young people as experts
- Digital media were viewed with suspicion and negativity by carers and were rarely used to communicate with young people about substance use. Instead, they were most often used by carers to gather information about substances, particularly drugs. It is likely that the responses regarding digital media were due to the context in which care is provided: in residential care, digital media were controlled and closely monitored; in foster care, their use was deemed impersonal and inappropriate within a family setting.

1. How do carers and looked after young people communicate about alcohol, tobacco and drugs?

Shared doing provided an important way in which to have conversations with young people about substance use. Shared doing provided an environment in which difficult conversations about substance use could occur in a more natural and less intense manner. Carers could influence the likelihood of communication by taking young people to a particular location, such as going for a walk along the beach or going for a drive in the car. For example, as Marie (residential care staff, Unit B) noted, being in this environment enabled young people to “*kind of say what they need to say or ask what they need to ask*”. These environments also meant that conversations were shaped by space, context and time: they occurred in settings in which communication seemed natural, often away from the residential unit or foster home and when the activity was finished, so was the conversation. Carers appeared to have learned through natural, spontaneous conversations about substance use in particular environments that the approach works, so they then use shared doing as a method for future communication about substance use.

Communication within shared doing also occurs more spontaneously, depending on the situation and the environment. It appears that the crucial part of shared doing is to make the conversations feel natural to the young people, even if the conversations are carefully planned and deliberate. They provided an opportunity for young people to open up more than they might in other environments. Shared doing also reflected more blurred boundaries around carers' role identity: they were doing activities with young people that were similar to those activities that parents and children would do together.

Shared doing has also been discussed in the existing evidence as activities which encouraged the development of relationships and conversations about difficult topics. Moylan, Carey, Blackburn, Hayes and Robinson (2015) found that community men's sheds provided an opportunity for men, most of whom were retired, to come together and do activities such as woodwork, repairing bicycles and restoring old furniture. These social spaces also enabled these men to have conversations about topics, such as men's health, that might be uncomfortable in other situations. Kumpula and Ekstrand (2013) examined male caregivers' experiences of providing care to those in a forensic psychiatric clinic in Sweden. Shared activities were found to be a key part of their role, as a way of building relationships and blurring boundaries between caregiver and patient. Activities included going for a walk, going to the woodwork shop and working in the garden; chatting to patients whilst participating in these activities together provided caregivers opportunities to get to know the patients better and create better relationships. Scheinfeld, Rochlen and Buser (2011) used participant observation of 11 men during a four day adventure therapy retreat. The men spent the four days hiking and cooking together. They used these activities as a way of building relationships and talking about particular issues, including personal issues and emotions. Thus, doing activities together has been previously highlighted as a way of building relationships and talking about issues that might be difficult to discuss in a different setting. The use of shared doing in the current study has some similarities to the aforementioned examples: doing activities together can provide a safe environment to build relationships and have conversations about potentially difficult topics.

However, there are a number of key differences. Firstly, the term 'shared doing' has not previously been used before to describe these activities. This term provides a succinct, easily understandable description of the types of environments and activities that might encourage relationship building and communication.

Secondly, the population involved in the current study is very different to those in the existing literature. In the three studies mentioned above, all participants were men, whereas in the current study, young people and carers of both sexes participated. Carers in the current study may have created the environments to build relationships and have conversations with young people who are difficult to engage with and talk to. Previous research has highlighted that looked after young people have difficulties in developing relationships with carers and in communicating with them (Biehal, 2014; Lipscombe et al. 2003; Rosnati et al. 2007); these perceptions were also echoed by carers in the current study. Men are often viewed as being difficult to engage and as finding it more difficult to talk about sensitive topics (Basow, 1992; Golding, Brown, Foley, Harvey and Gleeson, 2007). Thus, it appears that shared doing provides an environment in which carers and young people can build relationships; blur the boundaries of their role; and have conversations which are difficult to have in more formal settings. Doing so is particularly important for looked after young people, as enabling them to develop good relationships with carers and having effective conversations about substance use can have implications in terms of their wider development and future outcomes, as highlighted in the findings of the integrative review in Chapter 2.

Thirdly, the activities discussed in the current study in terms of shared doing are different to those in previous research. The participants in the current study used activities which reflected family life, such as cooking, watching TV together, going for a walk and driving in the car. Thus, it is apparent that the activities chosen within the context of shared doing reflect the population: woodwork, hiking and gardening for men; and more homely activities for those in a care environment.

Carers also used more formal approaches to communication with young people. These formal approaches contrasted with shared doing in that they tended to be a way of providing information, rather than having more open, constructive conversations about substance use. Formal communication was used particularly in residential care, where such communication was viewed as part of carers' role as residential care staff. Participants' language when talking about these more formal approaches were in contrast to how they talked about shared doing. They talked about young people being "*given*" information, spoken "*to*", and "*educated*"; shared doing was described in terms of "*informal*", "*exploring*", "*open*", "*chatting*", "*natural*" and "*relaxed*". Carers talked about the importance of giving young people verbal and written information about substance use and about educating them. This education could be provided by staff through talking about the negative effects of drinking too much alcohol or the negative health effects of smoking; or using more formal approaches, such as development days, where young people might have a session on NPS by a local drugs organisation. There was a recognition that these conversations are not always the most effective ways of communicating with young people about substance use, but interestingly they were the most memorable conversations to young people. Formal communication provided a more universal approach to conversations about substance use: instead of focusing on a young person's use of substances, conversations could be had more generally about the issues associated with drinking, smoking and using drugs.

This approach to communication is similar to the types of communication young people experience in schools around substance use (Carney et al. 2014; Foxcroft and Tsertsvadze, 2011; Karki et al. 2012; Thomas et al. 2013). In their systematic review, Karki et al. (2012) conclude that providing information about substance use in schools was the most effective way of preventing or reducing such use. Formal communication provided in residential care may be a way of echoing the types of communication young people receive at school; looked after young people tend to have poorer school attendance than their peers, with those in residential care being more likely to be truant than those in foster care (Bundle, 2002; Meltzer et al. 2004;

Stein, 2005). Thus, formal communication in residential care may be a way of carers ensuring that young people are being informed about substances, particularly when school attendance is poor.

Young people's experience of communication differed to those of carers. While carers often talked about shared doing as an important way of communicating, young people tended to talk more about formal communication and conversations about rules. Young people's experience of communication reflected their own experiences with substances. The young people who reported that they did not currently use substances reported little or no communication about alcohol, tobacco or drug use, suggesting that such conversations may only occur when substance use was relevant. For the young people who reported experience of communication, conversations tended to focus on the substance, or substances, that they were using, rather than covering a range of substances. It may be that carers only talk about substances that are relevant to these young people, or that they only take on board the messages that are relevant to them. This seemed to be the case in foster care, where conversations tended to occur when they were required, covering only the substances that were relevant to young people at that time.

Carer's role identity may have influenced their approach: viewing themselves as more of a parent may mean that foster carers have conversations in the same way, and at the same time as they did with their own children. Conversely, residential care staff may have viewed such conversations as being part of their job, as something they "have" to do. Residential care staff talked about informing young people about substances even when they were not using them. For the young people in this study who did not report such communication, it is likely that these conversations may not yet have occurred as they had recently joined the unit. Previous studies have found that parents and young people differ in their experiences of how frequent conversations occur. Young people report lower rates of conversations than their parents do (Nonnemaker et al. 2012; van der Vorst et al. 2005), suggesting differences in how conversations are comprehended by young people.

Conversations within an environment of shared doing may only reflect more difficult discussions about substance use, in terms of dealing with problematic use, rather than more general use, which was reported by the young people who participated. The conversations that the young people spoke of were often in terms of general advice about alcohol use and encouragement to stop smoking. These conversations were perceived to relate to normal teenage behaviours of alcohol and tobacco use.

Shared doing appeared to occur more frequently when conversations focused on alcohol and drug use than for smoking. Conversations about smoking appeared to be more black and white: smoking within foster homes and residential units was illegal, so carers had to forbid it. These conversations tended to occur on a daily basis, because smoking was a very obvious behaviour, with young people having to go outside to smoke. Carers viewed smoking as common among this population, particularly in residential care. This perception reflects the findings of Meltzer et al. (2004) who found that rates of smoking among looked after young people are four times higher than in the general population, with highest rates in residential care.

Conversations about alcohol and drug use, however, tended to be more complicated. Drinking and drug use may be less likely to occur on a regular basis and young people are possibly more likely to hide their use. Thus, shared doing might be more appropriate to conversations about alcohol and drug use, whereby use can be deemed particularly problematic. Carers talked about having conversations about alcohol use within the context of shared doing when it was deemed problematic, when young people were drinking more than was acceptable and experiencing negative consequences, such as being arrested. Having these conversations can be difficult for young people, reflecting an almost universal view that talking to parents, or those in a parental role about substances, particularly drugs, is a challenge, due to fear of punishment, confusion and power imbalances (Hight, 2005; Mallick, 2003). Thus, shared doing was particularly important in facilitating conversations about alcohol and drug use, which were viewed as more difficult to have than conversations about tobacco use.

2. Which factors shape this communication?

Communication about substance use was influenced by a number of factors: connectedness; professional role identity; the context in which the communication occurred; and knowledge about substances.

In Chapter 1, connectedness was introduced as one of the theoretical frameworks for the study. Connectedness has enabled an understanding to be gained regarding the importance of relationships between carers and young people when communicating about substance use. Relationships were viewed as crucial for young people and carers, to enable young people to develop trust; deal with negative past experiences; and to facilitate communication. Relationships were the antecedent to communication about substance use: conversations were more likely to occur and were easier to have when carers and young people had good relationships. Shared doing provided carers and young people with an environment in which to spend time together and build relationships. When connectedness is high, parents or carers and young people spend time together, enjoy doing so and are able to communicate openly (Lezin et al., 2004). Previous studies have found that spending time together is fundamental to building these relationships, but social workers often lack sufficient time to do so (Holland, 2010; Leeson, 2010).

Young people were unlikely to talk about particularly sensitive topics like substance use if they did not feel they could trust their carer. Young people had a choice regarding who they would build a relationship with: some would struggle to communicate with carers if they did not feel they had a positive relationship with them. Rachel's experience of struggling to talk to carers when the relationship is new or lacking highlights the difficulties faced by these young people when communicating with a stranger, who is acting in a parental role but is clearly not their parent. She said: *"I think if you're new like in care or you don't have that relationship it's obviously harder tae talk tae like someone about your past...it will take time you'll need to build that relationship but once you have then you'll feel better about yourself"* (Rachel, age 15, foster care). Shared doing also provided an ideal opportunity for

carers to build these relationships and to have conversations about substance use. Thus, a key finding is that communication about substance use is better when there is engagement from young people, resulting from good relationships with carers.

Often young people would choose to talk to carers of the same gender as them; male carers reported that they would tend to talk to boys about sensitive topics, whereas female carers would talk to both boys and girls. These distinct gender roles in communication potentially stem from societal gender roles, in which women are viewed as more nurturing and empathetic (Feingold, 1994) and as more caring in their communication styles (Boundless, 2016) than men. In terms of those involved in the care of looked after children and young people, the vast majority are women (Cameron et al. 2002; Milligan et al. 2004). Gilligan (2000) conducted two focus groups with male foster carers and found that they tended to view themselves as playing a number of 'supportive roles' to their female partners, who act as the main carers (Gilligan, 2000). This finding suggests that as care work is female-dominated, women tend to play a bigger role in the care of young people than males. In Rosnati et al.'s (2007) study, female foster carers reported higher rates of open communication with children, particularly female adolescents, suggesting female carers may play a greater role in communicating with young people than males.

Contextualising the findings in terms of connectedness provides an understanding of the underlying factors of communication: carers and young people need to spend time together, get to know each other, develop trust before they can begin to communicate, both in terms of general topics and about substance use. Connectedness also provides a better understanding in terms of why some young people may struggle to communicate with their carers about substance use: they have not yet developed a strong relationship with their carer to enable them to feel comfortable having conversations with them. Thus, it is essential that carers and young people develop high levels of connectedness in order to facilitate these conversations; shared doing can provide a way in which to develop these

relationships and to have these more challenging conversations.

Carers' professional role identity affected both their relationships with young people and their communication about substance use. In Chapter 2, professional role identity was introduced as a theoretical framework for the study. In the study, carers' professional role identity appeared to make substance use specific communication more complicated than in mainstream family settings. For some carers, communication about substance use was part of their job: they needed to inform young people about substances and were unwilling to share information about their own substance use. For others, young people were treated in the same way as their own children and their approach to and communication about substance use occurred much in the same way. However, tensions arose in relation to the associated constraints and boundaries around caring for someone who is not your own child, particularly in relation to the context in which the caring occurred. In residential care, some carers wanted to provide a more realistic view of substance use by talking about their own experiences and teaching young people about substances, particularly alcohol. However, boundaries imposed by social work departments meant that such an approach was impossible: carers could not role model sensible drinking and had to obtain biological parents' permission before allowing young people to use alcohol in social situations.

In foster care, carers were still influenced by social work regulations, but they could bend these rules slightly: they may inform social workers about young people's alcohol use or obtain permission to allow young people to drink in the same situations as their own children, affecting how they communicated and how young people responded to them. Previous studies have shown foster carers can experience conflicting identities when caring for young people: some see themselves as parents, others as professionals and some as an amalgam of the two (Blythe et al. 2014; Schofield et al. 2013). The findings of the current study reflect this view of foster care but also extend the literature by showing similar conflicts in identity for residential care staff. In previous studies, residential care staff have talked about trying to create a

homely environment for young people, whilst also recognising that the unit is their workplace (Dorrer et al. 2010; Kendrick, 2013). In the current study, residential care staff talked about the nature of residential work in terms of shifts; working shifts and having a staff rota means that you are clearly staff members, that the residential unit is your workplace, not your home, reflecting the findings by Dorrer et al. (2010). However, some staff also talked about being a parent to these young people, which previous studies have not reported. While this might have reflected the need to be a corporate parent, the way in which some residential care staff talked about this parenting role suggested that they saw themselves as a parent in a similar way to foster carers.

In their theory of professional role identity Machin et al. (2012, p.1535) argue that a *“lack of collective identity within a professional group can lead to role fragmentation and confusion in conveying consistent public identity”*. Thus, it is important for professional groups, such as residential care staff, to have a strong identity. Residential care staff are said to lack a strong professional identity, due to a rather negative image of the work they do, affecting their long term commitment to their role (Johnson et al. 2005; Knorth et al. 2010; Milligan et al. 2004; Moses, 2000). Their professional role identity may also be affected by the tensions experienced in terms of parenting in a residential unit. Thus, easing the tensions associated with conflicting role identities may improve the way in which carers communicate with looked after young people about substance use.

The context in which communication occurred also affected conversations about substance use. In foster care, communication within the context of shared doing appeared to be a way of creating family-like environments, but also as a way of having difficult conversations with a young person who is not the carers' own child. Foster carers may be dealing with behaviours and topics that they did not have to deal with when parenting their own children, thus shared doing provides carers' with opportunities in which to have difficult conversations. Foster carers were also more open about their own substance use than residential care staff, divulging information about their own

experiences of being drunk and smoking as a way of educating young people about the harms of these substances and to encourage sensible use. Despite foster carers talking about treating young people like their own children, communication about substance use was still shaped by the rules, regulations and guidelines enforced by fostering organisations, social work departments and the law.

Communication within the context of shared doing occurred more frequently in residential than foster care. The environments created through shared doing appeared to provide carers with an opportunity to participate in family-like activities with young people, whilst having difficult conversations about substance use. They also provided an opportunity to get away from the residential unit, enabling carers and young people to have a quiet space to have conversations about substance use. Thus, shared doing provided an environment for carers to have particular conversations about substance use, those which tended to involve more challenging topics. Formal communication was also used in residential care settings as a way of informing young people about alcohol, tobacco and drugs. These sessions would often focus on one particular topic, such as NPS or smoking cessation, as a way of providing more general information about these substances, rather than focusing on one young person's use. As suggested previously, these formal approaches may have been a way of carers trying to replicate the types of universal prevention information that young people receive at school, as poor school engagement is common in this population.

Finally, carers' knowledge of and experience with particular substances influenced their communication about them. Carers spoke about their relative ease of having conversations about alcohol use and smoking. These were substances that they were familiar with, in terms of their own past and present use of them, as well as in terms of young people's use. They reported more difficulty around communication about drug use, particularly NPS. Drug use is far less common than alcohol and tobacco use in Scotland: more than 74% of adults report drinking alcohol and 22% are smokers (Brown et al. 2015) compared to only seven percent of adults reporting drug

use in the last 12 months (Inman, Carr, Hupert, King and Whitecross, 2012). Thus, carers' inexperience with drugs affected their communication about them. This was particularly obvious for NPS, which presented a novel, unique opportunity for communication. Carers' lack of knowledge and experience of NPS compelled them to use young people as sources of information, as experts who can inform carers about these substances. With alcohol, tobacco and other drug use, carers would inform and educate young people about these substances. However, with NPS, carers' viewed themselves as having limited knowledge and young people as being the experts. Treating young people as experts suggests a slight, albeit temporary role reversal in which young people are educating carers. Previous studies have found that young people feel uncomfortable when they are lectured about substance use and they wish to participate in conversations where they feel they are participating equally (Chaplin et al. 2014; Highet, 2005). Treating young people like experts may encourage them to be more open about communicating with their carers about substance use, if they feel that their contribution is of value and they are not being forced to disclose information that they do not wish to.

