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Mapping alcohol use through the care system

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‘Looked after children’ are those who are under the legal guardianship of their local authority (typically also known as ‘in care’). ‘Care leavers’ are no longer legally ‘looked after’ but are still entitled to support from their local authority as they move towards independence (up to the age of 25). This study explores looked after children and care leavers’ (henceforth LACCL) experiences of alcohol consumption (in regard to their own and others’ use), particularly in relation to their trajectory through the care system.

This research is important because the evidence suggests that LACCL tend to start using substances earlier, more regularly, and at higher levels than their peers (Department for Education and Skills, 2006). Relatedly, 12% of young people accessing substance misuse services are looked after (HM Government, 2017), and this group have disproportionately poor outcomes compared to the general adult population, such as in regard to mental health and education (Simkiss, 2012). In 2017 4.1% of looked after children in England were identified as having a substance misuse problem (not including tobacco), with this being more likely among older teenagers than those under 15 years old (Department of Education, 2017).

There is a growing literature on LACCL, including work focusing on their experiences of services and the leaving care transition. However, research on their drug and alcohol use is less common and tends to focus on consumption levels and trends.

Overall, this study aims to ‘map’ alcohol pathways through the care journey, with a particular focus on life milestones and critical junctures in the system. It investigates: LACCL’s relationship to alcohol and the role it plays in their lives; the factors influencing use; current and past drinking patterns; and periods of increased or decreased use.

Method

We conducted 20 face-to-face interviews with LACCL aged 16-20 from the north-east of England. The sample included nine young men and eleven young women. All were white British. They live in a range of placement types including foster care, residential care homes and living independently.

Findings

- The participants tended to start drinking around age 14, but initiation ranged between 12-17 years old. For many, starting to drink was influenced by their vulnerability and a result of being in the care system.

- Placement type appeared to influence alcohol use. Residential homes were seen to be particularly conducive in starting/increasing alcohol consumption (and other drug use), whereas foster care was seen as a moderating, protective factor.

- Most of the young people had gone through periods of increased or decreased alcohol use, often through a conscious decision. Reasons for abstaining or reducing use were often associated with the vulnerabilities and stresses that may be more likely for this group.

- Some had a particularly complex relationship with alcohol and other substances, in particular those who had lost a parent and/or other relatives to alcohol use.

- The majority of the sample drank minimally and/or occasionally. The main reason for this was a purposeful choice to avoid repeating the patterns of parents and other relatives.

- The majority of participants felt that being in care influences alcohol use in a negative way due to one's experiences prior to care and the influence of being in care in itself.

Conclusion

The project has generated new knowledge about the situated nature of alcohol use as it pertains to transitions through the care system. 'Mapping' alcohol pathways in this way gives a more nuanced understanding of LACCL alcohol use and alcohol-related related harm by shedding light on the factors influencing alcohol use. Overall, the findings show that LACCL's drinking patterns can traverse a number of different pathways. The multiple pathways highlighted in this report provide examples of LACCL's different relationship to alcohol and show these relationships are not static.

Background and aims

This study explores LACCL's experiences of alcohol consumption (in regard to their own and others' use), particularly in relation to their trajectory through the care system. It aims to 'map' alcohol pathways through the care journey, with a particular focus on life milestones and critical junctures in the system.

To be 'looked after' means to be a child or young person up to the age of 18 who is under the legal guardianship of a local authority. Care leavers are those aged 18-25 who are no longer 'looked after' but who are still entitled to support from their local authority depending on their circumstances. Children and young people tend to be placed in care due to abuse, neglect or family dysfunction (Department of Education 2017). There are over 75,000 LAC in England (Department of Education 2018) and north east England has a higher than national average number of looked after children per 10,000 under 18 year olds.

