TO WHAT EXTENT DO DIFFERENT TYPES OF CARE ENVIRONMENTS HAVE THE PROPENSITY TO BE CRIMINOGENIC?

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VOLUME I
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Acronyms

**APPG** All-Party Parliamentary Group for Looked After Children and Care Leavers

**BCN** Better Care Network

**BESD** Behavioural, Emotional, and Social Difficulties

**BP** Biological Parent(s)

**CAQDAS** Computer Assisted Qualitative Data Analysis Software

**CGAS** Child Global Assessment Scale

**CLA** The Children (Leaving Care) Act

**CLR** The Care Leavers (England) Regulations

**CP** Corporate Parent

**CPPCRR** Care Planning, Placement and Case Review (England) Regulations

**CSE** Child Sex Exploitation

**CYPP** Children and Young People’s Plan

**DfE** Department for Education

**EET** Education, Employment or Training

**GCSE** General Certificate of Secondary Education

**LA** Local Authority

**LCT** Leaving Care Team

**MOJ** Ministry of Justice

**MTFC** Multi Treatment Foster Care

**NACRO** National Association for the Care and Resettlement of Offenders

**NAO** National Audit Office

**NEET** Not in Education, Employment or Training
NPCC National Police Chiefs Council
P Peers
PIS Participant Information Sheet
RFR Risk Factor Research
RGA Research Governance Approval
RPFP The Risk and Protective Factors Paradigm
SDQ The Strengths and Difficulties Questionnaire
SEMH Social, Emotional and Mental Health
SEN Special Educational Need
SES Social Economic Status
SPSS Statistical Package for the Social Sciences
SS Social Services
TCH Therapeutic Children Homes
TFCO-UK Treatment Foster Care Oregon UK
TFCO-UK-A Treatment Foster Care Oregon UK - Adolescents
TFCO-UK-C Treatment Foster Care Oregon UK – Middle-childhood
TFCO-UK-P Treatment Foster Care Oregon UK – Pre-schoolers
UK United Kingdom
UREC University Recognised Ethics Committee
YJB Youth Justice Board
YOI Young Offender Institutions
Abstract

This thesis provides an exploration into the extent to which different types of care environment are criminogenic. It investigates: kinship; foster; and residential care, from the perspectives of care leavers, members of the Leaving Care Team [LCT] and carers. The research looks at experiences: before; during; and after care, with quantitative risk assessment and semi structured interviews. The overall aim of this thesis is to evaluate the extent to which different types of care environments have the propensity to be criminogenic and highlight what can be changed to improve life chances of looked after children, free from offending.

In order to do so, the following research questions were central: are care environments criminogenic?; to what extent does the Risk and Protective Factors Paradigm [RPFP] successfully measure this?; to what extent does attachment to significant others help answer this question?; and what, if anything, can be done to reduce criminogenic risk in care?

The main findings within the risk assessments showed residential placements to be the most criminogenic, with the highest increase of risk ‘during care’ and reduction after care. Foster placements had constant risk levels, showing concerns with the ability of foster care to reduce risk. With kinship placements being seen as the least criminogenic. All participant groups, showed Living arrangements, Emotional/Mental Health and Family /Personal Relationships to be the biggest influence to offending.

The central findings from the semi structured interviews were as follows: attachment underpins the experience of risk; Clear differences within institutional versus family settings, with long term foster care offering same outcomes as kinship; having ‘no one to let down’ was the most cited reason for offending.

The recommendations were as follows:

Recommendations for research: urgent prospective longitudinal studies focused on attachment in care and its consequences on risk and offending.

Recommendations for practitioners: focus on attachment; listen to the cared-for and carers more closely and consistently.

Recommendations for policy makers: invest in and plan for high quality care for all placements; transform residential care, moving away from authoritarian parenting practices; have a 'care-revolution' in terms of attachment-focused training, monitoring and practice; mainstream family preservation/early intervention programmes (alternatives to care) and massively recruit foster- and kin-carers.
DECLARATION

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I would like to dedicate this research to the memory of two dear friends:

Emily Piper, a very dear friend, who passed away when I first embarked on this journey.

"Live! Live the wonderful life that is in you! Let nothing be lost upon you. Be always searching for new sensations. Be afraid of nothing."

Em inspired me to study for this PhD, making me believe it was possible. Her love and encouragement has never left me, and I will forever be grateful for her belief in me, even when I doubted myself.

Regan Metcalfe, a dear friend and colleague, who passed away just after my submission. Regan was a powerful voice for care leavers, and was a wonderful soundboard for the work within this thesis. Her love and dedication to improve the lives of care leavers was contagious, and was a true inspiration to this piece of work.
The Author

Kimberley Marsh has researched areas mostly relating to individuals coming through the care system. Kimberley herself is a care leaver and benefactor of the existing social care system from a young age, and fully appreciates the effects the complex relationships and foundations established during care have on individuals and their behaviour outside the system. She completed her BSc in Sociology at the University of Surrey, for which her dissertation focussed on evaluating educational achievements by students emerging from the care system. She further continued her research during her MSc with Distinction in Criminology and Criminal Psychology at the University of Portsmouth. She focussed her research during her MSc on assessing various care environments and the extent to which they affected criminogenic behaviour. The author has elaborated her area of study to assess in detail different stakeholders and interrelationships during her PhD research at the University of Manchester.

She has been actively involved in extending her contribution in the field of her research and acquiring the necessary skills and networks to establish herself as an early stage researcher in the field of care environments. She has been a strong member of the ‘Care Leavers Foundation’, and has helped organise various workshops and training seminars for different stakeholders. She has regularly voiced her experience at the ‘All-Party Parliamentary Group for Looked After Children and Care Leavers’ [APPG] to facilitate policy making in the field. In connection to the project, she also devotes time to work for a project in the Department for Education [DfE] and has been involved in various dissemination events and reports generated on the activities carried out. The author hopes to complete her research and work towards improving the existing social care system, and wishes to develop a good information system to facilitate effective policy making.
Chapter One

Introduction: Description of Care, Care Experiences and Associated Outcomes

1.1 Introduction

This chapter lays the foundations of the thesis. It will offer descriptions of the broader issues around young people from different types of care environments and both their overall and offending outcomes. This chapter will then present the rationale for research, followed by the thesis aims, objectives and organisation.

1.2 Focus of the Thesis

The thesis will investigate the extent to which Residential, Foster and Kinship have the propensities to be criminogenic (‘producing crime or criminality’); as measured through the Risk and Protective Factors Paradigm [RPFP], using Attachment Theory as a critique. The study will consist of carrying out risk assessments and semi structured interviews, looking at the experiences of Care Leavers, members of a Leaving Care Team [LCT] and Carers, at each care episode: before, during and after care. Through reviewing relevant academic literature relating to the different placement types, offending behaviour, theoretical explanations and gathering empirical data through this study; discussion of possible criminogenic influences will be used to show the potential of the care system in reducing offending by looked after children.
1.3 Care in England and Wales

This section will start by providing an overview of the historic developments made within legislation for children in need of care, before moving onto current contributions of both legislation and policy. The reader will then be presented with a brief summary of the care system today, including the reasons for entering care, the population within the care system and differences amongst placement types.

1.3.1 Historical Overview and Legislative Developments

1.3.1.1 Early Legislation and Contributions for Children in Need

The Poor Relief Act (1601) introduced basic provisions for children in need (Hale et al., 2009). In 1815, The Poor Law was introduced to put responsibility on local parishes to look after those in need. However in 1834, The Poor Law Amendment Act saw the developments of workhouses and education developed for children (Chase et al., 2006). The real developments for children cared for outside the family home started from The Infant Life Protection Act (1872) highlighting the need for better regulations (Herring, 2009).

The Children and Young Persons Act (1933) defined neglect and abuse, regulated children’s employment and provided fundamental shifts in children’s safety (Hoyano and Keenan, 2007). Crucial developments were made within The Children Act (1948) which introduced the duty of local authorities to act as corporate parents (Oldham, 2009). In 1963, a newly amended Children and Young Persons Act introduced the guidelines of financial inputs on preventive measures to keep children with their families, acknowledging the importance of attachments to birth families (Bullock et al., 1993).
The *Children and Young Persons Act* (1969) integrated services for children, with *Local Authority Social Services* (1970) establishing social services departments (Chase et al., 2006).

