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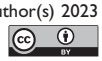

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Care-experienced young people's reflections on their relationship to and use of alcohol: A qualitative exploration

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Abstract

Evidence suggests that looked after children and care leavers start to use alcohol earlier than their peers and at higher levels. Much of this epidemiological research focuses upon a pathological vulnerability within the young people concerned, but qualitative research which elicits their experiences with alcohol enables a more nuanced understanding. This article explores the experiences and reflections of young people in care regarding their exposure to and use of alcohol. Twenty qualitative semi-structured interviews were conducted with young people who were members of Children in Care Councils (CiCCs) across the North East of England, and a socio-ecological model was used to guide data analysis. The findings suggest that experience prior to being in care, such as witnessing the detrimental effects of alcohol misuse and transitions within the care system, can both precipitate and deter an individual's use, particularly when

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entering and living in residential care. The study highlights how a mixture of social and contextual factors influence young people in care's perceptions and use of alcohol.

Keywords
Young people in care, looked after children, qualitative research, alcohol use, alcohol abuse

Background

Looked after children and care leavers (henceforth referred to as young people in care) aged 11–19 years have a fourfold increased risk of alcohol and drug use compared to their peers and have been found to drink alcohol more frequently and at higher intensity than those who are not care-experienced (Meltzer, 2003). Young people in care are among the most disadvantaged in society, often experiencing significant childhood adversity, including multiple forms of abuse and neglect, family dysfunction and absent parenting (Department for Education [DfE], 2017). The *Adverse Childhood Experiences (ACEs)* study (Dube et al., 2006) assessed the impact of childhood stressors commonly experienced by children prior to care entry, including emotional, physical and sexual abuse, emotional and physical neglect, household dysfunction, parental discord, family breakdown and reconstitution, parental mental illness, substance misuse and incarceration, upon a wide range of adolescent health behaviours and outcomes. It found that all stressors, with the exception of physical neglect, increased the risk of early onset drinking, with experience of an individual ACE increasing the odds threefold of adolescents having ever drunk by the age of 14 years. A large body of evidence also shows a significant association between parental substance misuse and the child's own use of substances (McGovern et al., 2018; Yule et al., 2013), with parental substance misuse being significantly associated with early onset adolescent drinking (Kerr et al., 2012; Vermeulen-Smit et al., 2012), intoxication (Haugland et al., 2015; Keeley, Mongwa and Corcoran, 2015) and the development of alcohol problems such as binge-drinking and alcohol consumption at risky levels (Kendler et al., 2013). Moreover, exposure to family conflict and intimate partner violence in childhood (Bair-Merritt, Blackstone and Feudtner, 2006), as well as physical and emotional abuse, have each been associated with increased chances of developing an alcohol problem, potentially leading to long-term health problems (Norman et al., 2012). Experiencing multiple ACEs has been found to have a modest effect upon heavy alcohol use (increasing the odds by two- or threefold) and a strong effect upon alcohol problems (increasing the odds by four- to sixfold) (Hughes et al., 2017). In addition, young people in care have fivefold increased odds of experiencing at least one mental health problem compared to their peers, further increasing their risk of alcohol problems in adulthood and poor life chances (Ford et al., 2007).

Following entry into care, environmental, psychological and systemic factors may further contribute to the alcohol use of young people (Backović et al., 2006; MacLean, 2012; Monshouwer et al., 2014). In a study by Meltzer (2003), children (aged 11–17 years old) placed in residential units were found to drink alcohol more frequently than those in foster care; 42% drank alcohol at least once a month, compared with 25%, figures considerably higher than the 9% for young people not looked after (Meltzer, 2003). Thus, while it is well established that the child's environment and transient lifestyle can have adverse effects on

young people in care, it is also the case that placement type, whether foster, kinship or residential care, can also influence levels of alcohol and/or drug use. Evidence suggests that instability within placements can also exacerbate the difficulties a young person may encounter (Rock et al., 2013) and that residential settings are particularly vulnerable in terms of raising the likelihood of engaging in multiple risk behaviours due to the proximity to peers with complex needs and the 'hostel'-like feel of the facilities (Barn and Tan, 2015; MacLean, 2012; McCrystal, Percy and Higgins, 2008; Monshouwer et al., 2014). Conversely, young people in foster care are less likely than peers living in other placement types to have an identified substance misuse problem: 2.1% compared to 10% respectively (DfE, 2018).