Research on young people's alcohol use suggests that excessive drinking (i.e. drinking to intoxication) is a 'normal' part of youth culture; a key part of bonding, friendship and having fun (Seaman and Ikegwuonu, 2010). In the current climate, alcohol brands are heavily marketed to young adults, via both traditional mediums and social media (Seaman and Ikegwuonu, 2010). The cost of alcohol-related harm to the UK is high and places a significant burden on society and the NHS. For example, approximately 10,000 young people under 18 are admitted to emergency departments each year due to alcohol-related harm. National statistics suggest that alcohol consumption levels are highest in north-east England (National Statistics, 2010). However, recent UK trends are more positive. Fewer young people are drinking regularly (Public Health England, 2018) and more 16-24 year olds are abstaining from alcohol consumption altogether (Fat et al., 2018).

Research on alcohol consumption trajectories (or 'drinking careers') typically explores patterns of initiation, recreational/heavy use, then transition into a more stable and moderate style of drinking as the individual takes on the responsibilities of adulthood (Nelson and Taberrer, 2017). However, this 'traditional pathway' may not apply to all, especially those vulnerable and marginalised young people who may not have the same educational and employment opportunities that mediate their drinking patterns (Nelson and Taberrer, 2017). An example of such a vulnerable group are those currently or formerly 'in care'. So, while it can be argued that teenage drinking is to an extent 'normal', at the same time LACCL may have compounding difficulties which can increase the risk of problematic substance use and dependency (Braciszewski and Stout, 2012).

Rates and trends

The existing evidence shows that LACCL are a vulnerable, high-risk group that tend have poorer outcomes than their same age peers in regard to education, mental health, offending and also substance misuse (Simkiss, 2012). Both the UK and international

research shows that this group have higher rates of problematic substance use and that this disadvantage lasts into adulthood (Braciszewski and Stout, 2012). The evidence suggests that they tend to use at higher and more risky levels than the general adolescent population, but this is not straightforwardly across all substances at all times (Ward, 1998, McCrystal et al., 2008, Backović et al., 2006). For example, in a US-based study (Vaughn et al., 2007) older youth in the foster care system reported similar rates of lifetime alcohol and illicit substance use as the general adolescent population. However, rates of substance use *disorders* were higher. Even if prevalence rates are similar to their non-care peers, those in care are more likely to start using substances earlier and to experience problematic use (such as abuse or dependence) (Baidawi and Mendes, 2010).

When looking solely at alcohol consumption rates, comparisons are even less straightforward. Overall, the published evidence demonstrates that alcohol consumption rates among those currently or formerly in care are *not necessarily* higher than the general youth population. For example, in a study of 14-16 year olds living in Belfast (McCrystal et al., 2008), those in residential care had similar lifetime rates of alcohol use as non-care peers, but the frequency of consumption was higher in the residential group. A systematic review of the international literature on substance use among current and former foster care youth (Braciszewski and Stout, 2012) found that although they appear to report similar alcohol frequency as their same age peers, for care leavers both lifetime and past year alcohol disorders were significantly pronounced compared to the general population (Braciszewski and Stout, 2012).

Context and motivations

A smaller body of work explores the context of substance use, such as the influence of residential care (Backović et al., 2006, MacLean, 2012, Monshouwer et al., 2015) and key times of transition such as leaving the care system (Baidawi and Mendes, 2010). This work demonstrates that a range of factors contributes to substance use, such as environmental, systemic, institutional and psychological factors. For example, a study comparing rates of alcohol, cannabis and tobacco use among teenagers in residential units and with their non-care peers (Backović et al., 2006) found no difference in alcohol use rates (although tobacco and cannabis rates were higher in the care group). However, one statistically significant difference was the main reason for drinking. The main reason cited among the care home youth was ‘the desire to be accepted by friends’ whereas for those living with birth family the main reason was ‘enjoying the taste of alcohol’. Also, those from care homes were more likely to state feelings of loneliness and lack of self-confidence, which may bear upon their reasons for drinking.