3. To what extent do digital media play a part in this communication?

In Chapter 2, the use of digital media, such as computers, the internet and mobile phones, were introduced, as a circumstantial factor unique to the current study. Examining digital media use in terms of communication about substance use aimed to provide a modern view of the current world in which the research was conducted. However, digital media were viewed negatively by carers and were rarely used to communicate with young people about substance use. Carers' lack of digital media use was unexpected: there is evidence from previous studies which suggest that parents use digital media to communicate with their children about general topics (Rudi et al. 2014) and in terms of providing information about substance use (Bourdeau et al. 2012; Miller-Day and Dodd, 2004; Sherriff et al. 2008). Such media have the potential to be included within the context of shared doing: they are an activity that carers and young people could do together, and require limited eye contact. Websites and other media could provide a prompt to

conversations about substance use. However, the use of digital media was lacking; carers' use of these media was limited to using the internet to search for information about substances for themselves and for young people.

Overall, there was a sense that digital media were challenging, caused more harm than good and their use was associated with bullying and safety concerns. A few young people had used digital media to gain information for themselves, but usually on an ad hoc basis. Digital media use was strictly controlled. Young people's status as vulnerable looked after young people influenced carers' negative view, as did their professional role identity: for those who viewed themselves as carers, using such media could provide a useful way of informing young people and having informal conversations about alcohol, tobacco and drug use. On the other hand, for those who view themselves as parents, digital media were perceived as inappropriate. The lack of digital media use could also be linked to carers' need for relationships with young people and digital media being viewed as a barrier to such relationships. Digital media have the potential to be useful for communicating with young people about substance use, but carers' negative perception of these methods mean they are regarded with caution and are therefore not used in the context of communication. Instead they were used by carers to gain information for themselves, particularly about drugs and NPS.

These findings were unexpected. As highlighted in Chapter 2, young people spend a huge amount of their time using digital media. Parents and young people may use such media to maintain relationships and extend their normal conversations, in terms of rule setting, informing each other of plans and exchanging information (Devitt and Roker, 2009; Kennedy et al. 2008; Rudi et al. 2014). There is also evidence that engagement with such media can be detrimental. Greater use of mobile phones, computers and the internet, including social media, is associated with higher substance use (Busch et al. 2013; Epstein, 2011; Koivusilta et al. 2005; Sánchez-Martínez and Otero, 2009). Young people can access a vast amount of information about drugs online, as well as being able to purchase them (Schepis et al. 2008; Vardakou et al. 2011); visiting drug use websites has been associated

with higher rates of smoking (Kam and Lee, 2013). Thus, while digital media can be an easy way of keeping in touch with young people and as a method of communication, there are also some negative outcomes associated with its use.

The majority of carers in the current study held the view that such media were unhelpful and were met with disapproval. These negative views and lack of engagement with digital media as a way of communicating with young people about substance use may reflect a number of factors: looked after young people are viewed as vulnerable online as well as offline; the discourse around digital media use is focused on the risks; and restrictions to digital media use, particularly in residential care, could negatively skew carers' views. Young people in care are often viewed as vulnerable, so carers may wish to limit their access to digital media as a way of protecting them.

As noted above, use of digital media has been found to be associated with negative outcomes, such as increased substance use. There are also concerns about cyberbullying (Cowie, 2011; Simpson, 2015). Sen (2010) conducted a qualitative study with social workers and Children's Hearing reporters in Scotland to examine looked after children and young people's use of the internet in contact with family and friends. Despite participants having very little direct experience of such contact, the internet was somewhat demonised, with participants viewing it as an "unmitigated risk" to looked after young people (Sen, 2010, p. 433). Sen (2016) and Ballantyne, Duncalf and Daly (2010) discussed the negative discourse within the social work community and beyond about digital media use. There appears to be a view that looked after young people are particularly vulnerable online due to their vulnerability offline; thus they are at greater risk of the negative effects of digital media than their peers. Thus, for those caring for looked after young people, the risks of digital media use will be greater than the benefits.

The carers in the current study share these discourses, viewing digital media as having more risks than benefits. This perception influenced their use of

digital media, as something that the majority would shy away from. However, Sen (2016) conducted interviews with looked after young people and care leavers and found that their experience of these risks was no different to those of their peers and in fact, their experiences with digital media were positive. They used digital media as a way of keeping in touch with friends and family, thus reducing their social isolation (Sen, 2016). Thus, digital media use by looked after young people might have more positive effects than carers perceive. Finally, Ballantyne et al. (2010) argue that viewing these young people as at higher risk can result in greater restrictions being put in place around digital media use. Such restrictions were prevalent in the current study: carers talked about limiting young people's access to particular websites, particularly in residential care. However, as Ballantyne et al. (2010) subsequently assert, these restrictions can backfire; in the current study carers talked about young people's use of mobile phones as being difficult to restrict, with a sense that they could access any website they wished.

Carers' negative discourse around digital media use and their lack of engagement with it in terms of communicating with young people could have potentially unhelpful results. As argued previously, digital media has the potential to be used as an environment in which shared doing can occur. Using digital media may be beneficial to young people as they engage with such methods on a regular basis and may feel comfortable doing so. Changing discourses around digital media within the context of looked after young people has the potential to encourage more opportunities and environments for shared doing, allowing young people to build relationships and communicate with carers about substance use. As highlighted by Sen (2016) looked after young people may benefit from digital media use as a means of reducing their social isolation.

What this study adds to the existing evidence

First, I published an integrative review of the literature, which highlighted the importance of synthesising the evidence on parent-child connectedness and communication across alcohol, tobacco and drug use (Appendix 1). Reviews have typically focused on one substance and therefore missed the nuanced

communication across substances, such as the relative ease of discussing alcohol and smoking compared to drugs. This review provided a more comprehensive understanding of the topic by examining connectedness and communication across the three substances.

Second, this study is the first to examine substance use specific communication between looked after young people and carers, who are not their parents. As detailed in Chapter 2, previous studies have provided some evidence regarding looked after young people's outcomes in relation to connectedness and general communication. However, these studies were mostly conducted with adopted young people, who tend to have better outcomes than their counterparts in foster and residential care (Dregan and Gulliford, 2012; Farruggia and Sorkin, 2009; von Borczyskowski et al. 2013). No previous studies have examined whether conversations about substance use occur within foster and residential care settings, or whether there are particular factors which influence them. This study provided evidence regarding the way in which communication about substance use occurs between looked after young people and their carers. Shared living provided an environment in which carers and young people could have these conversations about alcohol, tobacco and drug use. Furthermore, the findings of this study highlighted the importance of relationships in facilitating this communication, as well as the influence of carers' role identity on these relationships and communication.

Third, this study has extended the work of Machin et al. (2012) and Elliott et al. (2013) by examining professional role identity within new populations: social workers, residential care staff and foster carers. The influence of carers' role identity highlights the complexity of communication about substance use within foster and residential care settings. Carers experienced boundaries around their role identity: some perceived themselves to be "*like a parent*" to the young people in their care, but the extent to which they could be truly parents was limited. For residential care staff, they were only able to act as parents when they were at work; in foster care, parenting was limited by the restrictions imposed by social work departments and the length

of the placement. Carers' approach to and communication about alcohol, tobacco and drug use was also influenced by their role identity and the context in which they worked. For example, alcohol use could be monitored and young people could be taught about responsible drinking in foster care, but not in residential care. Foster carers were more open about themselves, and their own alcohol and tobacco use than residential care staff, due to the context in which they provide care to young people: a family home environment.

Fourth, this is the first qualitative study to examine communication about alcohol, tobacco and drug use together, whereas previous studies focused on one or two substances. It appears to be essential to examine these three substances together as young people tend to use more than one substance at a time (Fraga et al. 2011; Torabi et al. 1993). Some of the young people in the current study talked about using more than one substance, although most used alcohol or tobacco. A number of carers talked about other young people in their care who were using multiple substances, highlighting the need to cover all three substances in these conversations. As suggested by the findings of the current study, alcohol, tobacco and drug use do have different rules and approaches, but it is important to examine these three substances together, to ensure that conversations cover the different substances. For example, alcohol use was often viewed as a normal part of Scottish culture, with young people often being allowed to drink within certain boundaries. Drug use, on the other hand, was viewed as something that should be entirely forbidden and discouraged. These different approaches to each substance, while they may be needed, can mean that young people are exposed to mixed messages and contrasting rules around use. By examining alcohol, tobacco and drug use together in the current study, it was possible to gain an understanding of the nuanced communication occurring about these substances.

Fifth, this is the first study to highlight the importance of minimising eye contact when communicating with young people about substance use. There was a view that minimising the amount of eye contact a young person had

with carers during these conversations was beneficial; such conversations could allow the young person to feel more comfortable. The need for a lack of eye contact during these conversations may be particularly important for this population: as Howe & Fearnley (2003) explain, eye contact is lacking when young people have disordered attachment, as is often the case with looked after young people. They explain that eye contact is important in bonding and communicating with carers, but young people in care often avoid the “intimacy” of eye contact (Howe & Fearnley, 2003, p. 382). Shared doing provides an ideal opportunity for carers to build relationships and communicate with young people about substance use within a safe environment, where eye contact is limited. Carers in the current study talked about the difficulties of having conversations sitting face-to-face with young people. It seems obvious that these conversations would be difficult for young people, given the problems they may be experiencing in terms of making eye contact. The use of shared doing could potentially enable looked after young people to develop relationships with their carers more easily and also make conversations about substance use less intense and therefore more effective.

Finally, this is the first study to provide insight into the environment in which substance use specific communication occurs, as well as the content of these conversations. Previous studies have focused on the content of conversations rather than where these conversations take place. In the current study, the environment in which these conversations occurred has been described: shared doing provides particular environments in which to have conversations, such as driving in the car or cooking. They also occur in more formal settings, such as during review meetings or in development days. The content of these conversations has also been described, particularly in terms of the different rules and approaches to each of the three substances. Thus, the findings of the current study add to the existing evidence by examining the details regarding the environment in which these conversations occur.

Strengths and limitations of the study

This was a relatively small, qualitative study, which means that the findings may not be generalisable to all looked after young people and carers. Due to the population being studied and the need to work under the restrictions of the local authority's and university's ethical regulations, access to young people was attained through gatekeepers. Some gatekeepers may have received information about the study but decided not to pass the information onto young people, particularly if they deemed them too vulnerable to participate. Some gatekeepers felt that the young people had participated in a number of studies in recent months, so participating in another would be too much for them. Similarly, some young people may have felt under pressure from their carers to participate in the interview. In Chapter 5 I reflected on the difficulties I experienced in accessing young people who had experienced drug use. Gatekeepers explained that these young people would not engage, and that staff struggle to communicate with them, so no attempt was made to recruit them. Unfortunately, this means that the young people in the study had different experiences to substance use than these young people. It would have been interesting to gain an insight into how young people experience communication about drugs when they are using them. This means that some young people who might have been willing to participate were excluded. Developing closer relationships with gatekeepers may have enabled such young people to have been included in the study.

Despite these limitations, the findings of this study can enhance our understanding of carers' and young people's experiences of communication about substance use within the context of foster and residential care, and the role that professional role identity and connectedness have on this communication. This study was an original piece of research which provided insight into the experiences of looked after young people and carers in terms of how they communicate about substance use. The findings provide insight into how carers and young people communicate about substance use, as well as the influence of connectedness and professional role identity on this communication. These findings can contribute to the existing evidence on looked after young people's experiences within foster and residential care as

well as their experiences of communication about and rules around substance use.

Using the theories of connectedness and professional role identity has allowed these findings to be contextualised and provide deeper insight into the complex nature of substance use specific communication within foster and residential care settings. The findings highlighted the importance of relationships in facilitating communication and the tensions experienced by carers in terms of their role identity. Both connectedness and professional role identity appeared to influence carers' communication about and approaches to substance use.

Drawing upon a broadly social constructionist approach for this study also allowed for these findings to be better understood within the current care environment and policy context. The findings of this study highlight the complexity of the current care context, in which there are tensions between being a parent and being a professional. As described in Chapters 1 and 2, in recent years foster and residential care have gone through a shift in terms of how care is provided, influencing how carers view themselves as carers and how substance use is approached within these settings. Thus, a broadly social constructionist approach enables a better understanding of the findings within this current context.

A range of participants were included in the study. Young people aged 12-19 years were included, giving a diverse range of views and experiences. Including those in residential and foster care highlighted the similarities and differences in these care settings in terms of carers' communication about and approaches to substance use. Also, including foster carers, residential care staff and social workers also provided a diversity in experiences of caring, building relationships and communication. Given that the aim of qualitative research is not to achieve a representative sample but one which is diverse (Barbour, 2001; Ritchie et al. 2014), the diverse sample in the current study is a strength. Foster carers and young people in foster care were recruited from across Scotland, rather than in just one local authority

area. This diversity improves the applicability of the study's findings to other geographical areas. As described in Chapter 1, there are similarities in terms of care provision for looked after young people across the world, suggesting that the study's findings may have applicability to other countries who provide foster and residential care in a similar manner to Scotland. As detailed in Chapter 2, parents and young people worldwide communicate about substance use and experience challenges doing so; it seems likely that such communication and associated challenges will occur between looked after young people and their carers. Future research could examine substance use communication between carers and looked after young people in other countries.

Reflections on the use of qualitative methodology and the findings

As discussed in Chapter 3, qualitative methodology was particularly suited to this study, as the research conducted was exploratory in nature and aimed to explore people's feelings, perceptions and experiences of communication about substance use. Using qualitative methodology in the current study enabled an in-depth exploration of young people and carers' experiences of communication, as well as the factors which influenced this communication. Much of the previous studies on substance use specific communication have used quantitative methods, which enabled an understanding to be gained regarding the influence of conversations on young people's substance use. However, this study extends the evidence, by examining how communication occurs and the environments in which it takes place, as well as the factors influencing these conversations, such as relationships and professional role identity. In conducting this study with both young people and carers, I captured a diverse range of views and experiences. I have also grown as a researcher: prior to conducting the research I had never conducted an interview with a young person. The process of designing the study, gaining access to participants, conducting the interviews and analysing the data has provided me with a range of invaluable skills which extend beyond this thesis.

It is important to recognise, however, that there can be limitations in conducting qualitative research. As mentioned above, small sample sizes

can restrict the generalisability of the findings; however, having a diverse sample can improve the extent to which these findings are applicable. During my PhD, I have presented the findings of this study at a number of conferences, and on more than one occasion I have been told that my findings have relevance to those providing care to looked after young people. Qualitative research is often criticised for lacking credibility, due to its subjective nature (Green and Thorogood, 2014), so I ensured that I implemented a number of methods to ensure that my study was conducted in a rigorous and systematic manner. In Chapter 3, I explained that I used purposive sampling, therefore only recruiting appropriate participants; reflected on my experiences throughout the research process; kept a reflexive diary; provided a clear audit trail; conducted interviews with young people and carers; examined deviant cases; and shared my initial findings with my supervision team and another PhD student.

In Chapter 3, I also discussed my approach to sample size and data saturation. Initially, I aimed to interview 28 participants, as I believed that this number would enable me to capture a diverse range of views, whilst also being manageable. I interviewed a total of 31 people, because I felt that some of the interviews were shorter than anticipated, and I needed to gather rich data from my participants. Data saturation was reached when no new insights were being gained: my participants were all talking about very similar topics and I anticipated that conducting additional interviews would not provide any further insights. That said, I would have liked to gain a better understanding of how young people experienced communication about their own drug use. As mentioned previously, accessing these young people was problematic, with access being denied by the young people themselves and by gatekeepers. Conducting qualitative research with a vulnerable population, like looked after young people, can be challenging, because access is only ever granted by gatekeepers. They ultimately make the decisions regarding whether or not young people can participate in a study. In terms of the current study, gatekeepers appeared to be less willing, or less able, to recruit young people who were using drugs. They viewed them as particularly vulnerable, and seemed to have difficulties in developing positive

relationships with them themselves. These relationships seemed key in engaging young people to participate in the study.

Relatedly, while thirteen young people participated in an interview, the voices of the carers come through more strongly. This was not the intention of this study, where the aim was to gain an understanding of both young people and carers' experiences of communication. However, it was clear that some of the young people found the interviews rather difficult: some were shy whereas others had not experienced enough communication from their carers to be able to talk about it in-depth in an interview. However, it is important to note that this lack of communication is a finding in itself: carers and young people had different experiences of communication. It appeared that carers were waiting to talk to young people about substance use when they started using substances, rather than in a more preventative manner.

It is also important to reflect on the interviews, analysis and the findings, and consider my role in these processes. Within a broadly social constructionist framework, reflexivity provides an understanding of the relationships between the researcher and participants (Finlay, 2002b). In the current study, it is possible that the participants were portraying themselves in a particular manner, and the way in which they viewed me as a researcher may have influenced the information they provided.

To the young people in the study, I may have been another stranger, another person of authority who came in and demanded to know about particular aspects of their lives. While this was not my intention, it is possible that this is how they viewed me. Reflecting on the analysis, particularly in relation to the theme of '*the influence of connectedness and professional role identity*', has highlighted the difficulties these young people may have experienced in their interviews with me, a complete stranger. While I tried to build rapport and put them at ease, it is clear from the findings that relationships are crucial and act as the antecedent to communication. Therefore, it seems possible that these young people may not have been completely open with me about their experiences. They may have presented themselves in a particular way, as a

particular type of young person, and in their interviews told me information and stories along the lines of the person they were trying to present.