1.3.1.2 Legislation and Contributions Shaping Current Practice

1.3.1.2.1 Looked After Children

The connections between being poor, offending and parents failing at their responsibilities were acknowledged as early as the nineteenth century, with a recognition of the need to have residential options for children in ‘trouble’ or ‘in need’. Since then, there have been developments within legislation for children ‘in need’, highlighting the provisions needed to protect those in care (Hayden, 2007).

Since the 1980’s, the developments of social services have focused on the concepts of permanence (Biehal et al., 2010). The most influential act within the developments surrounding children in need is the *Children Act (1989)* which reformed the law relating to children and their families and adopted the rights of the child as a fundamental principle (Hughes and Rose, 2010). The same year the *United Nations Convention on the Rights of the Child* [UNCRC] produced comprehensive guidelines to ensure all children had: special protection measures and assistance; access to services such as education and health care; develop their personalities, abilities and talents to the fullest potential; grow up in an environment of happiness, love and understanding; be informed about and participate in achieving their rights in an accessible and active manner (Unicef, 2010).

The rights of the child were also highlighted within Article 8 of the *Human Rights Act* (1998) with the need to permit infringement on such right if it is in the best interest of the child, referencing the welfare of the child to be at the forefront (Connolly and Ward, 2008).
In addition, the *All-Party Parliamentary Group for Looked After Children and Care Leavers* [APPG] was established to provide a forum for feedback and accountability of the governments commitments.

Such positive direction was evident, with its legacy introducing positive steps in enhancing experiences within care. The clear poor outcomes were evident with developments highlighting the importance of education, increasing both support and finance. The placements experienced were improved, with the *Care Standards Act* (2000) ensuring regulation of care standards and Government papers *Quality Protects* (1998) and *Choice Protects* (2002) highlighting the need for placement moves to be kept to a minimal with a greater degree of choice and preference being made to kinship placements (Chase et al., 2006).

Although there were clear improvements to the system overall, the *Victoria Climbié Inquiry* was launched in response to the failings of social services in preventing the death of Victoria, with the *Laming Report* (2003) urging better and well connected practice within social services and their cooperation with the police, health and education services (DH, 2003). Also published, in partial response to the inquiry was *Every Child Matters* (2003) that developed five key outcomes that all children should be in possession of: Being Healthy; Staying Safe; Enjoying and Achieving; Making a Positive Contribution; Economic Wellbeing (DfES, 2003; DCSF, 2010a). These were successful reinforced in 2004 in *Every Child Matters: The Next Steps* and *Every Child Matters: Change for Children* which focussed on the workings of multi agencies (DfES, 2004a; DfES, 2004b). The *Children Act* (2004) included the need for integrated planning, commissioning and delivery of: health, social care and legislative framework and educational services. Its basis confirmed the implications needed through the UNCRC (DCSF, 2010b; Doughty, 2010).
In 2006 the green paper *Care Matters: Transforming the Lives of Children and Young People* and subsequent white paper *Care Matters: Time for Change* (2007) put forward an array of improvements including: corporate parenting; wellbeing; stability and attachments, improving the plight of children in care (DfES, 2007: 4). *Care Matters* put a huge basis on the importance of evidence based work, leading investments into social learning theory models for foster care. It introduced the idea of Multidimensional Treatment Foster Care [MTFC], originating in Oregon, as a placement intervention with the aim of changing emotional and behavioural concerns, which is now being used in the UK (Biehal et al., 2012b). These developments underpinned The *Children and Young Persons Act* (2008) which highlighted the need for such practices to ensure: stability, continuity and attachments. In addition, the second *Laming Report* (2009) was carried out after the tragic death of Peter Connelly, to review child protection procedures. Lord Laming urged improvements in: recruiting, training and supervising social workers The recommendations informed the guidance of *Working Together to Safeguard Children* (2010) with reforms to overhaul the profession, increase interagency work and make it fit for purpose, later updated in 2013 to include further focuses of agencies working together to further protect and support looked after children (DCSF, 2010c; DfE, 2013a).

The *Care Planning, Placement and Case Review (England) Regulations* [CPPCRR] (2010) made clear provisions on care planning for children who are looked after by a local authority.

The *Care Inquiry* (2012) examined how best to provide “a sense of security, continuity, commitment and identity through childhood and beyond” (DfE, 2010a: 12). It highlighted the need of “all options for the child are conceptualised with a common understanding and objective of permanence – aiming to provide high-quality and stable care; supporting
children’s sense of identity and belonging; and connecting past, present and future through childhood and transitions out of care, and on into adult life” (Boddy, 2013:30).

Finally, the Children and Families Act (2014) formally introduced the ‘staying put’ arrangements which allow children in care to stay with their foster families until the age of 21 years, if both the young person and the foster family are happy to do so (DfE, 2013b; New Belongings, 2016).

1.3.1.2.2 Care leavers

Alongside the above developments, there has an increase in attention to the need to improve services for care leavers. The Children (Leaving Care) Act [CLCA] (2000) ensured local authorities were to provide adequate support and services, access to education/training/employment, and improved opportunities for social relationships; aiding their transition from care up until the age of 21 or 24 if in full time education (Broad, 2005).

The Care Leavers (England) Regulations [CLR] 2010 made provision about support to be provided to certain children and young people who are no longer looked after by a local authority. This set out further guidelines on: assessment of needs; pathway plans; personal advisers; support and accommodation (Legislation, 2010).

In 2012 two key initiatives were developed in order to improve the services and outcomes for care leavers. The first was Access All Areas, to ensure solid multiagency workings with the government departments. This initiative aimed to address current policy, which makes it unnecessarily difficult for care leavers to have settled lives and achieve their full potential (Princes Trust, 2012). Responding to this was The Charter for Care Leavers.
This charter embodies principles that are put in place to improve the experiences of care leavers throughout preparation and transition into adult life (DfE, 2012a). Following these initiatives, The Care Leaver Strategy (2013) was developed, ensuring cross departmental commitments were put into place to assist the life chances faced within leaving care and transitions to adulthood (DfE, 2013c).

Most recently, the DfE funded project New Belongings, aims to raise expectations, aspirations and outcomes for all care leavers by embedding the principles of the Charter for Care Leavers; join up services to care leavers, as outlined in the Access All Areas report; and bring in the energy of local communities to support care leavers. The project is delivered by experts and care leavers, working across the country to improve services offered to care leavers. The first phase of the project commenced in 2013, and worked closely with nine local authorities, with the current project consisting of twenty eight local authorities. The project is working to ensure that all care leavers are ‘cared for’ ‘cared about’ and able to ‘care for themselves’ (New Belongings, 2016).

1.3.1.2.3 Conclusion

The above developments have shown considerable improvements in the last three decades, with clear commitments to focus on looked after children and those leaving care. The key elements of focus are evident, with all developments in place to ensure that all young people are physically and emotionally well, safeguarded, achieving their potential, prosocial and provided for. For these elements to be in place, the above legislation, policies and initiatives share the responsibility to ensure that attachments, stability, belonging, expectations and aspirations are in place for each young person looked after in local authority care. Not only will such experiences allow emotional wellbeing, but decrease the risk of offending. The key focus within this thesis is the extent to which these
developments are in place within young people’s experiences and their potential to help or hinder behavioural concerns. It is hoped that this research will provide evidences of successes, whilst also addressing the need for future developments to reduce the offending by looked after children and care leavers to be at the forefront of policy and legislative developments.

1.3.2 The Care System Today

Children who are looked after by local authorities are known as looked after children or children in care. Local authorities have duties to provide accommodation for a child or young person that is in need. Where it is not possible for a child to be kept at home, kinship care (placement with relatives or friends), foster care (family based alternatives) and other types of family and community based care are priorities, with residential care (non-family-based group setting) being used as the last resort (Better Care Network [BCN], 2009: 3; Hayden, 2010).

1.3.2.1 Numbers in Care

The number of looked after children has increased steadily over the past seven years and is at its highest since 1985. There were 69,540 looked after children at 31 March 2015, an increase of 1% compared to 31 March 2014 and an increase of 6% compared to 31st March 2011 (Zayed and Harker, 2015).