The vulnerability of young people with care experience is acknowledged in numerous policy documents, such as the UK Home Office's 2017 *Drug Strategy* and the National Institute for Health and Care Excellence (NICE) guidelines, *Drug Misuse Prevention: Targeted Interventions* (NG64; NICE, 2017) and *Alcohol Use Disorders: Prevention* (PH24; NICE, 2010), all of which identify children in care as a 'high-priority group' at increased risk from substance-related harm. Despite this awareness, there is limited research and a noticeable absence of data regarding the interventions that are most effective at decreasing risky drug and alcohol use among this group (Alderson et al., 2020).

Whilst these epidemiological studies highlight the risks experienced by young people in care, the existing research does not shed light on how they experience the risks they have been exposed to, the interaction these risks have with alcohol use and why some individuals do not (mis)use alcohol despite their vulnerability. The current study seeks to provide a deeper and more nuanced understanding of these issues by exploring the self-reported experiences and reflections of young people in care regarding their exposure to and use of alcohol. It specifically investigates the relationships the young people have with alcohol and the role they perceive it plays in their lives.

Methods

Young people in care were recruited from already established Children in Care Council (CiCC) meetings across the North East of England between June and August 2018. In the UK, each local authority has a CiCC specifically designed to give young people in care and care leavers an opportunity to express their opinions on how the local authority should run its children's services.

Once ethical approval had been obtained from Newcastle University (approval number 1479), the researchers liaised with participation officers running the local CiCC groups to access participants willing to take part in one-to-one semi-structured interviews. The participation officers discussed the research with group members and distributed a leaflet that outlined the purpose of the study, what participation involved, and issues of confidentiality and anonymity.

When a young person expressed an interest, the participation officer contacted the researchers and acted as a mediator to help organise an interview. Twenty-two young people agreed to participate but two females later changed their mind, reducing the study sample to 20. Semi-structured interviews were chosen to enable the researcher to be flexible in exploring participants' experiences and perspectives whilst also having the scope to venture into unforeseen areas (Ritchie and Lewis, 2003; Rubin and Rubin, 2012). The interviews focused on the young people's personal alcohol consumption, environments, the social

networks they associated with use, their exposure to alcohol consumption and intentions regarding future alcohol consumption.

Interviews were organised to accommodate the young people's preferred time and location but most ($n = 16$) elected to take part within established CiCC meetings, with three choosing their own home and one a local cafe. The interviews lasted between 20 and 40 minutes.

After the research had been explained, questions answered and written consent obtained, the interviews were conducted by one of two post-doctoral researchers, both of whom had previous experience of undertaking qualitative interviews with young people in care and working with those accessing drug and alcohol and/or youth services. Interviews were audio-recorded (with the exception of one as the young person declined) and transcribed verbatim. Transcripts were anonymised and all identifiable information relating to the participant sample was stored securely in a separate location.

The young people were each given a £10 shop voucher to thank them for their contributions.

Participant demographics

The young people participating in the research were aged 16–20 years and resided in the North East of England. They were all of White British ethnicity, which reflects the local population of children in care. The final sample comprised of 11 females and nine males. Six participants were in education (two of them in higher education), four were attending an apprenticeship or training scheme, four were currently in employment and six were classed as Not in Education, Employment or Training (NEET).

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, but most of the sample drank minimally (2–4 units per drinking session) and/or infrequently (monthly/on special occasions), although some of these young people had experienced periods of heavy episodic drinking. Five of the young people mainly engaged in heavy weekend drinking on 'nights out' in town centres, often accompanied by pre-drinks in someone's home. One young man previously drank daily but now abstained. Five of the participants also disclosed that they had current or past experience of other illegal substance use.

Further participant demographics are shown in Table 1.

Analysis

When analysing the interviews, we took an inductive approach, constantly comparing the interview transcripts to identify emerging themes. It was clear that alcohol use was influenced by multiple factors in the young person's environment. This led us to use the socio-ecological paradigm due to its utility in providing a theoretical framework through which to understand the findings.

The socio-ecological paradigm was first introduced in the 1970s by Urie Bronfenbrenner who proposed that behaviour and social environments influence one another in a two-way process (Bronfenbrenner, 1979). Since his original work, the model has been adapted, and this article draws on the framework described by McLeroy and colleagues (1988) which considers influences at multiple different levels: individual, interpersonal, organisational,

Table 1. Participant demographics.