Placement type may also influence drug and alcohol use. Once in care, looked after children may live in a range of placement types, such as residential care homes, live with foster carers or kinship carers, or remain with birth parents while under supervision from social workers. Recent English statistics show that those in foster care appear to be less likely than those in other placement types to have an identified substance misuse issue (2.1% compared to 10% respectively) (Department for Education, 2018). The evidence

suggests that residential care homes may be an environment that particularly increases the likelihood of risky behaviours, due to the 'hostel' like nature of homes, proximity to peers, and that such placements tend to cater for the most vulnerable and complex young people (McCrystal et al., 2008, MacLean, 2012, Barn and Tan, 2015, Biehal et al., 1995, Monshouwer et al., 2015). This may also apply to care leavers who are moving towards independence. For example, in a study of former foster youth in England (Barn and Tan, 2015), those who lived in transitional accommodation such as hostels and temporary accommodation, and who also reported lower levels of living skills, were more likely to have frequent illegal drug use. This suggests these environments may be unstable and inadequate for former foster youth and expose them to a risky drug environment.

Some research looks at the drug and alcohol use of vulnerable and marginalised young people, who likely face similar disadvantages as LACCL (Nelson and Taberrer, 2017, Melrose, 2004). In a study of the drinking patterns of English NEET (not in employment, education or training) 14-23 year olds (Nelson and Taberrer, 2017), alcohol was a significant factor in the majority of the participant's lives. Peers and friends were the main influence on drinking, and the participants drank as a way to belong, make friends and have fun. However, they also drank to cope with their social isolation and to relieve the boredom of having 'nothing to do'. So while they may have felt excluded from work, school and other social situations, they found a sense of belonging in drinking with friends (Nelson and Taberrer, 2017). Another study (Melrose, 2004) explored the substance use of looked after children, offenders and those excluded from school (sample age range was 13-18 years old). Thirteen of the 49 participants were members of all three groups. The young people in Melrose's study initiated alcohol use for a combination of reasons: to block things out and/or escape from past traumas, peer pressure and acceptance, and seeking thrills. However, Melrose argues that substance use for these vulnerable groups is more risky than for other young people as it further entrenches their social exclusion and disadvantage.

To summarise, the majority of the published literature on LACCL's drug and alcohol use focuses on prevalence rates and/or associated risk factors. Together the existing evidence presents us with a complex picture of substance misuse rates and the influences on use. One of the problems in trying to understand this group's substance use is that it is difficult to unravel to what extent increased and/or more risky use is due to negative pre-care experiences (such as neglect or abuse), to the experience of being in care, or both (Ward, 1998, MacLean, 2012, Barn and Tan, 2015, Braciszewski and Stout, 2012). There is less research, particularly qualitative, that specifically explores alcohol use, and little research that focuses on the nature or context of consumption. Some work focuses on the drug and alcohol of vulnerable young people (Nelson and Taberrer, 2017, Melrose, 2004), but does not explicitly focus on LACCL.

The aims of the current study are:

- To explore LACCL's alcohol use and how it relates to circumstances in their lives.
- To explore how alcohol intersects with their journey through the care system in order to 'map' alcohol pathways through the system.
- To generate new knowledge about the situated nature of this group's alcohol use as it pertains to transitions through the care system.
- To highlight the implications of the findings for policy and practice, particularly in relation to drug and alcohol services and child protection social work.

Method

Participants

The sample included nine young men and eleven young women, aged between 16-20 years old. Seven were classed as 'looked after' and twelve were transitioning towards independence and classed as 'care leavers'. All were white British, however one young man's birth family were members of the travelling community. This is in keeping with local demographics. We used purposive sampling techniques to ensure diversity with regard to age, placement type and experiences of alcohol and other drug use.

The participants lived in a variety of placement types: two were living independently, three were in long-term foster care, seven were in supported accommodation, two were in emergency/temporary accommodation, four lived in a residential care home (two of which were transitioning to independence by living in an independent flat within the residential home), one was in kinship foster care, and one lived with her biological father after leaving long-term foster care at 18 years old. Six were in education (two of which were in higher education), four were in an apprenticeship or training scheme, four were working (one of which was voluntary work), and five were classed as NEET (not in education, employment or training). One of the young women was a mother and another was pregnant. One of the young men had cerebral palsy.

Recruitment

We recruited participants through established local authority contacts who work with LACCL, in particular those working in regional Children in Care Councils (CICC). Each local authority has a CICC council made up of young people in care. A key contact cascaded information about the study to other local authority staff in the region and included the participant information leaflet. Staff also talked about the study at CICC meetings and handed out participant information leaflets. They contacted the researchers if a young person indicated that they would like more information and/or would like to take part. Our contacts then liaised between the researchers and the young person to organise an interview. Prior to interviews, researchers spoke to participants to discuss the study in more detail and go through the process of informed consent.