The data from the current study presents the views that these young people held at the time of the interviews with a researcher they did not know. They may have talked in different ways with someone else, or if they were asked different questions about their experiences. For example, only one of the young people talked about their experiences of communication within the context of shared doing. While it may have been that the remainder of the young people had not experienced shared doing, it is also possible that they had experienced it in terms of other sensitive issues, which were more relevant to them, such as related to sexual health or aggressive behaviour. Qualitative research does not assume that there is one 'truth' to be uncovered by research; instead it aims to uncover knowledge, with reality being constructed by the social, historical and individual contexts in which we live (Cruickshank, 2012; Kuper et al. 2008; Thorne, 2000). Therefore, while young people may have presented themselves in a particular way during their interviews with a stranger, a researcher, their stories uncover their experiences and views of communication within the current situation in which they live.

Carers may also have presented themselves in a particular way to me during the interviews. They too had a choice regarding what to tell me and what they did not want to; whether this was a conscious or unconscious decision, it makes little difference. Carers may be more skilled than young people in terms of presenting themselves in a particular way to a stranger, a researcher who is asking them a range of questions about things they may never had considered before. Their reputation was at stake during their interviews, so it seems possible that they presented themselves as the type of social worker, residential care staff or foster carer they thought I would want to include in my study: one who constantly talks to young people about substance use, not just because it is part of their role but because it is something they feel strongly about.

Carers only included in their stories their successes in terms of communication and relationships. While some of them did mention challenges they had experienced in communicating with young people and building relationships, these were discussed in a positive way, showing the ways in which they could and would overcome these challenges, as well as talking about them in relation to factors outwith their control. Excluded from their stories were experiences of failures in building relationships and in communication. While they may not necessarily have experienced these failures, it seems likely that some carers chose to conceal some of their experiences, or did not disclose them because they were not directly asked about these failures. Again, the stories presented in the findings reflect their current reality, which is influenced by current policy and practice, the guidelines they have to follow, social work demands imposed on them and a myriad of other factors influencing their role as carers for a very vulnerable and often challenging group of young people.

Finally, the findings and the way in which they are presented are potentially influenced by my own engagement in the research process, my own perceptions of the carers and young people I interviewed. As someone in a relatively privileged position, as an educated researcher doing a PhD at a university, my own reality and understanding of the world is likely to be very different from those I interviewed, whose stories I have had the opportunity to consider, analyse and present in a particular way. Before entering into this research, I had never been to a residential unit or had experience interviewing young people, particularly young people who were deemed vulnerable. I wanted to ensure that their voices were heard above their carers; in reality, the carers divulged far more information than the young people, which limited how much of the young people's voices can be heard. Being reflexive about the research process, my own experiences prior to and during the study and my preconceptions of the participants has been incredibly valuable in conducting this study. It has enabled me to think beyond what participants said during the interviews to consider the wider societal and contextual factors, my potential influence on the whole process and researcher-participant relationship. I hope that my interpretation of

participants' experiences and stories presented in this thesis correspond to the views and experiences they felt they were presenting throughout the study.

Implications of the findings for policy and practice

The findings of the current study have some potential implications for policy and practice within the field of looked after children and young people. The following suggestions may improve communication around substance use as well as relationships between looked after young people and their carers. Firstly, carers should continue to use 'shared doing' as a way of having conversations with young people about substance use. Shared doing enables carers to create environments in which communication feels natural, less intense and more comfortable. The environments highlighted in this study included driving in the car, walking, being in the kitchen and watching TV and were often chosen by carers. It is likely that other environments will also be used to facilitate communication, reflecting the needs of those involved. Young people could be encouraged to find environments which facilitate this communication. Carers should be encouraged to take advantage of the occasions in which they are alone with young people, in the particular spaces which appear to facilitate communication about substance use. These often time-limited spaces may encourage communication to occur more naturally and in a less intense manner. These environments may be particularly important when working with looked after young people. As mentioned previously, for some of these young people, communicating with carers can be particularly problematic, so ensuring that carers make use of every available opportunity to communicate seems critical. Having these conversations in a short space of time may be beneficial by ensuring that vital conversations occur; doing so in the environments created through shared doing may mean that these conversations are more effective than they would be in more formal settings or contexts.

Secondly, carers should also extend the use of shared doing to communicate about other sensitive topics, such as sexual health. Shared doing provides a way of creating a safe environment which appears to facilitate difficult

conversations. By extending the use of shared doing to other topics, carers and young people may be able to develop their relationships further and have more effective conversations.

Thirdly, two areas were highlighted which carers talked about feeling unprepared to talk about and deal with: novel psychoactive substances (NPS) and digital media. Therefore, carers should be provided with support in order to increase their confidence in having conversations about NPS and in using digital media in their communication with young people. Carers' knowledge of and confidence in communicating about NPS could be developed through regular training courses, particularly for those who have not yet received them. Training could also be provided on the positives of digital media use, as a way of challenging the negative discourse.

Finally, carers experienced tensions in their role because they are acting as parents but are not the parents of these young people. Carer's identity was influenced by the context in which they cared for young people. Residential care staff were particularly affected by these tensions, because they were acting like parents in a professional environment. It is important to raise awareness of the tensions experienced by all carers and recognise that they often see themselves as both parents to the young people and professionals. Considering these two roles and the conflicts in identity when providing training to social workers, residential care staff and foster carers may help to alleviate these tensions.

Implications of the findings for future research

There are a number of recommendations for future research that can be made from the findings of this study. Firstly, because this study used qualitative methodology, it enabled an insight to be gained into how carers and young people communicate about substance use. Therefore, it was not possible to determine whether the communication between carers and young people has an effect on young people's substance use. Future research should examine whether these conversations influence whether or not young people will start using substances or reduce the amount they are using.

Looked after young people tend to have poorer outcomes in terms of substance use and misuse than their peers (Backović et al. 2006; Blome et al. 2009; von Borczyskowski et al. 2013), so it is imperative to develop interventions to reduce or delay substance use in this vulnerable population. Currently, specific interventions to address looked after young people's substance use are lacking (Jones et al., 2007). A pilot randomised controlled trial (RCT) could be designed, based on some of the key findings of this study. For example, an intervention based on shared doing could be developed. Involving young people in the design of this intervention could gain further understanding of young people's experiences of shared doing. Conducting a pilot RCT would enable the feasibility and value of such an intervention to be understood, prior to conducting a full RCT and ensure that the intervention is based on the needs of both young people and carers.

Secondly, carers in the current study viewed digital media as a negative part of young people's lives. However, as detailed above, digital media play an important part in modern culture and are used by many people to communicate about their lives. It is likely that the negative view of carers in the current study regarding digital media reflects the population for whom they care and the context in which this caring occurs. Looked after young people were seen to be in need of protection from digital media, with such technology being perceived as involving bullying and exploitation. Future research, based on qualitative methodology, could explore carers' views and experiences of digital media, in order to help carers to view them more positively, and as a potential way of communicating with young people. Such research could also include young people, to gain an understanding of their views regarding whether they would prefer to use digital media with their carers.

Thirdly, future qualitative studies with looked after young people could use methods similar to those described within the context of shared doing. For example, conducting face-to-face interviews with these young people may limit their engagement and communication. Instead, conducting interviews with minimal eye contact may promote better communication, allowing young

people to relax and open up to a researcher with whom they are unfamiliar. In recent years, there has been an increase in researchers using novel, innovative research techniques with children and young people, such as pictures, drawing, and sentence completion; these methods are thought to make the research process easier for this population and minimise the unequal power relationships between adult researcher and child participants (Punch, 2002b).

However, some argue that such techniques are contradictory to this new theory of childhood; if children are viewed as being as competent as adults at participating in research, then the use of special methods can position children as being unable to have normal conversations or engage with methods traditionally used with adults (Kirk, 2007). I decided against using such novel techniques in these interviews, as I felt that these young people were capable of talking about their experiences. However, the theme of 'doing communication' has highlighted the need for environments which feel natural, where eye contact can be minimised and young people can take part in an activity in order to make them feel more comfortable when communicating. Thus, future qualitative studies with looked after young people could employ methods similar to shared doing.

Conclusions

This thesis has presented the findings from interviews with young people in foster and residential care, as well as foster carers, social workers and residential care staff. The findings have highlighted that relationships are important within the context of residential and foster care and act as the antecedent to communication about substance use. These relationships can take time to develop and are hugely important for enabling young people to feel that they can trust their carers enough to have effective conversations about substance use. Shared doing provides an important environment in which relationships can be developed. These environments can also encourage conversations about substance use, and other sensitive topics, by providing a more natural, less intense method of having conversations in which eye contact is minimised. Shared doing may be more suited to communication about alcohol and drugs than tobacco use, reflecting the need for shared doing as an approach to more difficult conversations. The context in which communication occurred was important, with differences in foster and residential care. Shared doing was used in both settings, but to varying degrees. Formal communication was only used in residential care, reflecting the more institutionalised nature of this setting. Carers' role identity influenced their relationships with young people and their approach to and communication about alcohol, tobacco and drug use. Future work with looked after young people should consider the effect of relationships and professional role identity, as well as providing opportunities in which to implement shared doing, to encourage conversations about substance use.

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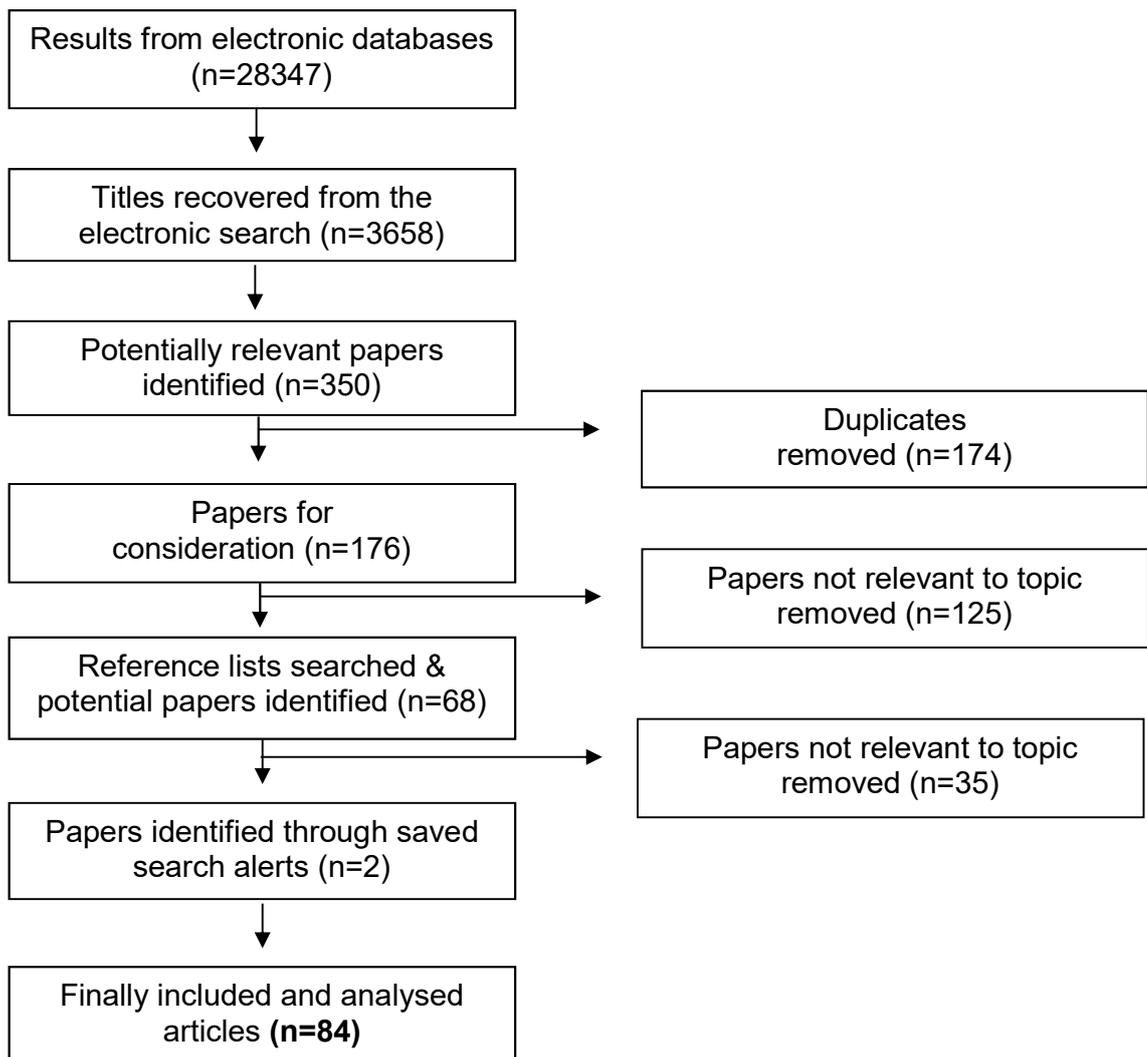
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Appendices

1. Publication resulting from PhD thesis
2. Flowchart of article selection
3. Tables of studies included in integrative review
 - 3.1 Connectedness
 - 3.2 General communication
 - 3.3 Substance use specific communication
4. Inclusion and exclusion criteria (Young People)
5. Inclusion and exclusion criteria (Carers)
6. Participant Information Sheet (Young People)
7. Consent form (Gatekeepers' consent for under 16s)
8. Consent form (Young People)
9. Consent form (Carers)
10. Flowchart for dealing with disclosures of sensitive information
11. Interview schedule (Young People)
12. Debrief sheet (Young People)
13. Summary of findings for participants (Young People)
14. Participant Information Sheet (Carers)
15. Interview schedule (Carers)
16. Debrief sheet (Carers)
17. Summary of findings for participants (Carers)
18. Example of field notes (Young Person)
19. Example of field notes (Carer)
20. Extract from a transcript
21. Example of memo
22. Extract from theme table used during data analysis
23. Diagram of themes and sub-themes

Appendix 2. Flow chart of article selection



Appendix 3. Tables of studies included in integrative review

Table 3.1 Connectedness

Authors	Location	Design	Participants	Key findings
Ackard et al. (2006)	USA Schools (n=31)	Cross-sectional survey data (n=4734)	Adolescents (age range 12-18 years; grades 7-12; 50.2% female; 46% girls, 51% boys were white)	Connectedness with parents may be protective against alcohol and cannabis use in adolescence.
Alhyas et al. (2015)	United Arab Emirates Schools/ households	Qualitative – focus groups (n=6)	Adolescents (aged 13-18 years; 50% female)	Improving parent-child relationships can reduce risk of substance use and encourage communication.
Arunachalam & Nguyen (2016)	Vietnam Households (n=10,044)	Cross-sectional survey data (n=10,044)	Adolescents (aged 15-25 years; all males; 89% living with parents; 47% at school/college)	Strong connectedness to family is associated with lower rates of smoking and drinking in Vietnamese males.
Carter et al. (2007)	New Zealand Schools (n=12)	Cross-sectional survey (n=643)	Adolescents (age range 14-17 years, median age 15 years; 51% male; 91% white)	High, but not medium, connectedness may be protective against adolescent substance use. May have only been measuring connectedness when upset, not generally.
Claes et al. (2005)	Canada, France, Italy Schools (n=11)	Cross-sectional survey (n=908)	Adolescents (mean age 17.2 years, 54% male)	High quality bonds with parents may be protective against adolescent substance use through higher levels of supervision and tolerance of peer relationships, lower levels of conflict and less orientation towards peers
Cheng & Lo (2010)	USA Child welfare services	Longitudinal survey data, 18 and 36 month follow up (n=1799)	Adolescents (age range 11-18 years, mean age 13.4 years; 45% white, 31% African American; 55% female)	Being in foster care may be more protective against drug use than being at home; feelings of closeness to a parent may be protective against drug use in adolescents in the child welfare system
Cheng & Lo (2011)	USA Child welfare services	Longitudinal survey data, 5 year follow up (n=1797)	Adolescents (mean age 13.4 years; 45% white, 31% African American; 73% receiving care at home at baseline)	Bonds with parents may be protective against cannabis use; finding suggest that the protective effect does not require it to be from biological parent, foster parents who provide appropriate bonds can protect against cannabis use

Cheng & Lo (2012)	USA Child welfare services	Longitudinal survey data, 18 and 36 month follow up (n=1005)	Adolescents (age range 11-18 years, mean age 13.93 years; 44% white; 59% female; 27% received out of home care)	Having strong bonds with parents may be protective against prescription drug misuse by adolescents in the child welfare system
Dorius et al. (2004)	USA Schools	Cross-sectional survey (n=4987)	Adolescents (age range 12-19 years, median age 15 years; 51% female; 88% white)	Feeling close to father may be protective against cannabis use, by mediating the effect of peer substance use; no effect of closeness to mother
Guibord et al (2011)	Canada Out of home placements	Cross-sectional survey (n=122)	Adolescents (age range 12-15 years, mean 13.75 years; 54% male)	High quality relationships with female caregivers can be protective against depression, but no association was found with substance use; having a nurturing caregiver appears to be beneficial for children in care
Mahabee-Gittens et al. (2012)	USA Households	Longitudinal survey data, 2 year follow up (n=3473 dyads)	Adolescents (age range 9-18 years, mean age 12.5 years at baseline, 14.6 at follow up; 53% male; 68% white; all non-smokers at baseline) Parents (66% female)	Connectedness with parents may be protective against smoking initiation during adolescence.
Mahabee-Gittens et al. (2013)	USA Households	Longitudinal survey data, 4 year follow up (n=5705 dyads)	Adolescents (age range 9-16 years, mean age 12.03 years at baseline; 51% male; 63% white; all non-smokers at baseline) Parents (46% college educated; 72% two parent families; 68% ever smoked)	Connectedness may be protective against smoking initiation between the ages of 12 and 15 years.
McLaughlin, Campbell & McColgan (2016)	UK Schools (n=9)	Qualitative – focus groups (n=9) including participatory methods (n=62)	Adolescents (age range 13-17 years; mean age 15 years; 58% female; schools based in least, mid and most deprived areas)	Range of family processes influence adolescent substance use. Parenting interventions which focus on authoritative parenting styles, spending time together, communication. Family meals as way of spending time together and having discussions.