1.3.2.2 Reasons for Care Entrance

In 2015, 61% of looked after children entered care due to abuse or neglect. Overall, the reasons why children and/or young people enter care, has remained stable since 2011, with the exception of entering care due to family dysfunction, which has increased from 14% in
2011 to 16% in 2015 (DfE, 2015a). Entering care due to socially unacceptable behavior has remained the same at 2% (DfE, 2015f: A1). The majority of looked after children have experienced: deprivation; poor parenting; abuse and neglect, experiences which separately and cumulatively present risk for emotional, social and behavioral concerns (Schofield et al., 2014).

1.3.2.3 Age of Looked After Children

When looking at all looked after children the ages in care, as of 31st March 2015, are as follows: 5% (n=3,710) were under the age of one; 15% (n=10,120) were between one and four years; 21% (n=14,310) were between the ages of five and nine years; 38% (n=26,140) were aged between ten and fifteen; with 22% (n=15,270) aged sixteen and over. This shows 60% (n=41,410) of the current care population is over the age of ten.

1.3.2.4 Entrances into Care: 2015

**Figure 1** Percentage of Children who started to be Looked After by Age Group

(DfE, 2015a: 7)
In 2015, there were 31,070 children who came into the care system, an increase of 13% since 2011. Children under the age of one year made up 19% of all care entrances (DfE, 2015a:7). The number of children, under the age of four years showed a slight decrease, with a rise in children aged five years and over (DfE, 2015a:6). The amount of looked after children aged between ten and fifteen years has shown a slight decrease, from 31% in 2011 to 29% in 2015, but those aged sixteen and over has increased to 16% from 12% in 2011 (DfE, 2015a:7).

The main reasons for care entrance were: abuse or neglect at 56% (n=17,380), showing a lower level than all children currently in care (61%); family dysfunction at 17% (n=5,390) showing a higher level than all children in care (16%), with socially unacceptable behaviour being 4% (n= 1,090) being twice as prominent as compared to all looked after children (2%) (DfE, 2015f: A1, C1).
**Figure 2** Increase in Children Starting to be Looked After in Foster Care and Decrease in those in Secure Units, Homes and Hostels

![Chart showing foster care and residential care placements over years]

(FDfE, 2015:e)

Foster care (including kinship placements) provides 78% of placements for children starting to be looked after. Secure units, children’s homes and hostels have declined from 10% in 2011 to 8% (DFE, 2015:e: 5). Such statistics are welcome, with this continual decline reinforcing the last resort status of residential care.
1.3.2.5 Prevalence of Placement Types and Placement Moves

**Figure 3** Number of Children Looked After at 31 March by Placement

![Figure 3](image)

(DfE, 2015a :5)

**Figure 4** Percentage of Children Looked After at 31 March by Placement Type

![Figure 4](image)

(DfE, 2015a :5)
The majority of children looked after are placed with foster carers. In 2015 the number of children in foster care (including kinship care) continued to rise with 75% (n=52,050) of the 69,540 children looked after were placed into a foster placement, with 10.8% of those in foster care (n=5,610) being placed with a relative or family member and just over 1% (n=530) being placed in foster placements for adoption or concurrent planning (DfE, 2015a; Zayed and Harker, 2015). This has shown an increase of 8% since 2011, a larger increase than the rise in overall numbers of looked after children (6%). There has also been a rise in those placed with parents and the community, although the increase is relatively small and the amount of young people within these placement types has remained relatively stable since 2010 (DfE, 2015a: 1). Finally, under 10% of looked after children (n=6,570) were placed in secure units, residential placements and hostels. Previous years have shown an increase in these placement types, in line with overall increases, but 2015 has shown a welcomed decrease.

In 2015, 67% (n=46,690) lived in one placement during the year, with 23% living in two placements and 10% having three or more placement moves, findings similar to previous years (DfE, 2015a: 6).
1.3.2.6 Duration of Placements

**Figure 5** Duration of Placements Ceasing During the Year Ending 31 March 2015

(DfE, 2015e: 5)

Figure 5 presents the differences in durations across the placement types. Foster placements (including kinship care) were just under a year and secure units, children homes and hostels under six months. Although these cannot be separated to show the differences within these placement types (for instance, the difference between short term foster care and kinship care or secure units and residential homes), overall we can see more stability within foster settings than institutional settings, findings which are pertinent to this study.
1.3.2.7 Conclusion

The above overview of the care system shows a wide range of experiences of those looked after in local authority care. Some children are placed into care and experience stability within family based settings, with those in non-family based settings experiencing more placement moves and lower durations in each placement.

The diverse format of the care population reaffirms the range of provisions the care system has to attempt to improve, and reflects the clear limitations in pursuing a ‘one size fits all’ approach (Hannon et al., 2010). It is therefore vital to look at each placement type and the extent to which the provisions in place allow positive experiences within care, offering protection from offending.

Despite developments, those in care are one of the most disadvantaged groups in society, facing particular difficulties in accessing educational, employment, housing and other developmental and transitional opportunities; often resulting in offending (Montgomery et al., 2006). Sections 1.4 and 1.5 will describe these outcomes, before presenting the rationale for this study.

1.4 Non CJS Outcomes of Care Populations

This section will summarise government findings on looked after children and care leavers, providing a basic description of the overall outcomes, and where possible, comparing these outcomes to children who remain with their family. However, it is important to note that official statistics often only give a partial picture, with debatable validity, limited sample sizes and often predetermined agendas (Bulmer, 1980). Although the Department for Education [DfE] states that every effort is made to ensure that the statistics are accurate
and complete, they express the need to take care to ensure the data collection processes and their limitations are taken into account when this data is used (DfE, 2015b: tables). In order to avoid narrowly focussed interpretations of the data, care will be taken in both interpreting the outcomes and offering additional evidence where available. The statistics will be interpreted in absolute terms (highlighting the disparity between outcomes; e.g. 5% achieved an outcome but 95% did not achieve this outcome) and/or relative terms (offering comparisons between the groups; e.g. the looked after population is five times more likely to have an outcome than the non-looked after population). When applicable, both interpretations will be considered, to allow the data to be shown in a clear and critical manner.

1.4.1 Education

**Figure 6** Attainment and Attainment Gaps between the Percentages of Looked After and Non-Looked After Children achieving 5+ A*-C GCSEs or equivalent (including English and Mathematics) 2009/10-2013/14

(DfE, 2015b:11)
Fig 6 shows the attainment of looked after children to be considerably lower than their peers within the general population, with only 12% (n=576) of those in care achieving 5 or more GCSEs (A*-C including English and Mathematics), compared to 52.1% of non-looked after children (n=325,661). Although girls achieved higher with 15.9% (n=353) gaining 5 or more GCSEs (A*-C), the achievements for non-looked after girls was also higher at 57.6% (n=175,536), showing the gap of achievement to be slightly higher at 41.7%, compared to the overall gap of 40.1%. Whilst looking at the boys achievements, only 8.6% (n=223) gained this level of education, with 46.9% (n=150,230) of non-looked after boys gaining the equivalent results. Therefore, both the overall achievement for boys and the difference between the groups were lower, with a 39.1% difference. In addition to the above comparisons, it is important to acknowledge that 91.4% of looked after boys (compared to 53.4% of non-looked after boys) and 84.1% of looked after girls (compared to 42.4% of non-looked after girls) did not achieve 5 or more GCSEs (A*-C including English and Mathematics).

Evidently, there will be a breadth of attainment within any population, with ethnicity showing a wide range of differences within the United Kingdom [UK]. The attainment of 5 or more GCSEs (A*-C including English and Mathematics) range from 8.2% - 14% within Traveller populations to 72.9% - 74.4% in Asian populations, with the remaining variations of ethnicity being between 47% and 67.2% (DfE, 2015g). These statistics show the attainment of looked after children to be similar to the range achieved within subgroups whose schooling is unlikely to continue beyond the age of fourteen years (DfE, 2010c). With differences between 30.1% (for boys) and 41.7% (for girls), compared to the national attainment figures, it is vital to provide further investigations into the underachievement of
looked after children in order to improve life chances and reduce the likelihood of offending.

General concerns are also apparent within progress between Key Stage 2 and Key Stage 4, with only one third (34.5%) of looked after children making progress in English, compared to just over two thirds of non-looked after children (69.3%). These differences increase within Mathematics, with just over a quarter (26.3%) of looked after children making progress, compared to just under two thirds of non-looked after children (64%) (DfE, 2015b: 11).