Pseudonym	*Gender*	*Age*	*Placement type*	*Age of initiation (in years)*	*Current alcohol use*
Steve	M	18	Residential	13	Weekly – binge drinker
Callum	M	17	Residential	n/a	Abstinent – waiting until legal
Kyle	M	17	Foster care	16	Infrequent/special occasions
Ashley	F	17	Emergency accommodation	n/a	No audio-recording available
Kelsey	F	17	Residential	14	Infrequent/special occasions
Megan	F	19	Independent living	12	Monthly – binge drinker
Rob	M	17	Independent living	n/a	Abstinent – waiting until legal
Lisa	F	16	Kinship care	12	Infrequent/special occasions
Nicole	F	20	Supported accommodation	16	Weekly – moderate
Jon	M	17	Residential	14	Monthly – moderate
Sam	M	17	Foster care	17	Monthly – moderate
Anna	F	19	Foster care	15	Weekly – binge drinker
Jack	M	17	Supported accommodation	12	Monthly – moderate Previously regular heavy drinker
Amber	F	20	Lives with biological father	14	Fortnightly – moderate
Estelle	F	17	Hostel	12	Infrequent/special occasions
Carrie	F	19	Independent living	15	Infrequent/special occasions
Jenny	F	17	Independent living	13	Infrequent/special occasions Previously most days
James	M	19	Supported accommodation	12	Abstinent Previously daily use
Sophia	F	18	Supported accommodation	16	Infrequent – moderate
Ethan	M	19	Supported accommodation	13	Weekly – moderate

community and policy. At an individual level, characteristics such as gender, ethnicity and age are considered as well as the attitudes, behaviours and knowledge held by individuals, which influence their alcohol use. The interpersonal level considers the formal and informal relationships that a person has with others and how their social networks shape their social identities. At the institutional level, the focus is on the agencies that shape behaviours, and attitudes are scrutinised. The community includes the environment in which an individual lives, especially the way in which it promotes certain social norms and/or offers social networks. Finally, public policy includes any policies or laws related to health behaviours (although our study did not consider this level).

Through this socio-ecological framework, the interrelationships between individuals and environmental settings that can influence behaviours and outcomes can be explored (Richard, Gauvin and Raine, 2011). Consideration can also be given to the proximal environment inclusive of peers, family and support networks and distal measures of community and societal factors (Gartland et al., 2019). The model acknowledges that individuals do not act in isolation and so the contextual factors surrounding them have to be examined in order to understand why they behave and respond as they do (McLeroy et al., 1988).

The quotations included in this article come from the young people in care we interviewed. All names have been changed to protect each individual's identity, and all of the information presented describes their own perceptions of their alcohol consumption and the

environmental factors they perceived to be significant. Formal measurements of frequency and duration of alcohol use were not used. The integrity of the analysis and findings was ensured by discussions among the wider team.

Findings

Individual level

At an individual level, participants recounted their first experience of consuming alcohol and their recollection of how they had experienced it. The age of initiation varied, and some young people recalled tasting alcohol when very young. For some, their first experience was unintended, often occurring as a result of imbibing alcohol without knowing what it was, perhaps due to it being left around the family home or because parents had given it to them. For Jack, Ethan and Sophia, the three young people who described unintentional alcohol consumption, it resulted in them purposefully drinking infrequently and avoiding being drunk, as discussed later in the findings. Several participants described scenarios wherein parents allowed them to taste alcohol:

> I think my first ever time when I got drunk, I was three years old. No lie. My mum left a pint on the floor and I drank it all. (Jack, 17, monthly moderate drinker)

> I'd say that the first memory [aged five to six years old] I have of trying alcohol was she [the birth mother] had a bottle of vodka with her, and I asked to try some. And she giggled a little bit, obviously, because, you know, it's very hard alcohol. And she said, 'Yeah, go ahead'. And I took a swig from it as if it were any old drink, and I spat it out everywhere and nearly cried, because it was that bad. (Ethan, 19, weekly moderate drinker)

Additional examples were provided where parents had misled the young person, seemingly with the intention of deliberately exposing them to alcohol:

> My mam gave me drink but it's always like she's never told me that. She once swapped my drink with hers, and I pointed at my drink and said, 'Is that mine?' and she went, 'No, it's the other one'. It was a Lucozade with vodka in it. So, she gave me that. (Sophia, 18, previously infrequent moderate drinker)

Beyond their first experience with alcohol, the young people reported beginning to consciously drink alcohol as a 'behavioural crutch' to cope with their lack of social skills and bolster their resilience to manage in challenging care environments. Some described finding the transition into care a daunting experience, often recalling anxiety and low confidence, particularly for those who had experienced placement breakdowns and those placed in residential settings. Many of the participants described using alcohol as a coping mechanism to deal with the lack of structure in their day and the perceived minimal or ineffective supervision they received. They articulated a need to occupy their time and found that alcohol was a helpful technique to 'fill time' or relieve feelings of isolation and upsetting thoughts. The trauma that predated their entry into care was also cited as a reason for

drinking alcohol. These young people reported a desire to 'forget' their experiences or manage the ongoing impact they were having on them:

> I think then it was probably to forget stuff that was going on. You didn't have to bother. You didn't have to care. You didn't have any worries then when you were drinking. Everything just disappeared. (Anna, 19, weekly binge drinker)

Furthermore, even participants who discussed currently only consuming alcohol within a social context with friends disclosed some wariness due to their previous knowledge of alcohol intoxication. The theme of being genetically vulnerable was voiced by several participants. Indeed, there was caution at the prospect that they may be susceptible to alcohol dependency at a genetic level, that it may be hereditary and therefore 'passed on':

> 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. (Lisa, 16, infrequent/special occasion drinker)

Similarly, Ethan reported enjoying the occasional whisky and coke for the pleasure of the taste but purposefully avoided being drunk as he associated being drunk with being a 'mess':

> 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 [the birth parents], and what they became. Which was a total freaking mess. (Ethan, 19, weekly moderate drinker)

Given the knowledge that many young people in care have about alcohol misuse, it was not surprising that participants reported heightened awareness of the connection between alcohol, risk-taking and undesirable behaviours. They described often feeling unsafe when in environments where alcohol was being consumed. These attitudes were often associated with prior experiences of intoxication, highlighting how they had observed first-hand the ways in which alcohol reduced the predictability of people's behaviours. These historical experiences of intoxication and associated detrimental effects often manifested later in life, and feelings of being unsafe continued into adulthood. Carrie was a young person who had been exposed to volatile behaviour and domestic violence linked to alcohol and drug use as a child. She described how this still affected her as an adult:

> If a drunk person walks past me I panic, because I think they are going to stab me, they're going to do something, they don't know what they're doing. That scares me a lot. (Carrie 19, infrequent/special occasion drinker)

Interpersonal level

At an interpersonal level, participants described how the formal and informal relationships they had experienced prior to entry into care could act as a deterrent to alcohol misuse. They

described how the alcohol and drug use they had witnessed in their parents and relatives was often in their thoughts and discussed how it influenced their own interactions with alcohol. Whilst there were times when they were more prone to misuse alcohol, such as to cope with stress and uncertainty, they would also frequently worry about doing so, and at the time of the interview they were making a conscious choice to control their consumption. Almost half of the participants highlighted a need to avoid following in the footsteps of their parents or other family members who had abused alcohol and/or used drugs. They explained how witnessing the negative aspects of such behaviour had influenced their current choices with regard to drinking:

> My mam was quite a big alcoholic and so was my dad. [They would] come in drunk every day. Dad was dead violent . . . I think they were dead irresponsible. That's probably one of the main reasons why I'm in care. (Callum, 17, never tried alcohol)

> My mum used to drink a lot . . . she used to get really nasty and come out with abuse and stuff. It wasn't very nice, because I witnessed it at a young age. (Lisa, 16, infrequent/special occasion drinker)

At the time of the interview, these participants described consciously taking actions to ensure that their lives followed a different trajectory to that of their parent(s). One described growing up in a chaotic environment where she observed her birth family using alcohol and drugs and constantly fighting. This negative association between intoxication and alcohol use had specifically influenced her choice to currently abstain from drinking due to her being fearful that she would be unable to control her own behaviour:

> 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, previously infrequent moderate drinker)

Similarly, Amber reported an awareness of multiple family members consuming alcohol excessively – behaviour she identified as 'unacceptable' – and observed that this had directly influenced her choices regarding her own consumption:

> I guess I didn't want to start [drinking alcohol] early, because I knew my mam had started drinking from a young age. And both my grandparents drank, and my dad drank. Even that young, I sort of understood and kept telling myself I didn't want to be like them. (Amber, 20, fortnightly moderate drinker)

It transpired, however, that some of the young people whose drinking habits had been affected by their experiences used alternative substances instead. Ethan was a child who had been born prematurely due to his mother's alcohol consumption. He explained that he had witnessed both his mother and his paternal grandfather die in circumstances that were directly attributable to excessive alcohol use. The combination of witnessing abuse and experiencing the loss of two family members deterred him from drinking. However, he knew he was still vulnerable to addiction and disclosed that until very recently he had used cannabis daily to 'relax and chill out'. Two other participants who had lost their

mothers due to alcohol misuse explained that they had experienced periods of excessive and problematic substance use. James (19 years) described drinking with friends in the park between the ages of 12 and 18 years, when he stated he 'went bad on drink'. He recalled how he had started drinking daily, 'preferring to be drunk', and secretly took vodka in his water bottle to college. He decided to stop drinking because 'it killed [his] mother', and he is currently abstinent. It is clear from his account that whilst he is appreciative of the dangers related to alcohol, he did not possess the skills and/or support to circumvent using it problematically. Jack (17 years) also lost his mother to alcohol-related liver disease when he was 15 years old after watching her health deteriorate. He described not wanting to end up in the same situation and therefore deliberately drinks infrequently on a monthly basis and then only lager or cider as opposed to spirits. Nevertheless, both Jack and James acknowledged that they have simply 'switched' to cannabis and smoke daily to relax and cope with the adversities of being in care. There was little acknowledgement of the risk associated with cannabis or indeed recognition that they too were experiencing dependency (albeit to a different substance) as their mothers had before them.

Amber provided an insightful recognition that being removed from the family home and placed in care had the potential to influence an individual's experience with alcohol in a positive way, by supporting young people's exposure to a less chaotic setting and offering them the necessary support. However, she also warned that despite these benefits, many young people in care may still end up repeating their parents' behaviour:

> 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, fortnightly moderate drinker)

Organisational level

One of the main themes to emerge from the data analysis was the potential role that different organisational structures and placement options could play in exacerbating problems with alcohol use. The predominant organisational structure discussed was residential care in which the majority of participants had lived at some point in their care journey.

The young people living in residential care expressed frustration regarding the inconsistency of the care provided between different settings. They also described enduring high levels of surveillance and the mandatory reporting of certain behaviours to professionals, which would not occur within a 'traditional' family home. They highlighted practices such as having limited access to kitchens and food, which served to increase the institutional feel, and emphasised the 'differences' from the experiences of their peers elsewhere. They also acknowledged that due to the organisational structure of residential care, such as staff rotas and having an allocated key worker, they experienced a lack of consistent '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 . . . Like, even if you have care workers and stuff like that, your 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. (Megan, 19, monthly binge drinker)

The young people also referred to the staff being unable to prevent alcohol use due to its availability within residential environments; it was stated that 'alcohol and drugs were everywhere' (Ethan, 19, weekly moderate drinker).

Due to staff rotas and changeovers, residential organisations were not perceived to provide the same level of support and response to young people drinking as would be expected in a traditional family setting where parenting would be more consistent. The configuration of residential homes was portrayed as clinical and housing a mixture of individuals of differing ages and with complex needs. This combination of factors, in addition to limited adult supervision, made it increasingly easy to access alcohol and experience situations that were potentially exploitative:

> When I first started drinking, I was with my friends . . . we were in care homes . . . I was around things that definitely influenced that, older men, so on and so forth. So, I think from a young age if that is acceptable, if people that are older than you are giving you that, then it becomes normal. (Megan, 19, monthly binge drinker)

Several other participants echoed this view, clearly articulating that the pre-exposure to adverse experiences prior to being in care, combined with current living arrangements that are unable to provide the necessary one-to-one support, resulted in young people using alcohol in an increasingly problematic way:

> I'd probably say that people coming from care and [those who] have experienced traumatic events and stuff . . . if you haven't got the right support, you're most likely going to start something. (James, 19, abstinent following previous daily alcohol use)