Data collection

The project was a small-scale exploratory qualitative study that comprised of 20 one to one, semi-structured interviews. We chose this method for its strength in exploring participants' experiences, feelings and perspectives. A semi-structured approach means that researchers had a question topic guide but remained flexible and had the scope to explore unforeseen areas of discussion. We asked the participants questions about their current and past drinking patterns, experiences of alcohol use (their own and others'), influences on their use, feelings towards alcohol, about periods of increased or decreased use, and to reflect on their alcohol use and relationship to drinking.

Most interviews lasted between 30 and 45 minutes. Interviews were conducted at a time and place convenient to the participant. Three participants were interviewed in their own home, one in a café, and the remainder during scheduled CICC meetings within local authority buildings. Interviews were audio-recorded with the young person's consent. One person declined to be recorded and detailed notes were taken during the interview. Two participants chose to have another person present during interview (one partner, one social worker).

Ethics

The study was approved by the Faculty of Medical Sciences Ethical Committee at Newcastle University (approval number 1479). All potential participants received a participant information leaflet prior to having any direct contact with the research team. This outlined the purpose of the study, stressed that taking part is voluntary and that all information is confidential and will be anonymised. However, it also highlighted that if the young person discloses any harm to themselves or others that the researchers are duty bound to inform social services in line with local safeguarding procedures. Before conducting interviews, the researchers reiterated the key points from the information leaflet and consent form to clarify that participant understood. All participants gave informed consent to participate. Interviews were held in a private space to ensure confidentially. The participants received a £10 ASDA gift voucher as an incentive for their time.

In case the young person experienced some upset or discomfort in relation to discussing personal issues and sensitive topics, or stated that they would like more information and/or support, the researchers had information about local drug and alcohol support services to hand. However, this situation did not arise in any of the interviews.

Audio-recordings were transcribed and anonymised by an external transcription service. The transcripts were saved securely and accessed by the research team only. Consent forms were locked in a secure filing cabinet. Data was accessed, stored and managed according to Newcastle University's Research Data Management Policy Principles and Code of Good Practice. We use pseudonyms for participants throughout the report.

Analysis

The interview transcripts were subject to thematic analysis (Braun and Clarke, 2006, Ezzy, 2002) . This is an approach commonly used in qualitative research in which analysis is an ongoing, iterative process. It is an inductive, but informed, mode of analysis that allows themes and findings to be interpreted from the data. Both authors listened to recordings and read transcripts multiple times in order to agree on main codes and themes. Qualitative software (Nvivo 10) was used to organise, code and analyse the data.

Findings

Current drinking patterns

The young people varied in their current alcohol consumption patterns; the sample included a range of drinking styles from abstainers to heavy episodic drinkers. Two young men (both 17 years old) had never tried alcohol, stating that they did not drink because they were under-age and it was illegal. However, both were looking forward to trying alcohol when they were 18. Five people mainly engaged in heavy weekend drinking on 'nights out' in town centres, often accompanied by pre-drinks in someone's home. However, the majority of the sample drank minimally and/or occasionally. Some young people had always been so, whereas others had made a conscious decision to reduce or stop drinking after a period of heavy use. Five of the participants disclosed that they had current or past experience of other illegal substance use.

The young people tended to talk about current drinking in a positive manner and as something that was for the most part, an enjoyable activity. The main reasons for drinking were socialising with friends, having fun, and relaxing. Cited negative effects included hangovers, the cost of a night out, making a fool of oneself, or having arguments with friends and partners. Only two young people stated that they drank for less positive reasons. One young woman said she had recently drunk due to university exam stress, and another young woman drank to forget things that were going on at home as she was currently her father's main carer. Nevertheless, both highly enjoyed the process of drinking and spending time with friends.

Eight of the 20 participants disclosed that their parents were (or had been) heavy drinkers, 'alcoholics', or involved in other substance abuse, and this was often the main reason the young person had been taken into care. Three of the young men had lost a mother due to alcohol abuse/alcoholism.