Two thirds (66.6%) of looked after children have a Special Educational Need [SEN], compared to only 17.9% of non-looked after children (DfE, 2015b: 14). The most common types of SEN for looked after children were ‘Behavioural, Emotional and Social Difficulties’ [BESD], now referred to as Social, Emotional and Mental Health [SEMH] difficulties, accounting for 38.9% of pupils with a statement of SEN (DfE, 2015b: 11). The type of school the young person was in affected the number of BESD within SEN statements: for primary schools this was 43.8% (n=630), for secondary schools 51.2% (n=970), special schools 30.4% (n=1,290) and pupil referral units 88.2% (n=110). Therefore, BESD were the most prevalent concerns across all ages and types of school. The statistics for the general population in the same year show a significantly lower level of concern with BESD: for primary schools this was 12.7% (n=7740), secondary schools 15.5% (n=9,230) and special schools 13.3% (n=13,065) (DfE, 2014e).
1.4.2 Emotional and Behavioural Outcomes

**Figure 7** Average (Mean) Score for Looked After Children on the SDQ, By Gender and Age, 2014

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire for children and adolescents. It consists of questions to highlight the emotional and behavioural difficulties a young person faces, establishing the level of concern and need for interventions. The answers are marked out of a total score of 40, with a higher score indicating more emotional difficulties. A score of 0–13 is categorised as normal, 14–16 is seen as a borderline cause for concern and a score of 17 and above is considered a cause for concern. Looking at children from the ages of five to sixteen, the national average SDQ score is 8.4, with looked after children presenting a higher average SDQ score of 13.9 (with boys having an average score of 14.6 and girls an average of 13.1) (Meltzer et al., 2000; DfE, 2012b; Dfe, 2015b). Furthermore, only half of looked after children (n=50.4%) are categorised as ‘normal’ (compared to 82.1% of all children), 36.7% are shown to be cause for concern (compared to 9.8% of all children), with the remaining 12.8% on the border for concern (compared to 8.2% of all children) (Meltzer et al., 2000;
Lindsay et al., 2010; DfE, 2015b:16). There are variations between the ages, with the lowest average SDQ score being recorded at just over 12 for girls aged between five and seven years, and the highest being shown for boys between the ages of nine and twelve years, with a SDQ score between 14.9 and 15.5.

Since 2012, it has been compulsory for Local Authorities [LA] to carry out a SDQ screening for all looked after children, to assist in allocating suitable interventions for those in need. Although this is deemed a very reliable way of assessing emotional and behavioural difficulties, there are two observations. Firstly, only 68% of the 34,770 expected scores were received, leaving nearly a third (n=11,120) unrecorded, and therefore giving an unrealistic picture of the severity of concerns amongst the looked after population. In addition, these official statistics present an overall score/categorisation, and fail to separate the data into conduct problem scores, hyperactivity scores, emotional symptom scores and peer problem scores. In addition, the official statistics do not show prosocial scores, making it difficult to identify the strengths of a young person and areas where they are in need of assistance. However, despite the critiques, these findings show looked after children are more likely to face emotional and behavioural difficulties than young people in the general population.

These high rates of concerns are also apparent within a young person’s transition to adulthood. Over half of care leavers (59%) state that it was difficult to cope with their emotional and mental health after leaving care, with many stating that the severity of concerns increased (CSJ, 2014; Bazalgette et al., 2015).
1.4.3 Substance Misuse

Figure 8 Percentage of Looked After Children Identified as Having a Substance Misuse Problem by Age and Gender, 2013

![Graph showing percentage of looked after children identified as having a substance misuse problem by age and gender, 2013.]

(DfE, 2015b:19)

Substance misuse is defined “as intoxication by (or regular excessive consumption or and/or dependence on) psychoactive substances, leading to social, psychological, physical or legal problems. It also includes problematic use of both illegal and legal drugs, including alcohol when used with other substances” (DfE, 2015b: 19). With this definition, 3.5% (n=1,680) of looked after children who had been continuously in care for twelve months on 31st March 2014 were identified as having a substance misuse problem. These rates are the same for 2013, but show a decrease of 0.6% from 2012. There is a slight variation between genders, with 3% (n=634) of girls and 3.9% (n=1,035) of boys identified as having a substance misuse problem. The highest rate of concern is shown between the ages of sixteen and seventeen years, with 9.2% (n=453) of looked after girls and 12.1%
(n=749) of looked after boys identified as having a substance misuse problem (DfE, 2015b:19). In addition to identifying the level of substance misuse, it is important to present the percentage of those who received an intervention. In 2014, only 56.3% of looked after children who had a substance misuse problem (n=946) received interventions for their substance misuse, with 43.7% (n=734) not being in receipt of an intervention. Again, there is a slight variation in intervention levels, with 59.5% (n=377) of looked after girls receiving help and a slightly lower level for looked after boys, at 54.4% (n=563). These concerns continue after care, with care leavers being twice as likely to have a drug problem as their peers, with 21% of care leavers involved in problematic drug use (CSJ, 2014).

However, it is important to note the absolute representation of statistics, to avoid further stigmatisation of looked after children and substance misuse. Although 3.5% of the looked after population are identified as having a substance misuse problem during care, 96.5% of the looked after population are not. Although the situation is worse on exit from care, 79% of the care population are not identified as having a substance misuse problem. However, after a young person leaves care they are not subjected to the same recordings of outcomes, and therefore this figure could be higher, as it does not include those who do not engage with leaving care services.

1.4.4 Care Leavers Outcomes

Care Leavers are one of the most disadvantaged groups in society. Compared to their peers, they face particular difficulties in accessing educational, employment, housing and other developmental and transitional opportunities (Mendes and Moslehuiddin, 2006). This section will provide a brief overview of their outcomes.
1.4.4.1 Employment, Education and Training

Figure 9 Former Care Leavers by Activity at Ages 19, 20 and 21

In 2015, 39% (n=10,269) of all care leavers aged nineteen, twenty or twenty-one were not in education, employment or training [NEET], findings that are often double to the non-care leaving population (DfE, 2016a). The rates are similar across the age groups, with those who are nineteen showing 38% and a two percent increase, for those who are twenty or twenty one (DfE, 2015a: 10). 23% (n=6,056) of care leavers are in education, employment or training [EET], showing an increase of three percent from the previous year.

1,580 (6%) of care leavers were in higher education, a figure which has dramatically increased (from 1% in 2003) but is still considerably lower than their non-care leaving peers (approximately 30%) and 4,739 (18%) were in other types of education (Jackson et al, 2003; DfE, 2015a: 11).
1.4.4.2 Living Arrangements

In 2015, 81% (n=22,010) of care leavers aged nineteen, twenty and twenty one were in suitable accommodation. The remaining statistics show 7% (n=1,840) to be in accommodation which was deemed unsuitable, with 12% (n=3,160) of care leavers’ accommodation not reviewed. However, annually between twenty and thirty percent of homeless people have been previously looked after (Wade and Dixon, 2006; CSJ, 2014). The majority of care leavers live independently (n=10,310). However, there has been an increase of those living with family members and former foster carers. Information has been collated for care leavers, who at the age of eighteen and three months, have remained with their former foster carers under the ‘Staying Put’ programme. In 2015, of the 3,230 children who were eligible for ‘staying put’ 48% (n=1,560) had remained in their foster placement, showing welcomed improvements for care leavers (DfE, 2015a: 11).

1.4.5 Conclusion

Although there have been vast improvements over the last three decades, achievements for looked after children are still lower than their peers, with concerns in emotional and behavioural outcomes. These findings do not change during a young person’s transition to adulthood, with: lower levels of EET; and higher levels of homelessness; and higher rates of substance misuse and emotional and mental concerns.

All of these factors can be seen separately or interlinked, but either way, these concerns coupled with the concerns of permanence central within the development of the system, show the ‘in care’ population and care leavers to be in possession of higher levels of risk, of offending, than the general population. It is not to say that all outcomes are poor, many
looked after children and care leavers having positive outcomes, highlighting the ability of care to provide the foundations needed for improved life chances. Both negative and positive experiences in care, and their associated outcomes within a young person’s transition to adulthood, is of central importance to this research, both of which need to be understood in order to develop further understandings in what works in order to achieve prosocial and fulfilled care leavers.