In contrast, foster care placements were described as having potentially mediating effects upon the alcohol use of the young people. Participants offered several explanations as to why such placements were more conducive to reducing consumption, highlighting the importance of having a good relationship with their foster carers, feeling genuinely cared for and being in a 'normal' family environment:

> 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. (Steve, 18, weekly binge drinker)

Indeed, Carrie believed that she would have consumed more alcohol had she still been living with her birth parents who were heavy drinkers and drug users. She stated that foster care helped her to control her behaviour including her alcohol use:

> . . . 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, infrequent/special occasion drinker)

Community level

Participants only discussed the influence of community factors on their alcohol use minimally. One environment that was mentioned as being conducive to increased levels of alcohol consumption was university. Whilst most young people starting university partake in a freshers' week (a welcoming period for new students at UK universities), participants were surprised that it was marked by a strong drinking culture and risk of intoxication: 'I walked into uni, and I was expecting a place of learning. Not a place to get absolutely smashed every day just because you can' (Ethan, 19, weekly moderate drinker). In addition, Nicole (20, weekly moderate drinker) had previously made a conscious choice to be abstinent. However, when she started university, she began to drink alcohol again due to it being so widely available: 'When I went to uni, it's such a big drinking culture, I did miss it [alcohol], so I started again'. Both Nicole and Ethan, who described themselves as moderate drinkers before going to university, found themselves faced with a situation where alcohol was a large part of the student lifestyle and feared that they would feel isolated from their peers if they did not join in. This can create a conflict for care-experienced young people as they may want to feel part of a community that is dominated by going out, getting drunk and taking drugs, but find that negative memories are reinforced or triggered by the influences that contributed to them being taken into care.

When describing the communities in which the young people lived, the majority of participants reported accessing alcohol and drinking underage. They stated they would use a variety of techniques to obtain alcohol, including getting it from acquaintances. Sophia, who was 18 and living in supported accommodation, used to ask friends to share alcohol with her ('I got it off my friend, they were over 18'), whilst others would ask parents to buy it: 'I just get our friend's mum to go in' (Kelsey, 17, infrequent/special occasions).

Additionally, participants explained that if they didn't have an acquaintance available to purchase or share alcohol, they would ask strangers to buy it for them. Anna (19 years old, weekly binge drinker), who was in foster care, stated that she would 'Ask people to go in the shop and stuff like that'. They also had an awareness of which local premises would serve them despite knowing they were underage: 'We would go to the shop in Byker. He [the cashier] would serve anyone. Normally we would get the tallest one of us to go in, but he would serve anyone' (Estelle, 17, infrequent/special occasions).

Although, the same could be experienced by any young person, the potential for children in care to mix with older peers due to their living environments and the lack of adult supervision make it increasingly easy for them to access alcohol and become intoxicated.

Public policy

The interviews did not specifically explore the influence of public policy on alcohol consumption. As such, it is not possible to present data at this societal level.

Discussion

Using a socio-ecological model enabled us to consider how experiences both pre-dating and during time in care can influence an individual's alcohol consumption. It allowed the study to chart the nature of drinking among young people within care environments and can inform more effective responses to it. But to do this, it is necessary to consider the

interaction between multiple factors influencing a young person drinking, as alcohol consumption always occurs within a social and cultural context (Vellaman, 2009).

When analysing the young people's knowledge surrounding alcohol and their attitudes towards it, it became apparent that individuals change their use of alcohol throughout their lives as both an antecedent to and a consequence of their care experiences. Whilst some participants discussed periods of heavy alcohol use, they also reported high levels of resilience, which is contrary to much of the literature (Rees, 2013), and described how they intentionally drank infrequently at moderate levels. Indeed, for many, the experiences which are typically considered to be risk factors were highlighted from the participants' perspectives as motivations for risk avoidance. Avoiding the unhealthy patterns of alcohol (mis)use they had observed among their relatives or the violence, neglect and bereavement they had experienced as a direct result of alcohol dependency are good examples. This deliberate avoidance of alcohol, even though it may be sporadic, demonstrates that this group of young people continuously grapple with a wariness associated with alcohol use at an interpersonal level. Yet there is an associated risk that they may transfer their substance of choice rather than abstaining completely in their desire for the 'comforting' feeling that intoxication creates.