Starting to drink

Three of the participants whose birth parents drank heavily recalled accidently drinking an adult's alcohol for the first time at a very young age. A few described being allowed to try alcohol moderately at family occasions as a way of learning about responsible alcohol

use. However, the young people began consciously drinking with friends between 12 and 17 years old, with the majority having tried alcohol by age 14. They typically drank in public areas such as parks and fields, for the purposes of getting intoxicated, which often resulted in vomiting. They cited drinking cheap white cider and spirits such as vodka, drinking "whatever they could get their hands on". They typically obtained alcohol asking a passer-by to go into an off licence or by knowing a shop where they could get served underage.

Such patterns can be located in a typical teenage trajectory of beginning to experiment with alcohol and bonding with peers, with some young people clearly stating that it was their choice and they were not unduly influenced or subject to peer pressure. However, for some of the young people in the study, their vulnerability and fact of being in the care system did influence this phase in their lives. For example, some started to drink for reasons such as to 'fit in', 'make friends', 'peer pressure', and to 'forget'. We go on to explore such influences below.

Placement type

One of the main themes in regard to starting and maintaining alcohol consumption was placement type. For many of the young people who experienced living in a residential home, this was their first placement within the care system. Significantly, moving into the care home tended to coincide with beginning to consume alcohol, typically with others living in the home. For example, Estelle moved into a residential home at 12 years old and began to drink with other residents in order to 'fit in'. When asked if she would have started drinking at that age if she had not been in that environment she felt not:

"I don't think I would have drank at all because I if was still at my mum and dad's, my dad would probably kill me if I did. He would probably ground me forever" (Estelle, 17, temporary hostel accommodation).

The young people described residential homes as environments that particularly encouraged and/or were conducive to alcohol consumption and other drug use. This was due to availability and/or similarly vulnerable young people living together and influencing each other. A young woman who started drinking at 12 years old upon entering residential care reflected on this:

"When there's a group of people put together, that are all maybe a little bit more vulnerable than everybody else, they're going to rub off on each other and they're going to do things that aren't safe and that they shouldn't be doing" (Megan, 19, living independently).

Other environmental and institutional factors may play a part, such as the regulatory nature of such homes and the differences between a 'normal' family home. For example, homes have increased levels of surveillance, such as risk assessments and the mandatory reporting of certain behaviours to police and social workers. Rules and regulations include kitchens being locked at a certain time, resulting in residents having

no access to food. Such 'differences' to their peers outside the care system served to frustrate residents. Jenny described how this made her angry and increased her desire to drink heavily to deal with this, but then she would 'kick off' within the home when intoxicated.

Some participants also described how residential staff were limited in some aspects of discipline and also by the reality that they are not the residents' biological parents/family, and therefore lack genuine *parental* care. Megan described this when asked if the residential workers knew the extent of her regular intoxication with others in the home and how they dealt with it:

"I think they knew [we were drinking], they did know, but, like I say, there's not so much they can do……. And there's no parental authority. Like even if you have care workers and stuff like that, your [real] mam doesn't swap with another mam in three days' time and then come in. And you don't have locks on your [doors]- Just things like that. There's no parental authority, like there isn't, and there's nothing really that they can do. It's really just basic things that they can do" (Megan, 19, living independently).

In contrast, the participants spoke about the potentially mediating effects of foster care and how it differed to residential care. For example, both Megan and Jenny reduced their alcohol consumption when they left residential care and were placed in a foster home. Reasons for this included: having less desire to drink, having a good relationship with and 'respect' for their foster carer, being in a 'normal' family environment, and feeling genuinely cared for:

"I think foster care, if you're on your own and it's just you and the carers, I would feel like it would be more relaxed, it would just be like a homely environment. [But] In a residential home, I feel like if you were with people your age, if there was a bunch of 15, 16 year olds living together, I feel like they would pressure each other into trying different stuff" (Steve, 18, semi-independent flat within a residential home).