1.5 CJS Outcomes of Care Populations

This section will provide an overview of the prevalence of offending concerns within the care system, highlighting the prevalence of offending amongst looked after children and the proportion of looked after children and care leavers in Young Offender Institutions [YOI] and prisons. As highlighted above, care will be taken whilst interpreting the outcomes and presenting additional evidence where available. This section will start with an introduction to criminality and care, presenting the definitions of crime and the main sources of data to be analysed. Subsequently, it will present the main explanations for differences in criminal justice outcomes for looked after children, compared to the non-looked after population. After the main areas of research have been introduced, this section will conclude with a discussion of the official position of looked after children and care leavers, before outlining the rationale for this study.

1.5.1 Criminality and Care

Although a crime can be defined clearly as “An action or omission which constitutes an offence and is punishable by law” (Oxford Handbook, 2016), it is important to go beyond this definition and highlight how offending statistics are gathered, presented and potentially influenced by the care system.
1.5.1.1 Offending Data

The DfE statistics which will be presented in 1.5.2 are representative of individuals who were convicted or subject to a formal warning or reprimand under the Crime and Disorder Act 1998, during the year of an offence committed whilst being looked after. These will be presented alongside data from the Ministry of Justice [MOJ], allowing a comparison with the non-looked population. With both sets of data, it is critical to observe the ‘dark figure’ of criminality and acknowledge that both sets of data are linked to those individuals who have been caught, with the real level of criminality often being higher for both groups.

As discussed in 1.4, care will be made to ensure both absolute and relative presentations are made, highlighting the levels of concerns within the care population and their position in comparison to the overall population. Where available, additional statistics will be presented from both research and other Criminal Justice System [CJS] agencies.

1.5.1.2 Offending Explanations

Before presenting the offending data for looked after children and care leavers, it is crucial to present the reasons why there might be a difference between the care population and the general population. The main explanations will be briefly highlighted below, with Chapter Two presenting further examples throughout.

1.5.1.2.1 Individual Risk and Pre-Care Concerns

One explanation for the possible increase in offending amongst the looked after population is centred on the risks (for example, abuse, poor supervision, limited educational achievement, emotional and behavioural concerns) experienced by the child or young person before entry into care. This body of research argues that involvement in offending is not directly related to being within care, but rather the risk factors that increase the
likelihood of offending are similar to the risk factors for entry into the care system. In addition, this explanation highlights how many looked after children have experienced many pre-care concerns which can be termed as risk factors for offending. Therefore, many argue that the correlation between care and criminality is often based on ‘shared’ risk factors (Schofield et al., 2014; Staines, 2016). As highlighted in section 1.3, the majority of looked after children enter care due to abuse or neglect (61%), and many do so after prolonged exposure to harm within their family home (Staines, 2016). These traumatic experiences can have a huge impact on a child/young person, both in terms of emotional and behavioural concerns (Fitzpatrick, 2014). In addition, such experiences are likely to impact upon an individual’s ability to settle within care, due to attachment concerns and lower levels of resilience.

This explanation does not void the care system of responsibility. Instead, it highlights the impact pre-care concerns have on the levels of offending within the looked after population, and focuses on the risks centred on the individual, rather than the system. It is crucial to examine the ability of the care system to reduce these pre-care concerns, a central component of this thesis.

1.5.1.2.2 System Concerns: Adverse Influences and Structural Criminalisation

In addition to the shared risk factors for entry into care and involvement in offending behaviour, being placed in care itself is noted to have the potential to adversely influence an individual’s behaviour (Shaw, 2012). Thus, offending within the looked after population can be a product of the care system itself.
There are many adverse influences or ‘risks’ associated with the care system. The next chapter (section 2.5) will present these within the theoretical framework of the Risk and Protective Factors Paradigm [RPFP], with this section providing brief examples.

The overall care system can be seen to adversely impact upon many areas of a young person’s life both within care and as they transition to adulthood. This effect often stems from the inability of the care system to provide appropriate and stable environments, limiting the likelihood of attachments, positive relationships, resilience building and positive foundations for adulthood. As a consequence of inadequate placements, behavioural management becomes increasingly poor (Staines, 2016). These concerns are often more prevalent within residential placements, due to their ‘last resort’ status, with research highlighting an increased risk of criminality due to the challenging group dynamics and presence of criminal peers (Hayden, 2010; Schofield et al., 2014; Staines, 2016). In addition, staff turnover, low staff to young person ratios and inadequate training impact upon behavioural management, making discipline increasingly difficult (Staines, 2016). However, this is not to say that these adverse influences are not apparent within other placement types. Rather, they are linked to the adequacy of service provision and the ability to identify suitable placements which enhance values, identities and relationships, decreasing the risk of offending and concerns with the system.

The response to these adverse influences, which are apparent due to the failure of the care system, is often further stigmatisation and criminalisation, rather than the presentation of suitable solutions.

The care system is embedded with stigma attributed to looked after children, with the perception that being ‘in care’ is associated with trouble (Hayden, 2007). These stereotypes, held both within and outside the system, often mean looked after children are
viewed as ‘troublesome’ instead of children who are ‘in need’ of assistance (Fitzpatrick, Williams and Coyne, 2016). Not only is the care system noted to increase the risk of offending through their initial failings, they are also deemed responsible through their inability to dispel such stigmatising and labelling, leaving a system fuelled with low expectations.

Finally, the concerns with structural criminalisation are crucial for understanding why looked after children are more likely to offend. The system routinely criminalises children for behaviours that might not be seen as crimes in family life (for example, breaking household items), through over surveillance and over reporting. The corporate parent often does not incorporate responsive parenting, instead having a lack of tolerance for perceived ‘problematic’ behaviour, resulting in escalation of behavioural concerns, increased involvement with the police and higher rates of placement moves, all of which provide further adverse influences upon a young person in care (Taylor, 2006; Hayden, 2010; Staines, 2016).

These concerns are also more prevalent within residential settings, with a recent report by the Howard League for Penal Reform (2016:1) noting that those living in children’s homes ‘are being criminalized at excessively high rates compared to all other groups of children, including those in other types of care’.

Although there is a wide body of evidence referring to the ‘excessive criminalisation’ of some looked after children, there is little in place to reduce it (Fitzpatrick and Williams, 2016). Some LAs put protocols in place between staff members and police, highlighting the behaviours which need police intervention and those which can be dealt with informally within the care setting (Fitzpatrick, 2014). In addition, some residential placements use restorative justice, to avoid a young person being formally involved within
the CJS (Fitzpatrick, 2014). However, despite the guidance in place encouraging carers and staff to use police contact sparingly, these protocols are noted to be failing to reduce the problem substantially, with some practitioners viewing the CJS as a useful aide to the care system (Schofield et al., 2014; Shaw, 2015).

1.5.1.2.3 Conclusion

The above evidence provides clear explanations as to why looked after children and care leavers may be more likely to offend than non-looked after children. Both the risk factors before and during care interact, with looked after children who have previously experienced trauma being vulnerable to negative influences during care, which is further heightened by unnecessary criminalisation (Staines, 2016).

In summary, the reasons why this might be apparent can be attributed to one or all of the following: the care system’s inability to address pre-care concerns/negative experiences, the negative influences the care system has on a young person or the care system’s response to the behaviour of the looked after population. It is vital to understand the interplay between experiences before entry into the care system and those that follow, to understand the extent to which the risk of offending is produced by care, or by the care system’s inability to reduce individual risk experienced before care. In turn, such an understanding will assist in narrowing the gap in offending between looked after children/care leavers and the general population, through reducing risk and where apparent, eradicating unnecessary criminalisation of looked after children.
1.5.2 Overview of Statistics

1.5.2.1 Offending in Care

**Figure 10** Percentage of Looked After Children Convicted or Subject to a Final Warning or Reprimand During the Year by Gender

While the majority of looked after children do not offend (94.4%), they are still disproportionately represented in the CJS, evidenced by both official statistics and international research (Herz et al., 2012; Fitzpatrick, Williams and Coyne, 2016; Staines, 2016).