In addition to the difficulties with alcohol faced by young people with care experience moving into adulthood, there are equally difficult problems at the earlier stage of adolescence. The young people typically described early onset alcohol use, with 12 out of the 20 participants drinking by the age of 14. This echoes much other research, which has found that 25% of children in care aged 11–19 years drink alcohol at least once a month, compared with 9% of those who are not looked after (Meltzer, 2003). The initiation to alcohol usually arises from the normalisation of alcohol consumption prior to children entering care (Jennison, 2014; McGovern et al., 2018), observing frequent intoxication (Haugland, Strandheim and Bratberg, 2012; Haugland et al., 2015) and witnessing the development of alcohol problems including dependency (Kendler et al., 2013). Based on the findings of this study, we identify an additional factor: the greater exposure to freely available alcohol and/or drugs in certain care settings, in particular residential homes, supported lodgings and independent living.

A further significant finding was that the young people interviewed felt that being involved in the care system had often influenced their alcohol use in a negative way. In particular, they identified experiencing significant instability in residential homes due to the lack of a home environment, inconsistent staffing arrangements and transitions between multiple placements. A change of placement could provide potential opportunities for new social networks to be established and a change of the 'norms' to which young people are exposed, both of which could also have positive effects on drinking behaviour, especially if backed up by interpersonal support from professionals such as social workers, foster carers and residential workers. We would also suggest that the current delivery of psychosocial interventions could be improved to move away from the vertical delivery of drug and alcohol interventions by special services and towards a system that would allow several interrelated issues to be tackled at once (Alderson et al., 2020; Buffardi, 2014; NICE, 2019).

Another important finding is that drinking patterns for young people in care can traverse several different pathways, as with all adolescents. An individual's relationship with alcohol is not static and may change in response to changes in the young person's environment. This study has shown the important role that past experiences of alcohol use play in the choices made regarding alcohol consumption by young people in care and how varied these choices

are. But it also shows how they are challenged and modified by later experiences both while in care and after leaving, indicating a need to better understand and conceptualise the dynamic interaction between the different individual, social, environmental and cultural factors that determine an individual's alcohol trajectory. This reminds us again that looked after children are not a homogenous group. The findings also support McLeroy and colleagues' (1988) socio-ecological perspective by showing that alcohol consumption by young people in care is a socially conditioned behaviour. Interventions to support them in their alcohol use need to be delivered at multiple levels, therefore. Individual approaches need to provide training, facts and guidance about alcohol use, harm minimisation techniques and refusal skills, whilst increasing an individual's belief in self-efficacy. Interpersonal approaches, by contrast, should include the provision of peer education programmes about alcohol-related harm. Approaches at this level should also consider training foster carers, residential staff and social workers to be consistently aware of problems associated with alcohol consumption (Brown et al., 2019), particularly about how key transitional moments can influence this and/or the use of alternative licit and illicit substances. This study stresses the importance of focusing on each individual's personal circumstances and working to address issues in co-occurrence. Finally, at an institutional level, the most fruitful interventions would ensure that high-quality care is provided to young people; this would include helping staff to provide environments that promote healthy decision-making regarding alcohol use. In addition, the encouragement of more open discussions about alcohol consumption, its inclusion in regular assessments and the introduction of resilience-promoting therapies would be beneficial.

Strengths and limitations

A strength of this study was the opportunity to engage with existing groups such as the CiCC, where young people in care are represented. This helped to identify potential participants with both care experience and exposure to alcohol use/misuse and provided the option to them of meeting in a familiar environment. The opportunity to engage young people at a familiar venue enabled them to feel relaxed and encouraged them to participate when they felt ready rather than having to commit to a pre-arranged time and date.

A limitation of the study is that the number of participants involved in the research was small, and so the findings may not be generalisable. As all the participants already attended the CiCC, the cohort may have been particularly motivated and resilient and so may not be representative of all young people in care.

Conclusion

This article has provided a nuanced understanding of the alcohol use and alcohol-related harm experienced by young people in care by considering the influence of both social and contextual factors. Key findings suggest that experience prior to being in care combines with experiences within the care system to influence an individual's alcohol use in later life. Although general findings about risks of harm have been established in previous research, considerable variety was found among the participants within this study in terms of their attitudes to and use of alcohol as well as in the patterns of its usage over time. The socio-ecological paradigm shows that opportunities to intervene occur at five different levels: individual, interpersonal, organisational, community and, although not discussed here,

public policy, stressing a further need for coordination and consistency across all the relevant services.

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