One young woman who was a minimal drinker believed that foster care "straightens people out" and that she would have drank more if she had not been removed from her birth parents who were heavy drug and alcohol users:

"… but we've all, like, because of our foster carers, if I still lived with my mum, no offence to her, I would have probably been in prison, on drugs, on the streets, but because I had a different path I was saved, kind of thing" (Carrie, 19, living independently).

Transitions and changes

As with young people's drinking more broadly, LACCL in our sample had drinking 'careers' that transitioned through periods of increased or decreased alcohol consumption. Examples of periods of increased use included: living away from home at university, living in a residential home (as discussed above), or during a period of travelling/living overseas with other young people. Sometimes changes towards less

consumption occurred subtly and gradually in the process of getting older and moving towards independence, such as the young person no longer wanting to drink in parks and public places, consumption becoming legal at 18, entering a relationship, or beginning to earn money. Sometimes a reduction in alcohol was the result of a conscious decision.

One young woman, who started drinking later than most of the other young people (at 18 years old), decided to stop drinking after reflecting on her behaviour and the potential negative consequences of intoxication. This period of abstinence lasted a few months until she went to university, which she described as having a 'big drinking culture'.

"I just didn't really like the out-of-control feeling you get when you're drinking, so I stopped. I think it helped me realise when I need to stop and stuff like that. So, now, I'm fine really, on alcohol, but I used to be maybe a bit aggressive and get quite bad when I was drunk, so I stopped……I found it fine. I didn't find it hard to stop. It was just, when I went to uni, it's such a big drinking culture. I did miss it, so I started again…..I didn't get peer pressured into it. People were fine with me not drinking, but I just missed it and I wanted to drink again" (Nicole, 20, university accommodation in term time, supported accommodation at other times).

Other reasons for stopping/reducing drinking were the particular vulnerabilities and stresses that are more likely to occur in the lives of vulnerable young people. Megan, who loves 'nights out', became pregnant at 15 and had reduced her drinking due to motherhood. She no longer takes drugs recreationally as it is 'scruffy' and is aware of others' perceptions of mothers who drink too much alcohol. Another young woman stopped drinking due to the stress of coming into contact with her birth mother via Facebook and the possibility of developing a relationship.

Another care leaver had reduced her drinking due to caring responsibilities. Amber implied that her father was a former heavy drinker and cannabis user. He had recently had emergency heart surgery and since then her drinking had been 'non-existent'. She felt she had to be more adult than other young people her own age:

"As you can tell I've never been a big drinker, but I would like to drink more and get out more. But since my dad got poorly and he's been out of hospital and stuff, it's just not possible because I've got to be there all the time, in case something happens, or he can't do something. It's very frustrating because I want to act like a 20-year-old; not like someone who's much, much older, who doesn't drink, who doesn't go out. I just want to be like your average 20-year-old that can go out and have a drink. But I can't because I've got a house, I've got my dogs and I've got my dad, which makes it pretty impossible to go out and have a decent night out without worrying what's going on back home. And it's really frustrating" (Amber, 20, living with biological father).

However, reducing alcohol use is not necessarily straightforward, and some of the young people had a complicated relationship with alcohol and other substances. Two of the young men who had lost their mother due to alcohol misuse had recently made a choice to stop drinking, but only after a period of extensive alcohol use. James started to drink at 12 years old. James (19), whose mother died when he was four, drank fortnightly with

friends in parks until he turned 18 and then “went bad on the drink”. He drank alcohol every day, secretly having vodka in a water bottle while at college as he “preferred to be drunk”. He decided to stop drinking because “it killed my mother” and did so without assistance from services. He now abstains. Jack (17) also started drinking at 12 and has been a regular polydrug user from 14. His mother passed away from liver disease in 2016 and Jack decided he did not want to go down that route and end up in the same situation. He now drinks monthly and only drinks lager or cider, as opposed to spirits. However, both Jack and James admitted that they have simply ‘switched’ to cannabis and smoke daily as a way to relax and cope.

Choosing different pathways

As described above, many of the participants were minimal or non-drinkers. Some of these young people had made a deliberate choice about this. They never or rarely drank, avoided intoxication, and did not imagine that their drinking patterns would change in the future. Interestingly, the main reason for making this choice was to avoid being like their parents and/or other birth family members who had drank (and/or used drugs) heavily. These participants wanted to ensure their lives took a different pathway.