Although offending rates are falling for looked after children, they are still higher than for all children (DfE, 2015b:18). 5.6% (n=1,710) of looked after children between the ages of ten and seventeen years were convicted or subject to a final warning or reprimand in 2014, showing a 0.5% decrease (6.1%) from 2013 and a 1.3% decrease (6.9%) from 2012. However, rates of overall offending were over twice as high for boys at 7.4%, compared to 3.3% for girls, with these differences remaining constant across all age intervals. The
figures for all children are not yet available for 2014, however, comparable figures show lower rates of offending for all children, with 1.2% convicted or subject to a final warning or reprimand in 2013 (DfE. 2015b:18).

These figures show those in care to be five times more likely to offend than their peers who are not in local authority care. The overall offending patterns of looked after children have dramatically decreased since 2007, with 9.5% (n=2,900) of looked after children committing offences, a level which has continued to decrease (DCSF, 2010d). However, the offending rates for all children have also dramatically fallen, from 3.9% in 2007 to 1.2% in 2013, showing the difference to double from two and a half times more likely to five times more likely. This widens the gap of negative outcomes for looked after children (Fitzpatrick, 2014).

As predicted within the Age Crime Curve (Moffitt, 1993), only 0.4% of looked after children between the ages of ten and twelve years were convicted or subject to a final warning or reprimand. However, these rates of offending increase to 4.9% for thirteen to fifteen-year-olds and double to 10% for those aged sixteen to seventeen (DfE, 2015b:18).

Evidently, the above statistics highlight clear comparisons between looked after children and non-looked after children, with the potential explanations presented within section 1.5.1.2. However, it is important to also provide absolute interpretations of the statistics showing that in 2014, only 5.6% of looked after children between the ages of ten and seventeen were convicted or subject to a final warning or reprimand, while 94.4% were not. Although this is still higher than the non-looked after population (98.8% were not convicted or subject to a final warning or reprimand), it provides a less fatalistic interpretation of the position of looked after children, and moves away from suggesting
that they are inherently criminal. Understanding the statistics in this way is crucial for reducing an already stigmatised and often unnecessarily criminalised group of people.

In summary, the vast majority of looked after children do not offend. However, when compared to the offending outcomes of non-looked after children the differences are alarming and continuing to increase. Looked after children should not be more likely to offend than their non-looked after peers, and until this difference is eradicated the care system is failing in their duty as a corporate parent, in one or all of the ways discussed in 1.5.1.2.

1.5.2.2 YOIs and Prison Statistics

Less than 1% of all children in England are in care, but looked after children (aged between fifteen and eighteen years) make up 33% of boys and 61% of girls in custody (PRT, 2014). With Schofield (2014) referencing, between a quarter and half of children in custody are or have been in care, a finding in line with the National Association for the Care and Resettlement of Offenders [NACRO] (2006), showing that 41% of all children and young people in youth custody had been in care at some point (NACRO, 2006 Schofield, 2014: 1).

The latest statistics (March 31st 2015) show the gap between looked after and non-looked after children in YOIs to be at its highest in the last five years, with 206 of the 706 children in YOIs (36.8%) being looked after children (Staines, 2016). This is a huge increase from 2011, with 140 of the 1,601 children in YOIs being looked after children (8.7%). Despite the overall numbers of young people in YOIs continuing to decrease, looked after young people in YOIs are increasing (Fitzpatrick, Williams and Coyne, 2016).
Between 23% and 27% of the adult prison population has been in care, and almost 40% of prisoners under the age of twenty one were in care as children. These statistics are striking in comparison to the general population, with only 2% of adults spending time in prison (Krinsky, 2010; MOJ, 2012; Who Cares Trust, 2016). However, it is important to note that the duration these individuals spent in care could range from days to years (Staines, 2016).

As highlighted in section 1.5.1.2, there are clear explanations for why this level of concern is apparent, with the care system failing to address pre-care concerns and presenting further criminogenic influences. Furthermore, the system continued to fail care leavers, rarely providing support to young adults in custody, and failing in their role as corporate parent (Fitzpatrick, Williams and Coyne, 2016). It is crucial that these ‘careless’ practices are addressed, with the care system taking responsibility for looked after children and care leavers, as they would their own children.

1.5.2.3 Conclusion

The disproportionate number of offenders who have been in care is reproduced year after year in the prisons statistics, with the likelihood of offending being five times higher for looked after individuals than their non-looked after peers. Although care does not equate to offending for all young people (94.4% of the care population in 2015 were not convicted or subject to a formal warning or reprimand), the differences between young people ‘in care’ and the general population should not be apparent. At the time of writing, a Lord Laming inquiry is being carried out to investigate this increased difference. The central importance of this review is to understand the concerns faced within the looked after population and provide detailed evidence to local authorities of their crucial responsibility to provide stability, security and hope for the future, all of which are vital to ensure the corporate
parent has carried out their moral responsibility to be a good parent (PRT, 2016). This clear focus was the driving force of this thesis, commencing in 2010, to investigate the experiences in care with the aim of concluding with key recommendations to transform young people’s life chances and move away from the concerns with care being a stepping stone to custody. In order to achieve this, it is vital to examine the extent to which different types of care environments (residential, foster and kinship) are criminogenic, either through their inability to address pre-care risk, or through the risks they directly produce within the care experience.

Young people entering care in the year ending 31st March 2015 showed only 4% to be placed into care due to socially unacceptable behaviour, a low prevalence considering that 45% of care entrances were over the age of criminal responsibility (DfE, 2015f). Research is vital to ensure these figures do not go on to replicate the prevalence of looked after children in YOIs or care leavers in prison. Care has the opportunity to allow looked after children to find strength, or gain external resources and reverse negative spirals (Rutter, 2006).

1.6 Rationale for Primary Research

Looked after children and care leavers are one of the most disadvantaged groups in society, with lower presence in EET and higher prevalence within the CJS than their peers. These findings are replicated year after year and should not be taken as a given (Taylor, 2006). This thesis aims to uncover the experiences (before, during and after care) of: care leavers from kinship, foster and residential placements; a LCT; and carers, to identify the experiences which lead to criminal behaviour and the extent to which they can be attributed to the care system. Each participant will provide retrospective assessments of the
risk experienced or perceived, as highlighted within the Risk and Protective Factors Paradigm [RPFP] and the influences to behavioural and/or offending concerns: before, during and after care. Furthermore, the research will consist of semi structured interviews to allow a further investigation into: overall risks; experiences of attachments; and the links to offending, through the care periods.

Through such a research design, the study seeks to inform social care policy, helping to ensure the factors that can protect young people from crime are more readily understood, with risk factors reduced and permanence increased to allow an increase in attachments made within care. This thesis will add to the research domain, by offering comparisons through the care journey (before, during and after) through both risk assessments and interviews. It will compare evidence drawn from: care leavers, professionals, and carers for each placement type, highlighting the expectations and the system constraints.

Finally, the research will provide an examination into the extent to which measuring risk as a predictor of offending provides the foundations for models of interventions, with the measurement of attachment as a key focus. This thesis aims to be positioned as an attachment focused critique of the RPFP in criminology, care literatures, and in practice.

1.7 The Thesis Aims, Objectives and its Organisation

1.7.1 Aim and Research Questions

The overall aim of this thesis is to evaluate the extent to which different types of care environments have the propensity to be criminogenic and highlight what can be changed to improve life chances of looked after children, free from offending.

In order to do so, the following research questions are central:

(i) are care environments criminogenic?
(ii) to what extent does the RPFP successfully measure this?

(iii) to what extent does attachment to significant others help address this question?

(iv) what, if anything, can be done to reduce criminogenic risk in care?

1.7.2 Objectives

To achieve the overall aim, the thesis has the following objectives:

- To investigate and analyse official sources to provide the background context of care leavers and their offending behaviour, addressing its extent and seriousness.
- To review the research evidence about care leavers’ experiences within different types of placements and their possible relationships to becoming involved in crime.
- To explore secondary data by using existing literature and national statistics on care leavers and criminal behaviour, highlighting the specific situation of care leavers.
- To collect and analyse primary data through risk assessments and interviews, with: care leavers; professionals; and carers, to explore experiences within different types of placements and explanations for criminal behaviour.
- To summarise and evaluate the use of the RPFP as an explanation for the onset of care leavers heightened criminal behaviours within different types of placements and the evidence base of contributing factors, with a central focus on the importance of attachments.
• To inform the development of a model of intervention, which addresses current social care policy for individuals in care, helping to reduce crime levels within the care leaving population, based on the theories and evidence above.