Resnick et al. (1997)	USA Schools (n=134)	Cross-sectional survey data (n=11,572)	Adolescents (age range 12-18 years)	Connectedness to parents may be protective against substance use in adolescence
Spoth et al. (2001)	USA Schools (n=33)	Intervention , 4 year follow up (n=667 families of 2 parents, 1 adolescent)	Parents (of 11-12 year olds; mean age 37.8-38.2 years; 52% female)	Brief family based intervention which aims to improve family factors, including parent-child bonding may effectively improve substance use outcomes for adolescents.
Stevens-Watkins & Rostosky (2010)	USA Schools	Longitudinal survey, 6 year follow up (n=1599)	Adolescents (age range 14-18 years, mean age 16 years at baseline, mean 22 years at follow up; all male; all African American)	Connectedness to parents may be protective against binge drinking during adolescence but not early adulthood.
Tilson et al. (2004)	USA Schools (n=4)	Cross-sectional survey data (n=428 dyads)	Adolescents (age range 11-15 years, mean age 13 years; 54% female; 37% Asian, 35% multi-ethnic, 28% African American) Parents (mean age 41 years; 79% female)	High connectedness may be protective against smoking only in non-smoking families; more complex interactions at play when parents are smokers.
Traube et al (2012)	USA Child welfare services	Longitudinal survey data, 18 and 36 month follow up (n=827)	Adolescents (age range 11-14 years, mean age 12.7 years; 58% male; almost 50% white, 30% African American; 67% never been placed in out of home care)	Caregiver connectedness was only factor that impacted on substance use at multivariate level at baseline follow up; suggests connectedness with caregiver may be protective for those in child welfare system
White & Halliwell (2010)	UK School (n=1)	Cross-sectional survey (n=550)	Adolescents (age range 11-16 years, mean age 14.13 years; 50% male; 91% white)	High connectedness may be protective against smoking and excessive drinking; only UK study to look at connectedness and substance use.
Yang, Tan & Cheng (2014)	USA Schools	Cross-sectional survey data (n=46,588)	Adolescents (Asian, Pacific Islander and White)	High connectedness may be protective against substance use during adolescence.

Table 3.2 General communication

Authors	Location	Design	Participants	Key findings
Cable & Sacker (2008)	UK General population (all born within 1 week of April 1970)	Longitudinal survey data, 14 year follow up (n=13,919)	Adolescents (all born in April 1970; data from age 16 then 30; 50.4% male)	Open communication with parents may be protective against how much adolescents drink, but not how often.
Fang et al. (2009)	USA Community (online survey)	Cross-sectional survey (n=1187 dyads)	Adolescents (age range 10-14 years, mean age 12.83 years. 35% black, 26% white) Parents (all mothers, mean age 40.3 years; 42% had some college education/degree)	Communication between mothers and daughters may not have direct effect on alcohol use, but may protect against factors that increase alcohol use, such as low body esteem, low self-efficacy and having friends who drink.
Guilamo-Ramos et al. (2005)	USA Schools (n=86)	Longitudinal survey data, 1 year follow up (n=5313)	Adolescents (age range 12-14 years; 51% female; 58% white)	Better communication with parents may be protective against binge drinking during adolescence.
Horton & Gil (2008)	USA Schools	Longitudinal survey, 2.5 year follow up (n=451)	Adolescents (age range 11-13 years, mean age 11.7 years at baseline; all males; 55% white, 45% African American)	Communication with parents may be protective against alcohol use during adolescence, but less so as get older. Familism (loyalty/trust in family) as stronger predictor.
Lanz et al. (1999)	Italy Adoptive, biological and separated/divorced families	Cross-sectional survey (n=450; 160 biological families; 140 separated/divorced families; adoptive families)	Adolescents (age range 11-18 years, mean age 14.9 years; 54% male; 62% adopted from Latin America, 31% from Asia)	Findings suggest that those in adoptive families experience positive communication with parents; suggest that task of adoption require parents to develop high-quality communication skills.
Luk et al. (2010)	USA Schools	Cross-sectional survey (n=1308)	Adolescents (mean age 16.04 years; 50% male; 48.5% white, 24.4% Hispanic; 78% two-parent households)	Ease of communicating with parents may be protective against substance use for adolescent males, but not females. May communicate differently with males as perceive as higher risk than females.

Oman et al. (2004)	USA Households	Cross-sectional survey (n=1350 dyads)	Adolescents (age range 13-19 years, mean age 15.4 years; 52% female; 48% white) Parents (48% two parent households; 66% low income; 87% had high school education)	Communication with parents may be protective against alcohol and drug use during adolescence. Higher number of protective factors reduces the likelihood of adolescent substance use.
Razzino et al. (2004)	USA Schools	Cross-sectional survey (n=527)	Adolescents (age range 12-19 years, mean age 15.1 years; 55% female; 91% white; 76% from intact families)	Communication with parents (in terms of self-expression) may have indirect role in alcohol and drug use, by influencing adolescents' academic motivation and choice of friends.
Rees, Holland & Pithouse (2012)	UK Foster families	Multi-method qualitative study, using interviews, surveys, relationships maps, diaries (n=10 families, 16 adolescents)	Adolescents (age range 9-16 years; 63% white) Foster carers (age range 39-61 years, mean age 50.2 years; all white; carers for average of 9.5 years)	Family mealtimes in foster families are one of most important sites for family communication, meals used for sharing and monitoring; potential for these times to be used to discuss sensitive topics
Rosnati & Marta (1997)	Italy Adoptive and biological families	Cross-sectional survey (n=253 families, 103 adoptive, 150 biological = 759)	Adolescents (age range 16-19 years; 55% female; all adopted from foreign country) Parents (aged 36-over 60 years; 50% female)	Adopted adolescents appear to have good communication with parents; although adoptive mothers experience more problems with communication; mother-child relationship as important protective factor against psychosocial risk during adolescence.
Rosnati, lafrate & Scabini (2007)	Italy Adoptive, foster and biological families	Cross-sectional survey (n=276 families, 81 foster, 98 adoptive, 97 biological = 828)	Adolescents (age range 11-17 years, mean age 13.81 years; 51% female; 41% adopted from L.America, 58% Asia; foster care at 9 years) Parents (mean age 38-45 years)	Adopted adolescents report good communication with parents; foster parents report poorest quality; suggests difficulties in managing relationships when child lives with them but isn't fully part of family

Rueter & Koerner (2008)	USA Adoptive and biological families	Cross-sectional survey and observation of family interactions (n=592 families- 2 parents/2 children, 384 had adopted child (one or both), 208 biological)	Adolescents (mean age 16.01 years; adopted before age of 2 years) Parents	Adopted adolescents more likely to display problems when they receive too much/too little control and communication they receive is lacking, with little warmth or listening; adoption status related to adjustment
Rueter et al (2009)	USA Adoptive and biological families	Cross-sectional survey and observation of family interactions (n=615, of 2 parents and 2 children, 407 had adopted child (one or both), 208 biological)	Adolescents (mean age 14.9 years; adopted before age of 2 years) Parents (52% female)	More problematic communication and conflict displayed in adoptive than biological families; may be due to higher rate of behavioural problems in adopted than general population/past negative experiences
Samek & Rueter (2012)	USA Adoptive and biological families	Cross-sectional surveys and observation of family interactions Families (n=616, 2 parents, 2 children, 692 adopted, 540 biological adolescents)	Adolescents (mean age 14.9 years; 55% female; 54% white; most adopted from outside USA) Parents (56% college educated, 91% married, 96% white)	High rates of conformity and communication associated with more sibling emotional and behavioural closeness in adoptive families; suggests that poor communication can have detrimental effect on adolescents' feelings and time spent with siblings
Spoth et al. (2001)	USA Schools (n=33)	Intervention, 4 year follow up (n=667 families of 2 parents, 1 adolescent)	Parents (of 11-12 year olds; mean age 37.8-38.2 years; 52% female)	Brief family based intervention which aims to improve family factors, including communication, and reduce risk factors may effectively improve substance use outcomes for adolescents.
Stanton et al. (2002)	USA Community (recreation centres n=9)	Longitudinal survey, 4 year follow up (n=383)	Adolescents (age range 9-15 years, median age 11 years at baseline; 56% male; all African American)	Open communication with parents may be protective against drug use during adolescence.

Tobler & Komro (2010)	USA Schools (n=61)	Longitudinal survey data, 3.5 year follow up (n=2621)	Adolescents (age 12 years as baseline; 51% female; 38% African American, 32% Hispanic; 67% from low-income families)	Consistently high levels of communication and monitoring may be protective against substance use during adolescence.
Vuchinich et al (2002)	USA Foster and biological families	Cross-sectional survey and observational task (n=69 families, 2 parents, one child, 23 low-risk, 23 high risk 23 foster families; =207)	Adolescents (mean age 11.26-13.57 years; 47-100% male in each group)	Communication in foster families more closely linked to child behaviour problems than in birth families; association between communication and problem behaviours; suggests that positive communication with foster parents can be protective against problem behaviours.
Yang et al. (2007)	USA Community (community/recreation centres, schools, churches)	Longitudinal survey, 2 year follow up (n=817)	Adolescents (age range 13-16 years, mean age 14.2 years at baseline; 58% female; all African American)	Open communication may not be protective against substance use during adolescence; may have been due to confounding factors; but authors still recommend that parents communicate with adolescents.

Table 3.3 Substance use specific communication

Authors	Country	Design	Participants	Key findings
Bandi et al. (2008)	USA Schools	Cross-sectional survey data (n=1629)	Adolescents (age range 11-18 years; all were smokers)	Communication about smoking may facilitate young, but not older, adolescents to stop smoking.
Beatty, Cross & Shaw (2008)	Australia School (n=20)	Intervention, 4-5 week follow up (n=1201)	Parents (of 10-11 year olds; most aged 30-40 years; 75% female; 78% married; 52% had <12 years of schooling; 55% born in Australia)	Short intervention which aimed to improve parents' communication with adolescents about substance use may enable parents to increase and improve communication. However, did not measure effect of intervention on substance use behaviour.
Bourdeau et al. (2012)	USA Previous studies	Qualitative – individual interviews (n=173)	Parents (of 15-18 year olds; mean age 51.5 years; 81% white; most mother/father pairs)	Parents use a range of strategies to communicate alcohol use rules to adolescents; conversations most frequently used.
Carlson et al. (2000)	USA School (n=2)	Intervention, 8 week follow up (n=650)	Parents (of 11 year olds; 72% female; 82% black in school 1; 72% female; 51% white, in school 2)	Self-help intervention to enhance parent-child communication about alcohol may be effective in improving communication in parents who are not already engaging in such discussions. However, did not measure effect of intervention on alcohol use.
Chaplin et al. (2014)	USA Households	Cross-sectional survey and observational task (n=116)	Adolescents (age range 12-17 years, mean 15.12 years; 55% female; 69% white, 14% Hispanic) Parents (90% female; 13% substance misuse problem)	Findings suggest that engaging in drug use discussions which involve scenarios/ things learned at school may be more protective than discussions about rules. More open communication associated with less discomfort and risk.

Cleveland et al. (2005)	USA Households	Longitudinal survey, 5 year follow up (n=714 dyads)	Adolescents (age range 10-12 years; 54% female; all African American) Parents (age range 23-80, mean age 37 years at baseline; 84% female; 91% African American)	Communication with parents may have an indirect effect on adolescent substance use, by influencing their perceptions of substance users, which affects susceptibility to use substances.
de Leeuw et al. (2008)	The Netherlands Households	Longitudinal survey, 3 year follow up (n=428 families, 2 parents, 2 adolescents)	Adolescents (mean age 13.4 and 15.2 years at baseline; 52% and 47% female) Parents (no information provided)	High quality communication with parents may be protective against smoking, while more frequent communication may be detrimental.
de Leeuw et al. (2010)	The Netherlands Households	Longitudinal survey, 4 year follow up (n=428 families, 2 parents, 2 adolescents)	Adolescents (mean age 13.4 and 15.2 years at baseline; 52% and 47% female) Parents (no information provided)	High quality communication with parents may be protective against smoking while more frequent communication may be detrimental, associated with higher rates and increased use.
Ebersole, Miller-Day & Raup-Krieger (2015)	USA Schools (n=12)	Qualitative – individual interviews (n=108)	Adolescents (aged 12-17 years, mean age 13.68 years; 54% male)	Parents use explicit and implicit messages to communicate about substance use; their own substance use influences how young people perceive these messages. Interventions should enhance parental efficacy in communicating about substance use, within the context of their own substance use.
Ennett et al. (2001)	USA Households	Longitudinal survey, 1 year follow up (n=537 dyads)	Adolescents (age range 12-14 years, mean age 13.6 years at baseline; 51% male; 80% white. Parents (mean age 40.4 years; 82% two parent household; 27% college graduate or higher)	Frequent communication with parents regarding alcohol and cigarette use may be detrimental in terms of increasing levels of alcohol use.

van den Eijnden et al. (2011)	The Netherlands Schools (n=16)	Longitudinal survey, 2 year follow up (n=537 adolescents, 368 parents)	Adolescents (age range 12-15 years, mean age 13.4 years at baseline; 56% female; 76% white) Parents (no information provided)	High quality communication with parents may be protective against alcohol use and related problems, while more frequent communication may be detrimental against alcohol use.
Guilamo-Ramos et al. (2008)	USA School (n=1)	Qualitative – focus groups (n=12)	Adolescents (age range 11-14 years; 50% female; 70% Dominican, 30% Puerto Rican) Mothers (mean age 39 years; 63% completed high school; 80% born outside USA)	Parents and adolescents view communication as important in preventing smoking but acknowledge there are a number of barriers to having such conversations.
Handley & Chassin (2013)	USA Households	Longitudinal survey data, 4 year follow up (n=454; 246 with alcoholic parent, 208 matched controls)	Adolescents (age range 11-17 years, mean age 12.6 years; 50.5% male) Parents (mean age 35.4 (mothers), 36.9 (fathers); 70% mothers and 73% fathers were white; most had some college/college degree; 54% were alcoholics)	Parental disclosure of negative alcohol experiences may be detrimental to adolescent alcohol use initiation; parents may use disclosures as warnings against alcohol use but instead normalise use and subsequently increase use.
Harakeh et al. (2005)	The Netherlands Households	Cross-sectional survey (n=428 families, 2 parents, 2 adolescents)	Adolescents (age range 13-17 years, mean 13.36 and 15.22, 50% male, majority of Dutch origin) Parents (majority Dutch origin)	Findings suggest that high quality, rather than frequent, communication about smoking may be protective against adolescent cigarette use.
Harakeh et al. (2009)	The Netherlands Households	Longitudinal survey, 2 year follow up (n=428 families of 2 parents, 2 adolescents)	Adolescents (age range 13-17 years; 98% white; 53% male (older) and 48% male (younger)) Parents (age range 35-62 years; majority white; 36% mothers and 50% fathers had college/university education)	More frequent communication with parents about cigarette use may be detrimental in terms of adolescents' smoking behaviour.

Harakeh et al. (2010)	The Netherlands Households	Cross-sectional survey data (n=428 families of 2 parents, 2 adolescents)	Adolescents (age range 13-17 years, mean age 13.36 (younger) and 15.22 (older); 53% male (older) and 48% male (younger) 98% white) Parents (majority white; 36% mothers and 50% fathers had college/university education)	High quality communication with parents may have a protective effect on adolescent smoking behaviour, while more frequent communication may have a detrimental effect. Parents' own smoking reduces quality of communication.
Hiemstra et al. (2012)	The Netherlands Households	Longitudinal survey, 5 year follow up (n=272)	Adolescents (age range 13-15 years, mean age 13.3 years at baseline; 52% female)	More frequent communication may increase adolescents' likelihood of starting smoking. When young people start to smoke, quality of communication may reduce.
Highet (2005)	UK Youth clubs and community centres	Qualitative – individual/dyad/ triad interviews (n=59)	Adolescents (age range 13-15 years; 54% male)	Communication about alcohol use appears to occur frequently and help adolescents develop a sensible relationship with it; communication about cannabis use more hidden, more difficult to talk about
Huansuriya, Siegel & Crano (2013)	USA Households	Longitudinal survey data, 5 year follow up (n=1349 (T1), 1276 (T2) dyads)	Adolescents (age range 12-18 years) Parents (no information provided)	More frequent communication with parents may have an indirect protective effect on adolescent cannabis use, by influencing their attitudes towards cannabis.
Huwer, Engels & de Vries (2006)	The Netherlands Schools (n=30)	Longitudinal survey, 2 year follow up (n=1072)	(Adolescents (mean age 12.71 years at baseline; 51% male; 82% white)	Communication about health risks may be more protective than others messages; more frequent communication may be detrimental and increase cigarette use among adolescents.
Huwer et al. (2007)	The Netherlands Households	Cross-sectional survey data (n=482)	Adolescents (age range 12-19 years, mean age 15.35 years; 56% female; 91% white)	Communication about smoking have an indirect protective effect by lowering adolescents' pro-smoking attitudes.