One such young woman described how most of her birth family used alcohol and drugs when she was growing up, and described it as a hectic and chaotic environment in which she did not feel safe, due to constant fights and the need to protect her younger siblings. She said this had specifically influenced her choice to not drink:

“I think it’s just made me think that I don’t need it. I always think that after just one drink from them and they’re all going mad, I feel like it might happen the same way for me. So I don’t ever want to try, to make sure that doesn’t happen” (Sophia, 18, supported accommodation).

One young man had been born prematurely due to his mother’s alcohol use and both his mother and paternal grandfather had also died due to alcohol-related circumstances. Ethan enjoyed a couple of whisky and cokes for the pleasure of the taste but avoided being drunk due to his experiences:

“I’ve been tipsy once. And I don’t get drunk. If I feel myself leaning over, I just stop. Because there’s not a lot of point. I don’t need it as an emotional crutch, and I don’t want it as an emotional crutch. I just want to enjoy the drink that I have. It’s mainly a social thing. It’s nothing important to me, you know? I don’t want to even risk becoming either of them, and what they became. Which was a total freaking mess” (Ethan, 19, supported accommodation).

However, after this discussion, Ethan disclosed that, like Jack and James, until very recently he has been a heavy cannabis user. This demonstrates that this group of young people have an understanding of the risks associated with alcohol use, however, they can often transfer their substance of choice rather than abstain completely, as they desire the often ‘comforting’ feeling that intoxication presents.

Even among those that drank to intoxication and enjoyed drinking with their friends, there was nevertheless a strong awareness and/or wariness of the risks of alcohol addiction and the possibility they could be like their family members as they may be pre-disposed to alcohol problems.

"Well, it's scary because I don't really want to turn like that when I drink. I know I don't, but when you first start having alcohol you're a bit wary because, obviously, my mum and dad were like… so, you're like, well, I might have the traits of it. So, it makes you scared because you don't really want to hurt someone, you don't want to do something that's wrong" (Lisa, 16, kinship foster care).

The influence of care on drinking

So far, we have shown the various influences and circumstances that may bear upon LACCL's alcohol use. During the interviews we explored whether the young people felt that being in care system affects alcohol use. Given the sensitivity of this question, we said the question could be about their use specifically or about young people in care in general depending on what they felt comfortable in discussing. There were a variety of opinions but the young people gave their opinions eloquently and poignantly.

Some felt it was likely to increase use or make it more likely, but some also conversely said it could work in the opposite direction, in that being in care and one's experiences could made one drink less (as we've seen above) and be adamant not to end up like one's birth family. They cited a number of reasons that could affect use, which reflect the above findings:

- The specific conditions of residential care could increase the likelihood of use, such as the lack of discipline and the difference to a 'normal' family environment, and being grouped together with similarly vulnerable children and young people.
- Having been around adult/parental drug and alcohol use when younger and also the childhood experience of trauma, abuse or neglect.
- The trauma of being in care in itself.
- Or, that entering care (particularly foster care) was a positive influence that could 'save' LACCL following in their birth family's footsteps.

Of those who discussed this issue, 12 young people felt that being in care influences alcohol use in the sense of making drug and alcohol use more likely, whereas four felt that it did not. Those who drank minimally were more likely to believe that being in care did not make alcohol use more likely and that consumption patterns were down to the individual person. This is the opinion of Jon who had until recently lived in a residential home where all the other young men but himself used drug and alcohol problematically:

"To be honest, I don't think being in care makes people want to drink. I think it's them. You can't blame it on care. Every child is going to do it. Every single child in the world will

do it. Maybe not in America because you will go to jail but in England you will do it. People who are 12 do it…It's just the type of people. You always meet that type of people who are like that" (Jon, 17, supported accommodation).