1.7.3 Organisation

The thesis will be organised into the following chapters:

**Chapter Two** explains the criminal justice outcomes for different care environments and discusses the use of RPFP as a dominant theory in researching the link between care and criminality. The importance of attachment is highlighted, before moving onto what is already known about reducing the behavioural concerns within looked after children.

**Chapter Three** provides a methodological discussion for this research. It starts by presenting justifications for the methodological approaches, before presenting information on: access, sampling and interview schedules. The ethical considerations faced are presented in detail, followed by details of the sample achieved. The chapter then moves on to present the methods of data analysis, before concluding on my reflexivity and positionality.

**Chapter Four** presents the quantitative analysis of the risk experienced: before, during and after care in kinship, foster and residential placements. The main focus surrounds the experiences expressed by the care leavers, and their subjective assessment of the influences of risk to offending, with an overview, of the perceptions of risk and their influences, presented by the LCT and carers/staff from each placement type. The chapter concludes on the importance of attachments and the extent to which this is adequately measured within the RPFP.
Chapter Five analyses the qualitative data gathered on pre care experiences, highlighting the attachments status of the care leaver participants and the influence of attachments to risk and offending.

Chapter Six presents the narratives surrounding care leavers experiences during care. It examines the importance of attachments in allowing self-actualisation and pro social behaviour. The main analysis compares the experiences between placement types and highlights the direct influences attachment has on offending.

Chapter Seven presents the narratives of the LCT and carers. It provides an analysis of friendships within care and the concerns with attachments and offending. The main analysis focuses on the attachments made within placements, as experienced by carers, before highlighting the perceived impediments in gaining attachments with looked after children. The final analysis presents the consequences of attachments concerns, in terms of emotional and behavioural outcomes.

Chapter Eight provides an overall analysis of all participant groups’ experiences after care and concludes the overall link between attachments and offending. It presents the care leavers current attachment status, whilst providing an analysis of the attachment trajectory apparent and the care systems ability to assist with pre care concerns and provide new attachments. The analysis then directly concludes the link between attachment and offending. The chapter concludes with observations of the LCT and carers/staff, and presents barriers in addressing the concerns between attachment and offending.

Chapter Nine presents the concluding points of the thesis. It brings together the key findings of each chapter, provides illustrations of influences and suggests how these findings could be applied to policy. The thesis ends with recommendations for future research.
Chapter Two

Literature Review: Explaining and Reducing the Criminal Justice Outcomes of Care Populations, with the Risk and Protective Factor Paradigm [RPFP] as a Dominant Approach

2.1 Introduction

This chapter will attempt to uncover areas of research, policy and practice, with the aim of offering insights that could inform models of intervention based on both the successes and hindrances of those in care. Ultimately, this may help to reduce offending by those who have experienced state care. This chapter will critically explore the dominant theory in researching offending amongst care populations, the RPFP, and its application in understanding and preventing offending for ‘in care’ populations, drawing upon both the resilience and vulnerabilities of non-offenders and offenders. It is crucial to understand that risk factors experienced before care and further adverse influences or ‘risks’ directly related to care itself, interact. Evidently, many children who enter care have experienced high levels of risk in their birth homes, making them particularly vulnerable to adverse influences from relationships and experiences within care (Staines, 2016). However, the system has a responsibility to address the risks experienced before care, and therefore, the risks presented within this chapter are linked to the care system’s failure to address pre-care concerns or its presentation of further risks.

By reviewing relevant academic literature relating to ‘in care’ populations and offending behaviour, and critically exploring the RPFP, the potential of the RPFP to provide insights and assessments to aid the reduction of offending within care will be highlighted. In addition to the central critiques presented by academics, namely France (2008), Case and Haines (2009) and O’Mahony (2009), attachment as a critique will be introduced.
Although attachment is noted within risk factors, namely the prevalence of family and personal relationships and living arrangements, the RPFP neglects the importance of attachments in explaining the precise causal mechanisms of risk (Leschied et al., 2008; Schofield et al., 2014). Thus, although risk presents areas of life in need of intervention, the RPFP alone fails to acknowledge the mechanisms which lead to the outcomes of risk within care. This chapter therefore argues for the importance of using Attachment Theory to assist with the understanding of risk, exploring the importance of attachment in reducing risk.

The chapter ends with illustrations of current interventions to reduce the concerns highlighted within the chapter.

Analysing those who have been in care and their narratives, as well as views of carers and key stakeholders, alongside what is already known, underpins the aim of evaluating different types of care and the extent to which they may produce risk of offending. Providing an investigation into the levels of risk experienced in care and the importance of attachments in deterring these outcomes, is noted to be vitally important in order to fully inform the development of the care system.

2.2 History of the RPFP

The idea of the ‘risk factor’ was introduced in medicine in the early 1900s (Case and Haines, 2009: 53). However, within criminology, the origins of the RPFP, Risk Factor Research [RFR] and the epidemiological approach can be traced back to the original research of Glueck and Glueck (1930) entitled ‘500 Criminal Careers’. This study was the first to provide a factorisation of the elements that were statistically significant and predictive of the onset and frequency of offending, and those which were not. Through this
research the concept of risk of offending was made paramount as a form of criminological enquiry relevant for exploring youth offending, opening up a new and powerful explanatory paradigm and scientific methodology in youth offending. Developments were then made with regard to linking the RPFP with crime prevention by Cabot (1940), who set out to explore the potential of the risk factor approach to implement prevention. In 1939, the thirty-year longitudinal study ‘The Cambridge – Somerville Youth Study’ was put into place, incorporating the first set of treatments to prevent crime amongst young people. The objective was to prevent the delinquency of boys through trained and experienced councillors, whilst also measuring the degree of success or failure of such preventions. However, there were numerous other research interests within this study, drawing upon the causes of delinquency, success of longitudinal studies and the interrelationships of physical, social, mental and emotional factors and offending (Cabot, 1940: 143). Although the preventive measures were basic, they included areas which are still prominent today, such as counselling, academic assistance and family guidance.

‘The Cambridge Study in Delinquent Development’ (established in 1961 and still ongoing), also known as ‘The Cambridge Study’ by West and later Farrington (cited in West and Farrington, 1977: xiv) turned the RPFP and RFR into an influential application for understanding, preventing and assessing youth offending in policy and practice. Although highly critical of both the RPFP and RFR, which will be presented within section 2.6, Case and Haines present detailed observations of the developments within the RPFP and RFR. They highlight how ‘The Cambridge Study’ was the starting point of RFR, and has been the touchstone of prevention youth justice policy and practice within England and Wales since the early 1990s (Case and Haines, 2009: 71). The importance of the ‘Cambridge Study’ and its influence in both the RPFP and RFR is widely recognised, with RFR being
one of the most influential areas of criminology and its applications to policy and practice (Case and Haines, 2009: 71). Such developments have resulted in the present day RPFP, which is considered to be based on highly scientific methods and evidence, and provide a comprehensive and inclusive method of enquiry, allowing clear categorised domains of life to be explored in relation to the prevention of offending (Case and Haines, 2009). The RPFP studies are predominantly based on variable centred approaches, using statistical correlations between each variable describing personal attributes and offending outcomes (O’Mahony, 2009). Characteristically, the studies are primarily quantitative, single cohort, prospective longitudinal studies. The breadth of this paradigmatic multifactorial approach, highlighting numerous pathways towards youth offending, has been praised for its ability to avoid narrowly focused historical moncausal approaches, which are noted to be overly concerned with areas such as attachment and biological dispositions (Tibbetts and Piquero, 1999).

2.3 Key Terminology and Concepts

2.3.1 Risk Factors

Risk factors are influences that hinder the adaption of an individual or enhance already vulnerable aspects of their life. These factors are statistical predictors that are significantly and robustly associated with an increasing likelihood of the commencement, frequency and duration of offending and related outcomes across studies of differing time and place (Stephenson et al., 2007).