Kam (2011)	USA Households	Longitudinal survey data, 4 year follow up (n=5874)	Adolescents (age range 9-18 years, mean age 12.59 years at baseline; 51% male; 67% white)	More comprehensive communication with parents about substance use may be protective against alcohol, cigarette and drug use among adolescents.
Kam & Lee (2012)	USA Households	Longitudinal survey data, 4 year follow up (n=2749)	Adolescents (age range 9-18 years, mean age 13.35 at baseline, 16.45 at 4 year follow up; 51% male; 67% white)	Communication with parents may be protective against alcohol use during adolescence. It may also prevent adolescents from visiting pro-drug websites, which was associated with higher cigarette use.
Kam & Middleton (2013)	USA Schools (n=3)	Cross-sectional survey data (n=561)	Adolescents (age range 11-14 years. Latino - mean age 12.4 years; 56% male; 84% low income. White – mean age 12.4 years; 51% female; 51% low income)	Communication with parents about substance use may have an indirect protective effect, influencing the norms that adolescents hold regarding use; however, parents' disclosure of their past substance use, may normalise these behaviours and subsequently increase use.
Kelly, Comello & Hunn (2002)	USA Schools	Cross-sectional survey data (n=82,918)	Adolescents (age range 12-18 years; 87% white)	Most adolescents have talked to parents about substance use and talking to three people has most protective effect on alcohol, cigarette and drug use. The authors state that parent-child communication has a "strong protective factor".
Komro et al. (2003)	USA Schools (n=15 communities)	Cross-sectional survey (n=1343 dyads)	Adolescents (age range 13-16 years; 51% male; 90% white) Parents (95% female)	Communication with parents about consequences may be detrimental in terms of adolescents' smoking while communication about punishments may be protective.
Koning et al. (2013)	The Netherlands Schools (n=19)	Longitudinal survey, 4 year follow up (n=703 dyads)	Adolescents (age range 12-16 years, mean age 12.19 years; 53% male) Parents (82% female; 79% mothers and 74% fathers had low education levels)	Parents' worries about substance use has a detrimental effect on the quality of their communication, which increases adolescent alcohol use.

Koning, van den Eijnden & Vollebergh (2014)	The Netherlands Schools (n=19)	Longitudinal survey, 2 year follow up (n=874)	Adolescents (mean age 12.9 years at baseline; 52% male)	While quality of communication was not associated with lower alcohol use, the authors recommend a combination of strict rules and high quality communication to protect against alcohol use during adolescence.
Kulbok et al. (2010)	USA Community (schools, churches etc)	Qualitative – group interviews (n=18)	Adolescents (age range 16-17 years; all female; 66% white, 33% African American)	Open communication about smoking viewed as protective against smoking initiation by adolescents and parents. Communication occurs as direct, explicit verbal messages and implicit behavioural messages
Levy et al. (2010)	USA Primary care/ community mental health centres	Qualitative – individual interviews (n=30)	Adolescents (14-18 years, mean 16.27 years; 80% female; 40% black, 20% white, 20% Hispanic; all smoked; all met criteria for DSM-IV for depressive disorder) Parents (73% mothers)	Adolescents appear to be more receptive to communication about smoking when they have a discussion with parents, rather than when they are lectured. Parental smoking as a barrier to effective communication.
Maggi et al. (2014)	Canada Adverts, schools, community centres	Qualitative – individual interviews (n=35)	Adolescents (age range 14-18 years, mean age 16 years; 51% male; all had smoked in the past)	Parent-child relationships can negatively and positively influence adolescents' likelihood of smoking, as well as communication about smoking. Adolescents prefer educational messages, rather than being lectured.
Mallick (2003)	UK Unknown	Qualitative – focus groups (n=7 groups)	Adolescents (aged 15 years) and parents	Communication about drugs is viewed as beneficial but often difficult to initiate conversations due to stigma around drug use. Communication can be difficult when adolescents feel they are being lectured and not listened to. Good communication appears to occur when there are good relationships.

Mares et al. (2011)	The Netherlands Households	Longitudinal survey, 5 year follow up (n=428 families of 2 parents, 2 adolescents)	Adolescents (mean age 13.36 (younger) and 15.22 (older) years at baseline) Parents (age range 35-62 years; majority white)	Communication with parents who are experiencing alcohol related problems may be protective against adolescent alcohol use; but unknown regarding content and quality of these conversations.
Mares, Lichtwarck-Aschoff & Engels (2013)	The Netherlands Schools	Cross-sectional survey (n=1349 dyads)	Adolescents (age range 11-12 years, mean age 11.62 years; 51% male; majority white) Parents (age range 30-64 years, mean age 42.87; all female)	Frequent high quality communication may have an indirect protective effect on alcohol use, by increasing adolescents' self-efficacy to refuse alcohol and have more negative expectancies of alcohol use.
Metzger et al. (2013)	USA Schools (n=16)	Longitudinal survey data, 2 year follow up; observational task (n=344 families of 1 or 2 parents and 1 adolescent)	Adolescents (age range 14-16 years, mean age 15.61 years; 58% female; 56% white; all had experience of smoking) Parents (most female; 76% married; 77% post-high school education)	Good quality communication with parents may be protective against smoking behaviour during adolescence.
Miller-Day (2002)	USA Schools (n=2)/church/community centres (n=4)	Cross-sectional survey (n=67)	Adolescents (age range 11-17 years, mean age 12.97 years; 57% male; 60% African American, 40% white)	Communication with parents may have an indirect protective effect, by influencing whether or not adolescents would accept or reject offers of substance use.
Nonnemaker et al. (2012)	USA Households	Longitudinal survey data, 4 year follow up (n=5864 dyads)	Adolescents (age range 9-18 years, mean 11.9 years at baseline; 64% white) Parents (57% had high school degree)	Communication about consequences of substance use may be detrimental in terms of adolescent cannabis use.
Otten et al. (2007)	The Netherlands Households	Longitudinal survey, 1 year follow up (n=428 families of 2 parents, 2 adolescents)	Adolescents (age range 13-16 years, mean age 15.22 (older), 13.36 (younger); 50% female; majority white) Parents (age range 35-62 years, mean age 43.8 (mothers) and 46.1 (fathers) years; majority white)	High quality communication about alcohol use with parents may have an indirect protective effect, while more frequent communication may have an indirect detrimental effect by influencing attitudes and self-efficacy.

Peterson (2010)	USA Schools	Qualitative – focus groups (n=7) with adolescents (n=48) and mothers (n=11)	Adolescents (aged 12-19 years; 88% white; 59% female; 79% attended public school; 65% lived with both parents) and parents (all women; 81% white; 73% married)	Parental and family factors viewed as major influence in substance use. Need for open communication from parents. Parents wanted more training around parenting skills.
Reimuller, Hussong & Ennett (2011)	USA Schools (n=13)	Longitudinal survey, 3 year follow up (n=1511 dyads)	Adolescents (age range 11-14 years, mean age 13 years at baseline; 52% female; 56% white, 36% African American) Parents (no information provided)	Permissive messages in communication with parents may be detrimental to adolescents' alcohol use, while negative alcohol messages had no effect on use.
Ringlever et al. (2011)	The Netherlands Households	Longitudinal survey, 3 year follow up (n=428 families, 2 parents, 2 adolescents)	Adolescents (mean age 15.22 years, 52% male) Parents (no information provided)	High quality communication with mothers may be protective against smoking initiation.
Sherriff et al. (2008)	UK Community (newsletters, parenting groups, university, council)	Qualitative – individual interviews (n=40) and secondary analysis of qualitative data	Parents (of 13-17 year olds; 88% white; aged 30-64 years)	Parents use a range of strategies to communicate with adolescents about alcohol use; also report concerns/barriers to this communication.
Spijkerman et al. (2008)	The Netherlands Schools (n=16)	Cross-sectional survey (n=1344 dyads)	Adolescents (age range 12-17 years, 42% aged 14-15 years; 54% female; 88% white) Parents (75% female; most living with partner)	High quality communication with parents may be protective against alcohol use during adolescence, while more frequent communication with parents may be detrimental.
van der Vorst et al. (2005)	The Netherlands Households	Cross-sectional survey (n=428 families of 2 parents, 2 adolescents)	Adolescents (age range 13-17 years, mean age 13.36 (younger), 15.22 years; 53% male (older), 52% female (younger)). Parents (fathers mean age 46 years, mothers 44 years; majority white)	More frequent communication with parents about alcohol use may be detrimental in terms of adolescents' alcohol consumption.

van der Vorst, Burk & Engels (2010)	The Netherlands Households	Longitudinal survey data, 3 year follow up (n=428 families of 2 parents, 2 adolescents)	Adolescents (age range 13-16 years, mean age 13.36 years; 48% male; majority white) Parents (36% mothers and 50% fathers had completed university/ college)	More frequent communication may be detrimental in terms of adolescents' alcohol use, particularly in moderate and heavy drinking males, who had the highest levels of communication.
Wills et al. (2003)	USA Households	Cross-sectional survey (n=297)	Adolescents (mean age 12.96 years; 53% female; all African American)	Communication with parents may have an indirect protective effect by influencing adolescents to hold more disapproving views of people their age who use substance use.

Appendix 4. Inclusion and exclusion criteria (Young People)

Criteria	Include/exclude	Reason/rationale
Age	Include those aged 12-19 years	The focus of the study is on young people (the World Health Organisation define adolescents as those aged 10-19 years). The maximum age of participants will be 19 years, reflecting the upper age at which most looked after young people currently receive support. There is a proposed change to legislation that means that looked after children could receive support up to the age of 25; if such a change occurs during the course of the study, participants aged 19-25 will also be included. In Scotland, those under 16 can participate in research if they are considered capable of understanding what is being asked of them.
Gender	Include both males and females	Both male and female participants will be included in the study. There are slightly more males than females in care in Scotland (53% vs. 47%) so the study population will aim to reflect the population.
Non-English speakers	Exclude	Young people who are not native English speakers and would require a translator during the interview will be excluded from the study as there are no resources available for translation.
Learning disabilities, mental health and behavioural problems	Exclude (if cannot give informed consent)	Young people who cannot give informed consent due to learning disabilities, mental health or behavioural problems will be excluded. This will include young people who are viewed by their social workers as being inappropriate for inclusion.
Secure accommodation	Exclude	Looked after young people are placed in secure accommodation when they are at high risk to themselves and others, with complex needs (including mental health problems, learning disabilities, sexually harmful behaviour, sexual offences and violence. There were a total of 65 looked after children in secure accommodation in Scotland in 2012, 12 of whom are placed in Edinburgh. These young people will be excluded because it would be inappropriate to include them, given their small numbers and highly complex levels of risk and needs.

Appendix 5. Inclusion and exclusion criteria (Carers)

Criteria	Include/exclude	Reason/rationale
Biological parents	Exclude	The focus and strength of the study is corporate parenting and professional role identity in the engagement of young people in communication about alcohol and drugs. Therefore, only formal carers who are employed to meet the needs of looked after young people (such as social workers, residential care staff, and foster carers). Parents who are looking after their children at home under supervision order will be excluded.
Kinship carers (i.e. friends and relatives)	Exclude	As with parents, kinship carers (friends/relatives) will also be excluded as focus of study is on corporate parenting; therefore, only formal carers (social workers, residential care staff and foster carers who are employed by the local authority) will be participating in the study. Thus, kinship carers who are looking after the children of their friends or relatives will be excluded.
Gender	Include both males and females	Both male and female participants will be included in the study. There are higher numbers of female social work staff (including social workers and residential care staff) than males in Scotland, with 84% of all social work staff and 81% of those working in children's services being female. There are no data available to examine the gender profile of foster carers in the UK, although there is a suggestion from the literature that males are underrepresented. Therefore, based on the characteristics of the population from which participants will be recruited, it is likely that there will be more females than males, but an attempt will be made to recruit an equal number of male and female participants.
Roles	Include any person in a formal caring role	Participants will be those working as formal carers on a daily basis within the City of Edinburgh, such as social workers, residential care staff and foster carers (who are self-employed by the authority or by an independent fostering organisation).
Non-English speakers	Exclude	Potential participants who are not native English speakers and would require a translator during the interview will be excluded from the study as there are no resources available for translation.

Appendix 6. Participant Information Sheet (Young People)

Edinburgh Napier
UNIVERSITY



Talking to carers about alcohol, smoking and drugs

Who am I?

My name is Hannah and I'm a research student at Edinburgh Napier University. I'm going to be talking to looked after young people about their experiences of talking to carers about alcohol, smoking and drugs.

Why am I doing this study?

We know that these types of conversations can be good for young people, but we do not know what it is like for young people in care to have these conversations with people like social workers, residential care staff and foster carers.

What will you be asked to do?

If you decide that you'd like to take part in the study, you will be asked to take part in an individual interview.

When?

I'll arrange to meet you at a time that is best for you.

Where?

We can meet wherever you feel most comfortable, such as at home, in your residential care setting, in a community venue, or at my university.



What will you ask me?

In the interview I'll ask you about your experiences of talking to carers about alcohol, smoking and drugs. You do not have to tell me anything that you don't want to. You also don't have to answer any questions you do not want to. We might talk about your experiences of using alcohol, cigarettes or drugs, but you do not have to tell me anything if you don't want to.



Who will know what I've said?

If it's okay, I'll be writing some things down and also use an audio recorder, if you are happy with this. These are just for me to listen to in case I don't have time to write everything down. If you don't want me to write something down, you can tell me. I would also like to use some of the things that you have said, in reports, but I won't use your real name.

Will you tell anyone about what I've said?

Everything you tell me during the interview will be kept confidential and I will not pass this information onto anyone else. However, there are times when I might have to speak to someone about what I have been told. If you tell me something that suggests you, or someone else, is being harmed then I cannot keep this information to myself. If this happens, I would have to tell a social worker or other trusted professional. This is because I have to follow ethical and legal guidelines. If you have any questions about this, please ask.

Do I have to do this?

Not at all! It is up to you if you decide to participate in the study. If you read this information and decide that you would like to participate, you will be asked to sign a consent form. You are free to stop taking part at any time during the research without giving a reason. If you decide to stop, your care will not be affected and the information collected can be destroyed, if you wish.

Who can I talk to about taking part in this study?

You can speak to me about the study. My telephone number is [REDACTED] [REDACTED] (shared telephone) or you can email me [REDACTED]. You can also speak to Norrie Brown, who knows about the study but is not directly involved in it. His telephone number is [REDACTED] and his email is [REDACTED]. You may also want to contact my Director of Studies, Lawrie Elliott. His telephone number is [REDACTED] and email address is [REDACTED].

What do I do now?

If you want to take part, please say to the person who gave you this information sheet. They can answer any questions you might have, or you can contact me. They will ask you if it's okay for them to give me your name and contact details, so I can get in touch about doing an interview. I'll phone you soon to arrange this. If you don't want to participate, you just need to tell the person who gave you this information sheet that you don't want to take part.

Appendix 7. Consent form (Gatekeepers' consent for under 16s)

Consent form

Edinburgh Napier
UNIVERSITY 

Substance use communication between looked after young people and formal carers

I have permission from _____ to pass on their contact details (name, telephone number, email address and/or home address) to Hannah Carver (researcher)	<input type="checkbox"/>
I have no reason to suspect that above named young person (who is under 16 years of age) cannot give informed consent to participate in the study	<input type="checkbox"/>

Name of professional: _____

Signature of professional: _____

Signature of researcher: _____

Date: _____

Contact details of the researcher

Name: Hannah Carver
Address: PhD student, School of Nursing, Midwifery and Social Care

Edinburgh Napier University

Email: 

Telephone: 

Appendix 8. Consent form (Young people)



**Talking to carers about alcohol, tobacco and drugs
Consent form**

I have read and understood the information sheet and this consent form

I have had an opportunity to ask questions about my participation

I understand that I do not need to take part in this study if I do not want to

I understand that I can stop at any time, without giving any reason

I agree to participate in this study

Name of participant: _____

Signature of participant: _____

Signature of researcher: _____

Date: _____

Contact details of the researcher

Name: Hannah Carver

Address: PhD student, School of Nursing, Midwifery and Social Care, Edinburgh Napier University

Email: [REDACTED]

Telephone: [REDACTED]

Appendix 9. Consent form (Carers)

Consent form

Substance use communication between looked after young people and formal carers

I have read and understood the information sheet and this consent form.

I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study.