In line with the above findings about choosing different pathways, being in care had the potential to influence in either direction; one could end up repeating their parents' patterns or being more determined not to have the same problems:

"And for kids in care, a lot of them do sort of follow in their parents' footsteps, whether it's alcohol, drugs, stuff like that. A lot of them do follow in their footsteps but there are also a lot of them that say, "No, I'm not going to be like my parents. I'm going to make a better life for myself." But it really just depends on what kind of experience they've had within the system" (Amber, 20, living with biological father).

However, the majority of the young people did feel that being in care influenced alcohol use in more a negative way, in terms of how much they drank, when they started drinking, and the reasons for drinking. This could be due to experiences prior to care and/or being in the care system itself.

"People in care normally always drink...It's because of their situations, they have to. Not have to...Like, [it] helps to forget stuff and that" (Jenny, 17, living independently).

"I just think it [being in care] does affect the way you think about things. You're much more easily led on by your friends and stuff…I know I was" (Anna, 19, foster care).

"And it's a social group, you know? It's like a little sector that care kids seem to fall into. And a lot of the time it's, you know, abused kids and neglected kids. Mainly neglected kids. Which is why care kids usually find themselves in this situation; it's because they'll find themselves abused and neglected, and go into care, and they'll have already had a history of drugs and alcohol...And so they'll come into care with this experience and share it with everyone else. You know, and that's why it's so readily available in care, it is because a lot of people in care are from abusive, neglected backgrounds….And then obviously you try it a couple of times, and somewhere in your head you realise that it makes you feel better, so you continue" (Ethan, 19, supported accommodation).

Conclusions

This project has generated new knowledge about the situated nature of alcohol use as it pertains to transitions through the care system. 'Mapping' alcohol pathways in this way gives a more nuanced understanding of LACCL alcohol use and alcohol-related harm by shedding light on the social and psychological factors driving alcohol use.

All of the young people who took part in this study were able to critically reflect on their own and others' alcohol consumption. While some of their drinking practices can be related to typical teenage drinking trajectories, this group faces additional vulnerabilities and influences in regard to alcohol use.

LACCL appear to be vulnerable to initiating alcohol use at an early age (as young as 12 years old), as peers and environmental factors can influence them. The main points of transition within the care system can also influence use, particularly entering and living in a residential care home. Our findings suggest these institutions are a particularly risky environment for starting to drink and/or increasing consumption.

Many of the participants drank very minimally and/or occasionally and were determined not follow the same pathway in relation to drug and alcohol use as their parents and other family members. In contrast, some had complex and difficult relationships with alcohol and other substances, particularly those bereaved in childhood. Negative and positive reasons for drinking co-exist – LACCL can drink to have fun with friends and find it enjoyable, but at the same time be drinking to 'forget', cope or 'fit in'.

Overall, the findings show that LACCL's drinking patterns can traverse a number of different pathways. The multiple pathways highlighted in this report provide examples of LACCL's different relationships to alcohol and show these relationships are not static.

This study has a number of limitations. The findings are based on a small sample and therefore not generalisable to all LACCL or those living in a different region. The majority of sample were LACCL involved in CICCs and who therefore may have been more engaged and willing to take part than other LACCL.

Implications

This project is of benefit to those seeking to reduce risky substance use and alcohol-related harm amongst LACCL (and other vulnerable young people). This research will particularly benefit residential home staff, foster carers, providers of health and social care services (particularly social workers in Children's Services), and alcohol and other drug charities and services.

Recommendations for policy and practice:

- Alcohol (and other drug) education and advice may be appropriate for some looked after children as young as 12 years old. This could be from a drug and practitioner, social worker, or other supportive adult.
- Residential home staff need regular training around drug and alcohol knowledge, such as spotting symptoms and providing low-level advice and guidance. Homes should consider having an embedded drug and alcohol worker. However, this all depends on funding and resources.
- Social worker and carers need training and awareness of how key transitional moments in the care system can influence alcohol consumption.
- Further, professionals and carers should have regular discussions with LACCL in which they reflect on their relationship to alcohol, even if they are minimal drinkers or abstainers as this will help to support the young person and for them to understand

their own situation. This should be built into meetings with social workers and young people's advisors.

- However, a universal approach to LACCL substance use is inappropriate as this group have a wide range of complex situations and relationships to alcohol.

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