Name of participant: _____

Signature of participant: _____

Signature of researcher: _____

Date: _____

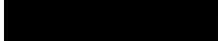
Contact details of the researcher

Name: Hannah Carver

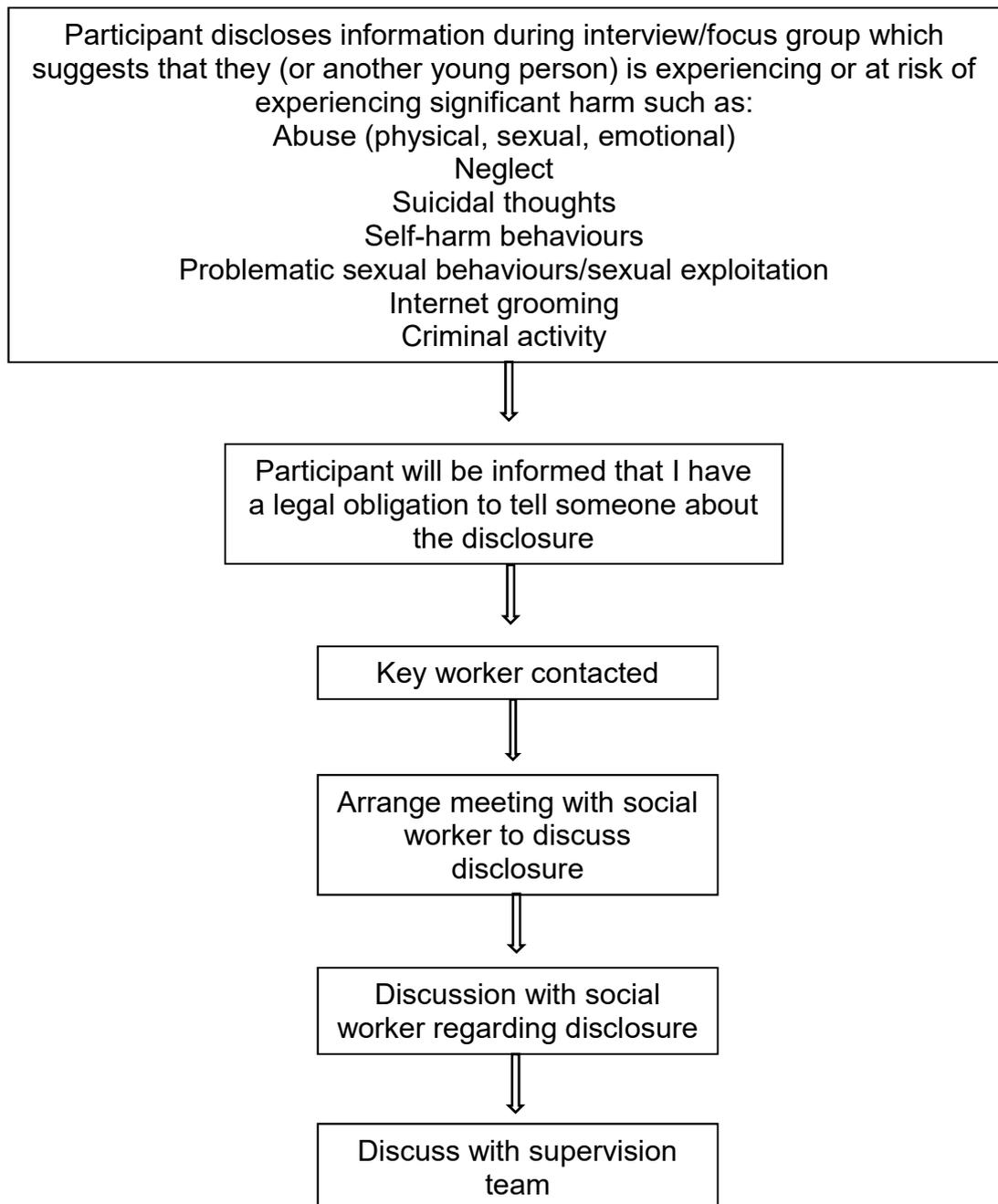
Address: PhD student, School of Nursing, Midwifery and Social Care

Edinburgh Napier University

Email: 

Telephone: 

Appendix 10. Flowchart for dealing with disclosures of sensitive information



Appendix 11: Interview schedule (Young people)

1. Tell me a bit about yourself, including how long you've been in care?
2. What do you talk about with your carers?
3. Do you talk to your formal carers about?
 - a. alcohol
 - b. smoking
 - c. drugs
4. If yes, what are your experiences of doing so? Who starts the conversations? Can you give me some examples of how and when?
5. If no, why not?
6. Is there anyone else you talk to about these topics?
7. Can you think of any things that they say or do that you find helpful?
8. Are there things that they don't talk about or do that you find unhelpful?
9. Have you used the internet, apps, websites, mobile phones etc. to get information about substances?
10. Have your carers used any of these sources when talking to you about smoking, alcohol and drugs?
11. Have you changed your behaviour as a result of the information you've received or the conversations you've had?
12. Do you think you might do anything differently in the future, based on what your carers have said?
13. Is there anything else you'd like to say?

New prompts/additional questions added during research

- In conversations about substance use, what types of things do they say? What about to other young people?
- When do they talk to you about substance use?
- Aware of other conversations around substance use in house/unit?
- Do they tell you different things to other young people? If yes, in what way?
- What do you like about smoking/drinking/using drugs?
- Why do you use substances?
- What do you dislike about them?
- If told not to drink/smoke/use drugs (or consequences of use e.g. no money/grounded etc) how does that make you feel?
- If don't use substances, have they had any conversations with you about not starting to use/dangers of use etc?
- How do you feel when having conversations about alcohol/smoking/drugs?
- Have your conversations about alcohol/smoking/drugs changed over time? Why/why not? What do you think/how do you feel about this?
- Do you get different messages from different staff members/foster carers? What do you think about this?
- Think about recent conversation you had about alcohol/smoking/drugs – what happened? When? What approach did carer use? How fair was their approach/what they were saying? How did you feel about this?
- How has this event/conversation differed from others? What was good/bad?
- Do they tell you about their own experiences with alcohol/tobacco/drugs? What do you think of this?
- Do they ask you about your opinion/how much you know about certain substances? Or to explain something about substance use to them?
- How do you want them to talk to you about substance use? Are there things you want them to talk about but they don't?
- Do you feel that it's easier to talk to them about one substance over another/others? Why/why not?
- Has your own experience of family members' substance use affected your own? Why/why not? Has it affected how you talk to carers?



Talking to carers about alcohol, smoking and drugs

Thank you for taking part in an interview!

I hope you enjoyed participating in the research. Your participation was very helpful.



The study is being carried out as part of my PhD. I am interested in finding out how looked after young people talk to their carers about substance use.

If you feel that you need to talk to someone about issues raised in the study, you can speak to your social worker, key worker, residential care staff or foster carer. There are also a number of organisations that you can talk to, if you want.

ChildLine	0800 1111
Samaritans	08457 90 90 90
Breathing Space	0800 83 85 87
Saneline	0845 767 8000
Rape Crisis Scotland	08088 01 03 02
Scottish Women's Aid Domestic Abuse Helpline	0800 027 1234
Edinburgh Women's Rape and Sexual Abuse Centre	0131 556 9437
City of Edinburgh Council Throughcare and Aftercare Service	0131 529 6400
Emergency Social Work Service	0800 731 6969
Social Care Direct	0131 200 2324
Who Cares? Scotland	0141 226 4441
Mental Welfare Commission for Scotland Adviceline	0131 313 8777 0800 389 6809
Edinburgh Citizen's Advice	0131 557 1500
The Access Point	0131 529 7438
Shelter Scotland Housing Advice Line	0808 800 4444
Victim Support Helpline	0845 603 9213

If you want to speak to me, or someone else from my university, about the study, our contact details are below.

Independent advisor contact details:

Name: Dr Norrie Brown
Address: School of Nursing, Midwifery and Social Care
Edinburgh Napier University
Sighthill Campus
Sighthill Court, Edinburgh, EH11 4BN
Email: [REDACTED]
Telephone: [REDACTED]

Researcher contact details:

Name: Hannah Carver
Address: PhD Student
School of Nursing, Midwifery and Social Care
Edinburgh Napier University
Sighthill Campus
Sighthill Court, Edinburgh, EH11 4BN
Email: [REDACTED]
Telephone: [REDACTED] (shared telephone)

Director of studies contact details:

Name: Professor Lawrie Elliott
Address: School of Nursing, Midwifery and Social Care
Edinburgh Napier University
Sighthill Campus
Sighthill Court, Edinburgh, EH11 4BN
Email: [REDACTED]
Telephone: [REDACTED]

Appendix 13. Summary of findings for participants (Young People)

Talking to carers about alcohol, smoking and drugs

Summary of the findings from my study

Thank you for taking part in an interview with me last year. My research looked at young people's experiences of talking to their carers about alcohol, tobacco and drug use. I interviewed 18 carers (foster carers, residential care staff and social workers) and 13 young people in foster and residential care. Here are the key findings from my study.

Relationships

- Relationships between young people and carers were really important: they allowed young people to feel comfortable with their carers and also helped them to have conversations, particularly about alcohol, tobacco and drug use.
- Relationships could be built in number of ways: through having shared interests and experiences, being open and honest with each other and doing activities together.
- Young people might have different relationships with different carers. Girls felt more comfortable with female carers and boys with male carers.

Role identity of carers

- Carers' roles were blurred, taking on roles of both parent and paid carer.
- Some residential care workers saw themselves 'like a parent', but within the boundaries of their job: they could only act as a parent when they were at work.
- In foster care, there was a view that young people were part of the family, but often social work regulations and guidelines prevented foster carers from completely embracing the young people as their own.
- Carers' role identity also influenced their approach to substance use: alcohol was viewed differently to tobacco and drug use. Within foster care, carers' approach to alcohol use echoed their own experiences as parents, allowing young people to try alcohol within the family home and learn about it through their own role modelling. Such an approach was not used in residential care, where alcohol use, as well as smoking and drug use, is forbidden.

Constraints, boundaries and rules

- Carers' relationships with young people were affected by particular boundaries imposed by the care context and their professional role identity.
- Most carers were keen to be open and honest with young people; residential care staff tended to feel they could not share intimate details about their personal lives, especially residential care staff.

Foster carers seemed more open about their lives. This might be because young people are living in a family home, where the boundaries between parent and paid carer are blurred and there are more opportunities to share details about yourself.

- These boundaries also influenced carers' conversations about substance use, particularly their own. In residential care, carers felt that they could not be honest about their own use of alcohol and tobacco, as they were worried about encouraging use. In foster care, again, carers were more open and honest about their experiences with alcohol and tobacco, as a way of encouraging sensible use of alcohol and smoking cessation. However, carers' own drug use was never discussed, which is likely to be due to drugs being illegal to use.
- In residential care, carers felt that although they might treat these young people like their own children, they were obviously not their parents, which affected the degree to which they had control over their lives, and particularly their substance use.
- Within foster care, there was a sense that fostering was more than a job, that they were acting as parents, but within the boundaries imposed by social work, which also affected their influence on young people's behaviour.

Doing communication

- Carers and young people talked about doing things together as a way of building relationships. They also used such an approach to have conversations about particular subjects, such as substance use.
- We called these activities "shared doing".
- Examples of shared doing included going for a walk, cooking, driving in a car, and watching TV. These instances created environments in which carers and young people could have conversations. These conversations might not have occurred or occur differently in different settings.
- Shared doing enabled communication to be less intense and more comfortable, with reduced eye contact and could allow young people to participate in the conversations.
- Shared doing occurred far more frequently in residential than foster care, suggesting different reasons and needs for these environments.

Digital media use

- We also looked at whether digital media, such as computers, mobile phones and the internet, were used by carers during this communication.
- Digital media were often viewed as unnecessary and harmful by carers, particularly for foster carers who viewed such use as inappropriate.
- They felt that they would prefer to talk to young people than use other resources like computers and mobile phones.

- Young people did not seem to have much experience of using computers/the internet in conversations with carers.

Conclusions

The findings of this study show that relationships are important within the context of residential and foster care. These relationships can take time to develop and are hugely important for helping young people to feel that they can trust their carers enough to have effective conversations about substance use. Shared doing provides an important environment in which relationships can be developed. These environments can also encourage conversations about substance use, and other sensitive topics, by reducing eye contact and providing a safe, natural way of communication. Future work with looked after young people should consider the effect of relationships and professional role identity, as well as providing opportunities in which to implement shared doing, to encourage conversations about substance use.

Recommendations

- Carers should continue to use 'shared doing' as a way of having conversations with young people about substance use. Shared doing enables carers to create environments in which communication feels natural, less intense and more comfortable. The environments highlighted in this study included driving in the car, walking, being in the kitchen and watching TV and were often chosen by carers. Young people could be encouraged to find environments which facilitate communication
- Carers should also extend the use of shared doing to communicate about other sensitive topics, such as sexual health, as creating a safe environment appears to facilitate difficult conversations
- Two areas were highlighted which carers talked about feeling unprepared to talk about and deal with: novel psychoactive substances (NPS) and digital media. Carers should be provided with support in order to increase their confidence in having conversations about NPS and in using digital media in their communication with young people. Possible ways of doing so include regular training courses for those who have not yet received them, on NPS and the positives of digital media
- Carers experienced tensions in their role because they are acting as parents but are not the parents of these young people. Carer's identity was influenced by the context in which they cared for young people. Residential care staff were particularly affected by these tensions, because they were acting like parents in a professional environment. It is important to raise awareness of the tensions experienced by all carers and recognise that they often see themselves as both parents to the young people and professionals. Considering these two roles and the conflicts in identity when providing training to social workers, residential care staff and foster carers may help to reduce these tensions.

Contact details

For more information, including a more detailed report/access to the final thesis, as well as comments on the study and findings, please feel free to get in touch:

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Appendix 14: Participant Information Sheet (Carers)

Substance use communication between looked after young people and formal carers

My name is Hannah and I'm a research student at Edinburgh Napier University. I would like to invite you to take part in my research study. Before you decide, please read this information sheet, which provides information about why the research is being done and what it would involve for you. Feel free to discuss the research with others. Please ask if there is anything that is unclear.

Why is the study being done?

The purpose of the study is to explore communication about alcohol and drug use between formal carers, particularly social workers, residential care staff and foster carers, and looked after young people. There is evidence that when parents talk to their children about alcohol and drug use, young people are less likely to start using substances, use them less frequently when they do and are less likely to develop problems. However, no research has explored this communication in looked after young people, who are at increased risk of problems. Gaining an understanding of communication between looked after young people and their carers is important, as it presents a potential route for interventions to reduce the risky behaviours of this group of vulnerable adolescents.

Why have I been invited?

You have been invited to participate because you are involved in the care of looked after children and young people in Edinburgh, and have been identified as a social worker, residential care worker or foster carer or other professional who works with looked after children and young people, on a daily basis.

Do I have to take part?

It is up to you if you participate in the study; your participation is entirely voluntary. If you read the information provided in this sheet and decide that you would like to participate, you will be asked to sign a consent form. If you decide to withdraw from the study, you can do so at any time and your data can be destroyed, if you wish.

What will happen to me if I take part?

If you agree to participate in the study, you will be asked to take part in an interview. This interview will be conducted at a time and location most convenient to you and can be done face-to-face or by telephone. It is likely that this interview will last about an hour. The interview will be audio-recorded, with your permission. During the interview you will be asked about your experiences of communicating with looked after young people about alcohol and drug use.

What are the possible disadvantages of taking part?

It is unlikely that participating in an interview will cause you any harm or distress. However, there is a chance that the topics may be perceived as sensitive or personal in nature. If you do feel distressed during or after the interview, I can give you information about sources of help and support.

What are the possible benefits of taking part?

It is unlikely that you will experience any direct benefits from participating in an interview. Some people have reported that participating in research interviews can be a beneficial experience. It is intended that the findings of the study will influence future practice for those working with looked after children and young people, hopefully improving the lives of looked after children and young people.

Will my taking part be kept confidential?

Yes. I will follow ethical and legal practice and all information about you, including what you say in the interview, will be kept confidential. However, there are limits to confidentiality; if you mention something that suggests a child or young person is being harmed or at risk of harm, I have a legal duty to report this. The consent forms will be stored in a locked drawer, in a locked room, and will only be accessed by the researcher. Audio recordings from interviews and transcripts will be stored in a password protected folder, on a password protected computer. Any identifiable information, such as names and places, in the transcripts will be removed and you will be given a pseudonym, so you cannot be identified in any reports. The research data will be stored for up to five years following the end of the study; it will then be disposed of securely.

What will happen to the results of the study?

It is likely that the results of the study will be presented at conferences and published in journals. They will also be reported in my final thesis, which will be accessible online. You will not be identified in any publication.

Who has reviewed the study?

All research conducted by Edinburgh Napier University is looked at by an independent group of people, called a Research Ethics Committee, to protect the interests of the participants and researchers. This study has been reviewed and approved by the Faculty of Health, Life and Social Sciences and by the City of Edinburgh Council's Children and Families Department. I also have a current PVG membership.

Further information about the study

If you would like more information about the study, you can contact me. My telephone number is [REDACTED] (shared telephone) and my email is [REDACTED]. If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to contact Norrie Brown. His telephone number is [REDACTED] and his email address is [REDACTED]. Alternatively, you can contact my Director of Studies, Lawrie Elliott. His telephone number is [REDACTED] and email address is [REDACTED].

If you have read and understood this information sheet, any questions you had have been answered, and you would like to be a participant in the study, please contact me to arrange an interview.

Appendix 15: Interview schedule (Carers)

1. Can you tell me a bit about yourself and your role? How long have you been a carer?
2. What are your experiences of caring for looked after children and young people?
3. Can you tell me what you see as the main challenges of working with looked after children and young people?
4. In your experience, what are the main difficulties they need help and support with?
5. Can you tell me what kinds of things you talk to them about?
6. I'm particularly interested in finding out about communication around sensitive issues – what types of things come up in your experience? (such as building relationships/attachments, sensitive issues such as substance use).
7. Do you talk to young people about substance use (tobacco, alcohol, drugs)?
8. If yes, can you tell me how you do this?
9. Are there things that work particularly well? If so, why do you think this works well?
10. Are there things that could work better? If so, why and what would help?
11. Do you use the internet, websites, apps, mobile phones etc. as part of this communication? Why/why not?
12. If don't talk about substance use, why not? Do you think you should be talking to them about substance use?
13. Where do you think the young people get information about substance use (tobacco, alcohol and drugs)?
14. Can you tell me how comfortable you feel in addressing sensitive issues such as substance use?
15. Do you feel prepared and skilled in dealing with sensitive issues such as substance use? Why/why not?
16. Are there other areas of education and training that would help?
17. Is there anything else you'd like to add?

New prompts/additional questions added during research

- In conversations about substance use, what types of things do you say? What about to other young people?
- When do you talk to them about substance use?
- Do you say different things to other young people? If yes, in what way? Why?
- If don't use substances, have they had any conversations with young people about not starting to use/dangers of use etc?
- How do you feel when having conversations about alcohol/smoking/drugs?
- Have your conversations about alcohol/smoking/drugs changed over time? Why/why not? What do you think/how do you feel about this?
- How has this event/conversation differed from others? What was good/bad?
- Can you think of a recent example of when you have had a conversation with a young person or young people about alcohol, tobacco and/or drug use.
 - What prompted the conversation?
 - When did it occur/where and who was there?
 - What did you say/do?
 - How did the young person/people respond?
 - How did you feel during/after?
 - Is there anything you would've done differently?
 - Did you use any resources during your conversation?
- What happens when young people are caught using substances (i.e. smoking, been drinking, used drugs)?
- What happens when you know of their drug use (when enter unit and told that they are smokers, drink, use drugs)?
- What would happen if a young person saw you smoking? How would you deal with this?
- Do you talk about your own experiences with alcohol/tobacco/drugs? Why/why not?
- Do you ask them about their opinions/how much they know about certain substances? Or to explain something about substance use to you?
- What do you think the best approach to talking to substance use is?
- How would recommend talking about substance use to other foster carers?
- Do you feel that it's easier to talk to them about one substance over another/others? Why/why not?
- Why do you use/not use digital media? What would encourage you to use it/use it more frequently?

Appendix 16. Debrief sheet (Carers)

Substance use communication between looked after young people and formal carers.

Thank you for participating in an interview; I hope you enjoyed participating. The study is being carried out as part of my PhD. I am interested in finding out how looked after young people talk about alcohol and drugs, with their carers, friends and also if they use the internet, mobile phones or other devices to look at information or talk about alcohol and drugs.

If you feel that you need to talk to someone about issues raised in the study, there are a number of organisations that you can talk to, if you want. These details are provided below, as well as the contact details of someone at my university who knows about my research, as well as my contact details, in case you have any questions about the study.

Samaritans	08457 90 90 90
Breathing Space	0800 83 85 87
Saneline	0845 767 8000
Rape Crisis Scotland	08088 01 03 02
Scottish Women's Aid Domestic Abuse Helpline	0800 027 1234
Edinburgh Women's Rape and Sexual Abuse Centre	0131 556 9437
City of Edinburgh Council Throughcare and Aftercare Service	0131 529 6400
Emergency Social Work Service	0800 731 6969
Social Care Direct	0131 200 2324
Who Cares? Scotland	0141 226 4441
Mental Welfare Commission for Scotland Adviceline	0131 313 8777 0800 389 6809
Edinburgh Citizen's Advice	0131 557 1500
The Access Point	0131 529 7438
Shelter Scotland Housing Advice Line	0808 800 4444
Victim Support Helpline	0845 603 9213

Independent advisor contact details:

Name: Dr Norrie Brown
Address: School of Nursing, Midwifery and Social Care
Edinburgh Napier University
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Email: [REDACTED]
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Sighthill Court, Edinburgh, EH11 4BN
Email: [REDACTED]
Telephone: [REDACTED] (shared telephone)

Director of studies contact details:

Name: Professor Lawrie Elliott
Address: School of Nursing, Midwifery and Social Care
Edinburgh Napier University
Sighthill Campus
Sighthill Court, Edinburgh, EH11 4BN
Email: [REDACTED]
Telephone: [REDACTED]

Appendix 17. Summary of findings for participants (Carers)

Substance use communication between looked after young people and formal carers

Summary of the findings from my study

Thank you for participating in an interview with me last year. The purpose of my study was to examine how foster carers, residential care staff and social workers communicate with young people about alcohol, tobacco and drug use. I conducted interviews with 18 carers (foster carers, residential care staff and social workers) and 13 young people in foster and residential care about their experiences of communication around substance use. I have now analysed the data and would like to share the findings with you.

Relationships

- Relationships were really important: they allowed young people to feel comfortable with their carers and also facilitated communication, particularly around substance use.
- Relationships could be developed in number of ways: through having shared interests and experiences, being open and honest with each other and doing things together.
- Young people could have different relationships with different carers. Often these relationships were dependent on gender: girls felt more comfortable with female carers and boys with males.

Role identity of carers

- Carers' roles were somewhat blurred, often taking on roles of both parent and paid carer.
- Some residential care workers saw themselves 'like a parent', but within the boundaries of their job: they could only act as a parent in certain circumstances and only when they were at work.
- In foster care, there was a view that young people were part of the family, but often social work regulations and guidelines prevented foster carers from completely embracing the young people as their own.
- Carers' role identity also influenced their approach to substance use: alcohol was viewed differently to tobacco and drug use. Within foster care, carers' approach to alcohol use echoed their own experiences as parents, favouring an approach in which young people could try alcohol within the family home and learn about it through their own role modelling. Such an approach was not used in residential care, where alcohol use, as well as smoking and drug use, is forbidden.

Constraints, boundaries and rules

- Carers' relationships with young people were affected by particular boundaries imposed by the care context and their professional role identity.
- While carers were keen to be open and honest with young people, they were constrained in terms of how much they could tell them about themselves, especially in residential care, where carers felt unable to share intimate details about their personal lives.
- Foster carers seemed more open to sharing these details; this openness may be due to the care context, in which young people are living in a family home, where the boundaries between parent and paid carer are blurred and there are more opportunities to share details about yourself.
- These boundaries also influenced carers' conversations about substance use, particularly their own. In residential care, there was a sense that you could not be honest about your own use of alcohol and tobacco due to concerns around encouraging use. In foster care, again, carers were more open and honest about their experiences with alcohol and tobacco, as a way of encouraging sensible use of alcohol and smoking cessation. However, drug use was never discussed in both settings, which is likely to be due to the negative associations of use and the legal context of such substances.
- In residential care, carers talked about boundaries around their own personal and professional identity. They felt that although they might treat these young people like their own children, they were obviously not their parents, which affected the degree to which they had control over their lives, and particularly their substance use.
- Within foster care, there was a sense that fostering was more than a job, that it was akin to being a parent, but within the boundaries imposed by social work, which also affected their influence on young people's behaviour.

Doing communication

- Carers and young people talked about doing things together as a way of building relationships. They also used such an approach to have conversations about particular subjects, such as substance use.
- We called these activities "shared doing".
- Examples of shared doing included going for a walk, cooking, driving in a car, and watching TV. These instances created environments in which carers and young people could have conversations. These conversations might not have occurred or occur differently in different settings.
- Shared doing enabled communication to be less intense and more comfortable, with reduced eye contact and could allow young people to participate in the conversations.
- Shared doing occurred far more frequently in residential than foster care, suggesting different reasons and needs for these environments.

Digital media use

- We also looked at whether digital media, such as computers, mobile phones and the internet, were used by carers during this communication.
- Digital media were often viewed as unnecessary and harmful by carers, particularly for foster carers who viewed such use as inappropriate.
- They felt that they would prefer to talk to young people than use other resources like computers and mobile phones.

Conclusions

The findings of this study have highlighted that relationships are important within the context of residential and foster care. These relationships can take time to develop and are hugely important for enabling young people to feel that they can trust their carers enough to have effective conversations about substance use. Shared doing provides an important environment in which relationships can be developed. These environments can also encourage conversations about substance use, and other sensitive topics, by minimising eye contact and providing a safe, natural method of communication. Future work with looked after young people should consider the effect of relationships and professional role identity, as well as providing opportunities in which to implement shared doing, to encourage conversations about substance use.

Recommendations

- Carers should continue to use 'shared doing' as a way of having conversations with young people about substance use. Shared doing enables carers to create environments in which communication feels natural, less intense and more comfortable. The environments highlighted in this study included driving in the car, walking, being in the kitchen and watching TV and were often chosen by carers. Young people could be encouraged to find environments which facilitate communication
- Carers should also extend the use of shared doing to communicate about other sensitive topics, such as sexual health, as creating a safe environment appears to facilitate difficult conversations
- Two areas were highlighted which carers talked about feeling unprepared to talk about and deal with: novel psychoactive substances (NPS) and digital media. Carers should be provided with support in order to increase their confidence in having conversations about NPS and in using digital media in their communication with young people. Possible ways of doing so include regular training courses for those who have not yet received them, on NPS and the positives of digital media
- Carers experienced tensions in their role because they are acting as parents but are not the parents of these young people. Carer's identity was influenced by the context in which they cared for young people. Residential care staff were particularly affected by these tensions, because they were acting like parents in a professional environment. It is

important to raise awareness of the tensions experienced by all carers and recognise that they often see themselves as both parents to the young people and professionals. Considering these two roles and the conflicts in identity when providing training to social workers, residential care staff and foster carers may help to alleviate these tensions.

Contact details

For more information, including a more detailed report/access to the final thesis, as well as comments on the study and findings, please feel free to get in touch:

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Appendix 18. Example of field notes (Young Person)

Participant: Michael (age 14)

Date: 13th May 2015

Location: Residential Unit

I arranged to meet Michael after interviewing another young person in the same unit. Before the interview, one of the residential care workers had mentioned that he had used legal highs once before and had had a bad experience so he said he would never use again – was interested to see if he had the same attitude/response (he did!).

He seemed relatively friendly but could tell he wasn't really that interested in doing the interview, although he did seem to open up a bit more as the interview went on. He talked about not liking being in the unit, staying in his room a lot and not liking most of the workers – I wish I had probed a bit more to find out what it was about why he liked some staff and not others (i.e. different relationships) but it felt awkward to keep asking and didn't want to affect the rapport. He had only been in the unit for 9 weeks and hadn't seemed to get to know many of the staff or other young people. He also talked about not going to school either.

He said that the staff in the unit only talked to him about smoking because he smokes; said he doesn't listen to them and continues to smoke – should've probed more about how he feels re. conversations about smoking – often around rules for smoking. Mentioned that he had talked to mother about legal highs after use – said her reaction and his negative experience influenced his decision not to use again. Shocked by revelation that he has been smoking since 10 years of age.

I thought that generally the interview was okay but I wished I had probed more – I found it really difficult to encourage him to say more and talk more in depth, without feeling I'm forcing them, so I need to think of better probes to get them to talk more.

Appendix 19. Example of field notes (Carer)

Participant: Susan (foster carer)

Date: 19th May 2015

Location: Susan's house

I was really anxious about this interview beforehand as it was the first interview I had done with a foster carer and the first interview I'd done in someone's house. Fortunately, I'd spoken to Susan on the phone beforehand (I even checked if she had a dog as I don't like dogs – she did but he was very small and not at all scary!) and she seemed really friendly. She was really friendly and welcoming when we met, so that helped my anxiety!

I felt that the interview went well, she had a lot to say so I was worried that it might over-run but luckily it didn't. Had to pause the interview for a bit as Susan's mother arrived home (she has dementia), and we chatted for a few minutes, but that was the only distraction.

At times, Susan talked about really distressing stuff, such as experiences with foster children that were difficult as well as traumatic experience with ex-husband who was an alcoholic – violent, smashed house and pulled a gun on his children. She seemed calm when talking and made sure she was okay when I left – I think she must've talked about it many times as didn't seem affected.

After reflecting on the interviews with Hope and Michelle, where I felt I didn't ask enough about in-depth experiences of each substance, I made sure that I did so in this interview, covering exactly what was actually said when she would have conversations about substance use.

I felt that the interview went well and lasted about an hour as she had a lot to say. At the end, I made sure to offer her the debrief sheet with details of where to get support if required (due to sometimes distressing topics raised) but she said she didn't need to speak to anyone, as these things were in the past and she had already dealt with them. I felt comfortable about this and left, feeling quite confident about my first interview in someone's house.

Appendix 20. Extract from a transcript

Ian - 24th August 2015 (Residential care worker, Unit C)

Hannah: with alcohol em the conversations you have obviously you said are different to the ones you would have with your own kids [Ian: yeah] because you can't give that permission in [Ian: no] the way that you would with your own

Ian: cos if I was to give my cos you're I think cos there's the parents of these kids as well I mean cos sometimes we have to liaise wae them about if they're goin' to a party or if they're goin' to on holiday cos you've got to get permission because they have the parental rights [Hannah: okay] and things like that so we couldnae say aye aye go ahead I'm gonna give you permission to go and have a few beers and we and if a parent heard that they'd go ballistic or parents have generally said no because they maybe think maybe they'd say aye but because we're under the social work they're gonna say hmmm I better no say aye to them or they'll report us to the social work or so kinda thing so em...I wish we could say I mean there is like I say I mean we do say no but we also say look like I said these are all the kinda the areas that you need to be careful about and because but if you're abs- cos some of them get *absolutely*...pissed [whispers] and in some very vulnerable situations em and it's it's...it's no about it's about what other people might do...

Hannah: yeah so what type of things d'you say to them in these kind of conversations about drinking?

Ian:...be careful be safe...em if you are gonna drink make sure it's a reasonable amount not that I want you to drink but make sure it's a reasonable amount cos we know they're gonna do it anyway em and...I th- I mean it's a time a timing as well to come in em and if generally if they're kinda stuck or they phone we'd say look oh...you we'd use for a safety aspect we would get a taxi for them em phone a taxi or tell them to jump in a taxi and get back here as quick as possible rather than being absolute drunk out there and being wandering around and god knows what could happen to them

Hannah: so kind of messages of [Ian: being safe] being safe [Ian: yeah] not doing things that are kind of putting themselves in risky situations [Ian: yeah definitely]...d'you think it would make it easier if you were kind of I suppose you're in a parental role but not...have that kind of overall parental responsibility in the way that you have with your own kids?

lan: I think it would be aye I think it would be easier I mean I think again that's about I mean it's easy for me to say that cos I'm a parent of my kids but you'll get some parents I know some parents who disagree with that my thinking eh quite a lot of the parents have that same mentality as me in terms of and it's worked for their kids whereas actually the parents who who've been dead against their kids their kids are actually the ones who go oot drinkin' more because it's like they're at that teenage rebellion against their parents kinda thing...

Appendix 21. Example of memo produced as part of coding

Participant: Rachel (age 15)

Interview date: 29th May 2015

Location: Foster carer's house

Care experience: Been in care for approximately seven years, in one placement prior to current one; been in current placement for three years.

Notes: Drinks alcohol but doesn't smoke/use drugs; seemed really mature and wise for her age

General information

- Been in current foster care placement for three years; was in another placement for four years before that; taken into care at age of 8; first foster placement broke down then came to current placement. Only had limited experience of foster carers (2 placements). Another foster child recently moved in – he has his own problems but *"it's got nothin' to do with me...it's his life he can do what he wants"* (page 1). In fourth year of high school, finished last exam today.
- Current foster placement as *"much better"* (page 1) than previous, because *"I'm more suited here...it's kinda like ma environment...it's what I'm used to"* (page 1). With previous foster carers, had to follow certain rules and would be consequences if didn't; recognition that children need rules but current placement is much more laid back. In current placement, there's an emphasis on knowing what's right and wrong and what should be doing – having agency and making own decisions rather than strict rules – *"it's like well you know you should be doing that and I'm like oh yeah I know and she's like right so do it next time I'm like right okay"* (page 1).
- Current foster carers "get me", they don't view her as a foster child; previous foster carers made distinction between her and their own children – *"they don't see me as a foster child whereas my old carers were like they're my children and you're...but they don't like I'm kinda like I'm treated the same as her own children"* (page 1). All children in household are treated the same way. Being treated like their child makes placement better than previous one; feeling like part of their family
- Supportive of each other as a family; foster carers on her side and will fight for things she wants if they agree; if they disagree, they'll tell her and she'll respect that. Respecting each other's decisions. Gets on well with foster carers.
- Having good relationship with foster carers "makes it easier to talk about stuff" (page 2). In previous placement, they didn't have a connection so it was difficult to talk to them about what wanted/wanted to do. Previous foster carers had rules and *"what they say goes...rather than like oh like my opinion"* (page 2). In current placement, foster carers encourage her to tell them if there's something she wants as *"we can't read your mind"*; they encourage her to be open with them. Might not agree with what she wants/is doing but they say they'll support her and give her advice – *"we might no agree wae your decision but we'll support you and we'll give you advice on how to like handle whatever it is you're getting' up to"* (page 2). Foster carers as being there to look after you; living with them so it's

easier to talk to them. Have different relationship with foster carers and social workers.

- Came into placement at age of 12/13 which is difficult time in life anyway – doing things you're not meant to. But foster carers know when you're lying to them – *"they always find out"* (page 3) – better to be open and honest with them rather than lying; telling the truth and being honest is better than lying as you might lose their trust and then they won't believe you in future when you are telling the truth.
- Friends as going overboard with drinking; acts like the mum of the group and trying to encourage friends to be sensible/dealing with them when drunk. Always knows what she's doing when drinking. Always keeps her "head in check" (page 6) when drinking, doesn't get so drunk that she doesn't know where she is. Getting really drunk as embarrassing – assumption that it's embarrassing for her but maybe not for others – *"I don't...like get absolutely...pissed and just oh where am I? like d'you know what I mean that's just embarrassing well for me like to me...like I see that as embarrassing"* (page 6). Knows when to stop drinking; some friends don't know when they've had enough to drink, in the morning they feel awful and she doesn't.
- Foster carers used to smoke so they know how hard it is to quit. They know she doesn't smoke and trust that she is telling the truth, not lying to them. foster carer does advise her not to smoke, says it's bad for your lungs. Aware of negative effects of smoking, doesn't attract her and doesn't see the point of smoking.
- Although was young when lived with mum, was aware of everything in terms of her drug use. Would never take drugs because aware of the negative effects – *"like for me personally knowin' the states that she was in or the damage they done [sic] because she couldn't stop"* (page 8). Doesn't want to end up like parents; unsure if all foster children have similar view; people look up to mums and dads but she doesn't look up to hers in a good way – wanting a better life for herself, wanting to do good rather than ending up like her mum. Peer pressure as "massive" in terms of drugs – lots of teenagers using drugs; if you have morals, should stick to them and not be pressured into using drugs; no point in giving into peer pressure as won't benefit self or friends. Own friends don't take drugs but knows people who do, they are pressured by friends to use. Some people say peer pressure isn't a big thing and can stand up for themselves but *"but it is when you're in a situation where everyone else is doin' it"* (page 8). Some people don't know the consequences of using drugs, but she does as seen effect on mother/reason taken into care; People see drug users on the street and think it's funny but it's different when it's your own family; effects on family doesn't want to use drugs; never considered taking drugs as aware of negative effects.
- Social worker as being there for you, representing you and checking your placement is going well. But social worker involvement makes it seem more like a placement than a home – *"the more social workers are involved the more you feel...it is a placement...rather than...a home"* (page 10). Social worker involvement as highlighting care status. Only friends and boyfriend know that she's in care, no one else does; private person, difficult to keep care status private if there are social workers in your house. Some foster children get extra support at school but she

doesn't – "I object" (page 10). Recognition that some foster children need extra support if placement has broken down or they can't handle being in care; but for her, it should feel more like a home than a placement. View as home not placement, which is why they get on so well and can talk to foster carers. Never sees social worker and prefers it that way. Social worker knows she's doing well as she's not said anything and neither have foster carers.

- Foster carers as helping you build a new life and being there for you – *"that's what they're there for though like d'you know what I mean they're there tae kinda...build a new life for you basically like put you in the right direction, d'you know what I mean so and that's what they do"* (page 10).
- Knows what she wants for her future; Life doesn't always turn out the way you want but still have ideas and dreams; Foster carers know what she wants so they try to steer her in right direction – grateful for help; Will continue to do what she does and foster carers will support her; If foster carers disagree, will say that and get her to think about which is the best option; Plans to keep her life the same as it is.

Communication

- Having good relationship with foster carers *"makes it easier to talk about stuff"* (page 2); in previous placement, they didn't have a connection so it was difficult to talk to them – *"we didn't have that like connection that it was harder to say stuff..."* (page 2). In current placement, encouraged to talk to foster carers and ask if there's something she wants. Their approach and encouragement to be open by saying they'll support her regardless makes her feel *"more comfortable with how to talk to them"* (page 2). Really open with foster carers and will tell them everything – *"I'm so open like with them like I tell them everythin' so...and probably more than I should"* (page 2); you feel more comfortable with yourself when you can be open and honest as you're not lying to them and hiding things; don't have to worry about them finding out about things as tell them everything, *"obviously it's within circumstance"* (page 2). Feels good to talk to them; better talking to foster carers than social workers because *"they don't have to live with you...they only hear stuff"* (page 2) – social workers not always getting the full story/picture; better talking to foster carers as you *"go through like every day with these people"* (page 2). Living with foster carers so it's easier to talk to them than to someone else. Have different relationship with foster carers than social workers.
- Talks to foster carers about *"everythin'"*; about relationships, boys, friends, alcohol, health, if upset about something, *"basically everythin'"* (page 3). Comfortable talking to them about everything because *"we built that relationship"* (page 3). At the start of the placement it was difficult to talk to them because placement was new; foster carers made her feel *"a hundred percent at home"* (page 3); recognition that it was hard at the start to build a relationship and talk to them. Better to be open and honest with them rather than lying as they always find out, might lose their trust and they won't believe you when telling the truth in the future. There isn't really anything that wouldn't talk to foster carers about.
- For foster children it's difficult to talk about things that have happened in the past, despite knowing that foster carers are there to listen and they say they understand but feel that they don't understand what you've

experienced. Appreciates their help and support; harder to talk about past than other things. Opened up over the last three years and now feels that she can talk to them about her past; more difficult to talk to someone about your past if you're new or don't have a relationship with them; difficult to talk to someone you don't know because you think *"it's got nothin' to do wae you"* (page 3). Talking about your past is good – it helps you get over it and move on rather than dwelling on what's happened. Need to build a relationship with someone before you can talk about past experiences, talking as beneficial, feel better about yourself – *"for stuff like that yeah it will take time you'll need to build that relationship but once you have then you'll feel better about yourself"* (page 3).

- Talk about alcohol because use is normal/common at age of 15/16, started talking about alcohol when started going to parties where alcohol was. Tempted by alcohol and drank at a party; foster carer asked if she'd been drinking and said she didn't think it was appropriate to tell her beforehand – foster carer said she'd rather she knew; prefer to know if drinking so she knew where she was in case anything happened, what she was drinking and how much as she didn't want her getting *"stupid drunk"* (page 4). Now tells foster carers when going to be drinking at parties – *"it's up to me to mention"* (page 4) – making her responsible for her own actions/behaviour. Making her responsible and getting her to tell them if she's going to be drinking rather than forbidding it as better because *"I'm gonna go and do it anyway"* (page 4). Foster carers monitor alcohol use – checking when she's coming home, having her phone on her, who she'll be with, asking her to get in touch to check she's okay; monitoring use as better than forbidding. Doesn't get into *"pure states"* when drinking, drinking at friends' houses when parents are there (page 4). Makes sure that comes home on time or stays at friend's house and gets in touch to confirm that okay. Their approach to alcohol is "quite easy" – they know she'll be drinking at her age, moderating drinking rather than forbidding as best approach – *"cos of my age I'd say because she knows like they obviously know what it's like so to say like oh like I 'hink if your foster carer moderates it rather than puttin' a complete stop to it"* (page 4). Approach as age specific – wouldn't be letting 12 or 13 year olds drink alcohol. Because foster carers moderate drinking and give her advice, it's easier to talk to them about drinking – *"the way they moderate it and...like give me advice about it and stuff it makes it easier for me to talk to them about it"* (page 4). Making her responsible for her own behaviour, although they have overall responsibility for her. They are responsible for her so that's why they use approach – they're not strict but they have their own rules around alcohol use – monitoring and moderating rather than forbidding which is best approach. Social workers as against her drinking; foster carers argued that as they are looking after they will use their approach – placement going well because she follows their rules so social worker agreed/accepted approach. Foster carer knew she was drinking when first had alcohol; would've been difficult to talk to foster carer about alcohol if she' been angry but she wasn't – she wanted her to tell her next time she was going to drink; if foster carer had been angry it would've been more difficult to talk about alcohol and explain why drinking - and *"I 'hink if she probably did get angry and flip out it'd made it harder to talk to her d'you know what I mean it woulda made it harder to*

explain why or cos then you'll get angry and you'll be like no no...so it woulda made a it would've made it harder to sit and like say explain yourself if she was also angry" (page 5); better to have constructive conversation and agree to particular rules/explore reasons for use rather than just shouting at her.

- Foster carers aware that going to parties now and that she knows the rules – getting her to text when out as reminder of the rules rather than “a pure lecture *all the time*” (page 5). Family as really open so everyone contributes to conversations. Conversations about alcohol occur “not a lot but...enough to like keep it in your mind and just be like oh do the right thing” (page 5) – reminders about rules and what should/shouldn't do. Conversations act as a reminder to follow the rules rather than choosing to ignore the rules and do your own thing. Conversations occur ad hoc – when going to parties, if in trouble as broke the rules and when social worker is asking. Know the rules so follow them. There's no point in constantly going on to foster child about alcohol – “*because they're just gonna be like right okay right okay right okay and then just not listen*” (page 5). Will have conversations about alcohol when it's necessary, such as when going to a party or when broken the rules and will talk about why broken the rules. Consequences for breaking the rules as acceptable.
- Foster carers talk about safety and to think about what she's doing and not making a fool of herself when drinking. Stuff foster carers is similar to what parents will tell their children. Foster carers as laid back about alcohol. Talk about own negative experiences of alcohol use and encouraging them not to do the same. Encouraging her not to make a fool of herself when drinking as she'll regret it the next day; advice as making sense.
- Foster carers talk about smoking although they know she doesn't smoke; smoking “*just doesn't attract me at all*” (page 6). Foster carers used to smoke so they know how hard it is to quit. They know she doesn't smoke and trust that she is telling the truth, not lying to them. “It's not really a conversation” about smoking because she doesn't smoke; foster carer does advise her not to smoke, says it's bad for your lungs. Aware of negative effects of smoking, doesn't attract her and doesn't see the point of smoking. Don't have proper conversations about smoking because it's not something she does – “*it's not really a conversation we have because it's not an issue*” (page 7). Foster carers as trusting her that she doesn't smoke, they know she doesn't. Feels that if did start smoking, would talk to them and they'd have something to say about it but wouldn't be angry/nasty – “*obviously if it did occur I'd I'd feel like they probably would have somethin' to say about it but it wouldn't be like...pure nasty*” (page 7). Foster carer says that can't criticise her if did start smoking as they started smoking at young age; understands but irrelevant as it's not something she does. Will have jokes about smoking, if someone asks if she smokes, foster carer will say “*no no she's a good girl she doesn't smoke*” (page 7). Don't have proper conversations about smoking because it's not something she does; it's not relevant, would get bored and wonder what the point is. Foster carer recognises that there's little point in talking about smoking as doesn't smoke, will talk about it if started smoking.

- Aware of other conversations about smoking – rumours that foster child was smoking, he's only 12; foster carer having conversation with him about whether he smokes and he was very defensive – *“he was like I don't I don't like pure rejectin' it”* (page 7); he said he didn't smoke so took his word for it. Advised him not to smoke as it's horrible but said she can't stop him smoking; encouraged him to talk to her if he was smoking. She wasn't pushing him to tell her but emphasising that it's horrible to see a 12 year old smoking.
- Conversations about drug use (for her) don't happen “because my mum took drugs” (page 8). Foster carer aware that not going to take drugs and reasons, had conversations with her about it and her mum so she knows why she won't use them. Has jokes with foster carers about drugs but doesn't take them seriously as know she won't use. Conversations about drugs would be much harder if you were using them as never going to be acceptable – *“I 'hink...for the ones who probably do...take drugs that would be a much harder conversation to have because you'd be like like you know like even they wouldn't approve of that”* (page 9). Alcohol and smoking are drugs but not as severe as “genuine” drugs – much more dangerous; people as stupid for using drugs. Recognition that while some people will use drugs, she won't. Foster carers would tell her all the negatives of using drugs but *“they know I already know that”* (page 9). Don't have proper conversations about drugs because they know she wouldn't use them; recognition that this situation is personal to her and not the case for all foster children – for some, might want to follow in parents' footsteps, because *“that's all they know”* (page 9). Self as not interested in taking drugs, foster carers know that so they don't talk about them. Have some conversations in the house about drugs if gossiping with foster carers' daughter and then explains to foster carer; foster carer says she doesn't understand why young people take drugs and they agree. Don't really have conversations about drugs unless gossiping – drugs aren't an issue so don't need to have conversations.
- Who contributes to conversations depends on who is in or what has happened; will all contribute to conversations if asked; everyone contributes and gives their opinion. Don't have planned conversations but will talk about it if someone has something to say. Conversations about drugs don't occur that often
- Talks to friends and sister about substance use. Doesn't talk to social workers as doesn't *“see the point”* (page 10); more social worker involvement makes it feel like a placement and not a home. If saw social worker regularly would run out of things to talk about.
- Not having “pure sit down conversations” about alcohol, drugs or sex as beneficial. Laid back approach to conversations, predominantly involve giving advice; informing her that she knows right and wrong and it's up to her to make decisions – *“you know yourself the right and wrong thing to do it's up to you whether you choose to do one or the other”* (page 10), but within context of support – *“she went obviously...like I'll be here for you”* (page 10). Foster carers advising her to do the right thing but recognition that she might not always do so. Advising her to be careful. Their approach as good – *“she's not gettin' on at me and nagging”* (page 11). Foster carer as worrying but recognition that that's what parents do. Nothing bad/unhelpful re. communication.

- Don't really use digital media for communication – texting foster carer when out as way of monitoring; don't have full conversations over text/phone as “*you're not payin' attention you're not listenin*” (page 11). Uses digital media when talking to friends about substance use. For foster carers, texting as way of monitoring and ensuring safety. Foster carer will text if heard something on the news and reminding her to be safe. But no full conversations.
- Foster carers' approach to communication about substance use as making her feel more mature and has a better understanding of right and wrong re. use. More mature and responsible as has their support and guidance. Still likes to go out but she does it “*within myself*” (page 12); self as more mature than friends; likes being more mature as feels more confident.

Appendix 22. Extract from theme table used during data analysis

Shared doing – in the car		
Angel (RC, B) Alcohol	“we were in a car going to a meeting [Hannah: okay] em a LAC review for her and we were in the car and we were talking about who would be at the LAC review...she was quite open about talkin' about...em how difficult her family life had been and she kinda just chatted away quite openly like...ma Mum took drugs ma Dad and she was q- I mean I was driving she was talking em I wasn't kinda prompting it she was quite openly givin' sorta the information em so that kinda led me onto talking to her about em h- how much alcohol and what alcohol was doin' to her and em she was quite clear about...em she knew it was wrong em she knew she was drinkin' far too much”	Conversations in the car as useful; allowing young person to be open without needing to prompt them too much. Exploration/asking questions rather than lecturing – she knew what she was doing etc
Diane (RC, B) Alcohol	“I take took eh took her over to the hospital cos she'd got arrested and everything got had cuffs on she was marked whatever so I was we'll go over and get you checked over so again away from this environment out and about in the car and chatting away and she kinda opened up a wee bit more and told me the story exactly what had happened the previous night [Hannah: mmhm] em and kinda talked me through it and I was asking questions and she was quite open”	Being away from unit environment as allowing young people to be more open. Asking questions rather than lecturing
Hope (SW) Various	“if you did it in the car it would stick more though eh there's things that she really holds onto em...because you you're watching the road and you mix it up with just different things like radio whatever”	Less intense as maybe not just talking about substance use/sensitive topic
Jennifer (RC, A) Various	“quite often take them drive in the car [Hannah: yeah] and they don't once there's no eye contact there's just it's the best they just chat away”	Lack of eye contact as key – less intense and personal
Jennifer (RC, A) Various	“we go we've got a wee place we go a drive to and we [Hannah: okay] sort of say right this is not working that's not working how do we move forward here we're gonna do this that and she goes aaaah and d'you know that sort of not necessarily formal it's just that it's a space out we go a wee drive and we sit and we have a chat and reflect on what's been going on and so sometimes the more sort of mark it rather than formal”	“we've got a wee place” – relationship, having something you do together. Exploration, informal,
Julie (RC, B) Various	“and the li- the best some- sometimes the best way em conversation you have it's in a car [Hannah: yes] if you're driving they cannae go anywhere [Hannah: <i>laughs</i>] [<i>laughs</i>] it's true...”	In a space where young people are almost forced to talk – they can't go anywhere
Marie (RC, B) Various	“they don't quite know how to ask they'll do it in the car so that they know you can't go [<i>pretends to stare</i>] [<i>laughs</i>] [Hannah: <i>laughs</i>] em that you're looking straight ahead and they can kinda look out the window and kind of say what they need to say or ask what they need to ask so that's always quite a good tool if you know somebody's kinda wanting to speak about something [Hannah: yeah] let's go along to Musselburgh [<i>laughs</i>] let's go a wee trip in the car and [Hannah: yeah] and then you can kind of very subtly ask or let them kinda just...spew it out”	Young people as starting conversations in the car – doing it on their own terms; lack of eye contact
Sharon (RC, D) Various	“drives in the car's always a <i>really</i> good way to talk to teenagers [Hannah: yeah] because they <i>don't</i> need to look at you [Hannah: yeah] so if there is topics that you	Lack of eye contact as useful; In a space where young people are almost

	need to discuss that's always a good way and they're more like they can't go anywhere if a car's movin' [Hannah: <i>laughs</i>] and they're so they're more likely to sit there you might not always get the information but it is a good a good place to start a conversation is in the car so"	forced to talk – they can't go anywhere; way of initiating communication
Sharon (RC, D) Alcohol	"I would just talk to them about that goin' for a drive in the car and sayin' d'you know so are you drinking this weekend?"	Being outright and asking what you need to ask – in the car gives you this opportunity
Sharon (RC, D) Various	"I think it needs to be...goin' for a drive in the car that's that's the ultimate top one [Hannah: yeah] for me...cos kids <i>don't</i> have to do the eye-to-eye contact when you're driving you can't d'you know so they'll quite happily chat away music's on"	Lack of eye contact, doing something else, more informal
Sophie (15, FC) Alcohol	"we used to drive to school because before like up till summer when I came into care Deborah used to take me like drive me back to [city] [Hannah: okay] back and forth everyday so we used to have these big conversations we'd just end up talking about everything like psychology and all that [<i>laughs</i>] [Hannah: <i>laughs</i>] and then and then we would just like talk about em and then we'd just talk about like experiences like that when we were younger and...how and then she said she can't condone it [alcohol use] or somethin' she said she can't condone it but then...if I do then...it's not like she said everyone will at some point so it's just not gonna be like a surprise but then she would have to report it to social work if I had"	Having conversations in the car about range of topics including alcohol Foster carer would have to tell social work about alcohol use – professional identity rather than as a parent. Quote as different to others – shared doing as way of promoting communication and connectedness, but this suggests opposite
Sophie (15, FC) Various	" <i>yeah</i> I fe- <i>yeah</i> I I like there's somethin' about easier being in the car cos you're not like...I don't like eye contact [Hannah: <i>yeah</i>] with people I d- I have a 'hing with eye contact but like I can...em...like but it's easier in the car but as well I think <i>yeah</i> "	Talking in the car as easier – no eye contact
Susan (FC) Drugs	"when you're driving a car that's a particularly sorta good time as well somethin' comes up on the radio and you pfff can you believe blah blah you know and maybe you know"	Car as useful – distractions from conversation with radio

Appendix 23. Diagram of themes and sub-themes