Risk factors are categorised in a variety of ways, but all loosely fall into groups which have been based on the earlier work of Bronfenbrenner (1979), who highlighted five environmental systems that influence development over the life course: 1) micro systems,
which include direct interactions with social agents and the environment an individual lives in; 2) *meso systems*, which reflect the interactions and relations between each of the micro systems; 3) *exo systems* highlight links between social roles that an individual has no control over, even though they are in direct contact with them; 4) *macro systems*, which explore the culture in which the individual lives; 5) *chrono systems* which highlight the overall transitions over the life course.

Within the RPFP are contained important domains of risk: family risk factors, including separation from biological parents, poor parental supervision and discipline, limited/poor attachments, isolation, low expectations, little encouragement and instability (Utting, 2003); school/educational risk factors, including low achievement, lack of commitment to school, poor relationships with education, low expectations, bullying, truancy and exclusion; community risk factors, including poor neighbourhoods, high levels of unemployment, high rates of crime and violence and high levels of substance misuse (DfE, 2014a); and personal/individual risk factors, including low IQ, low attainment, low empathy, unpopularity, poor interpersonal skills, ADHD, poor concentration, impulsiveness, risk taking, low self-esteem, low self-efficacy, hostile attitudes to the law through condoning offending and substance misuse, criminal peers and gang membership (Farrington and Welsh, 2007).

Through monitoring the risk factors within individuals’ lives, interventions can be put in place, which are designed to reduce risk, with the hope of reducing the likelihood of criminal behaviour (DfE, 2014a).

The risk factor vocabulary has evolved to express the subtleties of the person-environment interaction; however, this has been widely critiqued. Although the simplistic categorisation
of risk factors is appealing to academics, in practice it has become impossible to provide an operational definition of risk factors, how they work or how they should be measured and interpreted (France, 2008). With RFR being prominent within criminology, a huge array of differing definitions and concepts have become apparent, and can be categorised in the following way (Case and Haines, 2009: 27-29): causal risk factors, determining different forms of offending at different stages of criminal careers within developmental and/or proximal measures; predictive risk factors, increasing the statistical probability of offending in the future; linear risk factors, operating on a continuum; catchall concepts, applying broad explanations to offending of all young people; additive interactions, highlighting accumulation of risk factors; interaction of risk, with different combinations exerting differing levels of risk; overlapping risk factors, correlating with each other and the outcome of offending; correlational risk factors, contrasting to causality; multi–stage risk factors, highlighting links between one risk factor and another; proxy risk factors, areas of life that are linked to risk indirectly; challenging concepts, highlighting the positive force of risk factors in enhancing resilience through negative experiences; reciprocal risk factors, highlighting the interactive relationship between offending and risk factors; and symptomatic risk factors, which arise as the outcome of offending.

In addition, all of these definitions and concepts can be seen within an absolute or relative framework, with absolute risk examining the overall prevalence of the risk factors and the probability of offending occurring, and relative risk offering comparison between different levels of risk within offending cases and non-offending controls (O’Mahony, 2009).
2.3.2 Protective Factors

Protective factors are often referred to as the absence of risk factors, “the simple quantitative dichotomy of a risk factor” or as representing the same side of the coin as “a dichotomous variable” (Case and Haines, 2009: 39). Rutter (1987) argues that a protective factor in its own sense does not add much to the investigation of either the RPFP or resilience when it is merely presented as a variable. However, “the demonstration that these variables (protective factors) are highly robust predictors of resilience is important in showing that they are likely to play a key role in the processes involved in people’s response to risk circumstances” (Rutter, 1987: 317). They are, however, a separate part of the RPFP, being elements of both internal and external forms that allow the ability to cope and adapt to adverse situations. Protective factors can be found in the minds of individuals as well as in the environments that surround them, but each protective factor will only be protective in relation to specific risks (Schofield and Beek, 2005). They include individual qualities such as self-esteem, self-efficacy and intelligence, with environmental qualities being offered through stable, supportive families and access to social resources, such as quality education (Lesser and Pope, 2010: 30). These are more effective as the numbers increase or outweigh the risks, which are often the absence of such protections. Protective factors are not merely about desirable experiences, they are not the factors that make individuals feel good, but are variables that predict normal development in the presence of risk. Through outweighing or reducing the risks, the protective factors can decrease the likelihood of future offending or increase a young person’s resilience to the exposures of the risk factors (Schoon, 2006). Thus, it is not an evasion of risk, but a successful engagement with it.
Instead, the protection stems from adaptive changes that follow successful coping. A protective process can even stem from a variable that is deemed to be a risk factor (e.g. adoption can be seen as detrimental to a child, but if it removes a source of discord or abuse, it is deemed a positive process). Protective factors are noted to include the following: *family* protective factors, including good attachments, encouragement and guidance, supervision and discipline, high expectations, stability and continuity (Utting, 2003); *school/educational* protective factors, including academic achievement, encouragement, attendance and a positive attitude to schooling (Jackson et al., 2003); *community* protective factors, including an advantaged socioeconomic context, community based neighbourhood and low levels of crime (Lösel and Bender, 2003) and *personal/individual protective factors*, including flexibility, acceptance, self-esteem, self-efficacy in pro social behaviour, motivation, anger control and morality (DfE, 2014a).

Notions of risk and protection are inevitably linked conceptually and in individual cases. As Little et al. (2004: 108) state, “a protective factor can be understood only in the terms of patterns of risk”. This said, as Rutter (2006) highlights, the concept of protective factors and the related processes are vital within the exploration of the RPFP. The prediction of offending is improved by including protective factors as well as risk factors (Stouthamer–Loeber et al., 2002). Youth justice and its preventive programmes and interventions cannot solely rely on knowledge of risk factors, as they can be difficult to modify. Therefore, it is vital that protective factors are prevalent within research not only to allow development of prevention programs, but also to aid resilience if any of the many risk factors are part of an individual’s experiences.
2.3.3 Resilience

Rutter (2006: 1-4) highlights resilience as an interactive concept, referring to a relative resistance to environmental risk experiences, or the overcoming of stress or adversity, that can change within individuals’ experiences. This provides a necessary framework for understanding the varied ways in which some children do well in the face of adversity (Schofield and Beek, 2005). The resilience research agenda has moved from a focus on identifying resilience within children and young people, to looking at the ways of promoting it. Such processes challenge deterministic ideals of resilience as a fixed trait, suggesting that it in fact can be enhanced through positive influences (Rutter, 2006).

Resilience is different to the traditional concepts of risk and protection; this is due to its focus being on individual variations in response to the comparable risk or protective factors and experiences (Rutter, 2006). Thus, research surrounding risk and protection identifies and explores the individual differences and the causal processes they reflect. Resilience therefore differs from the alternative focus of the RPFP, referring to processes in place of defining a general quality of resilience. Although resilience has been linked closely to risk and protection (see, for example, Gilligan, 2001 and Schofield and Beek, 2005), it is not a reinvention of such concepts; its focus is entirely different. For example, if one is researching offending by those in residential care within the overall RPFP, risk and protective factors would be identified first as variables. The outcome of offending would then be observed with the assumption that such impacts of risk and protection will be similar, with the outcome of offending being dependent on how much the individuals from residential care experience each set of factors.
However, resilience acknowledges the variation in people’s responses to the same experiences. To use the above situation again, those interested in resilience would see that children in residential placements may or may not be subjected to the same risk and protection, but will be seen to be different in the way they react to such factors (offending or non-offending). The point is to better understand causal processes (Rutter, 2006). Through this, the outcomes are looked at with greater considerations of the underlying mechanisms and their variations. Such links to the mechanics of resilience have implications for preventive interventions. Although different through its interactive approach, resilience can only be explored once the risk and protective factors have been measured. Thus, resilience relies on such variables, but adds a new angle with heightened ability for causal links due to its shift in processes and mechanics, allowing focus on ‘how’ these external factors are dealt with by the individual within a more dynamic approach (Quinton and Rutter, 1988). Therefore, studying levels of risk and protection alone is not sufficient to assist in an overall understanding of the criminogenic influences of care. Instead, it is vital to adopt a person-centred, qualitative approach, to fully understand an individual’s reaction to their experiences of risk and protection within care.

The systematic study of resilience has produced a significant array of research since the 1970s (see, for example, Rutter, 1989; Gilgun, 1999; Schofield and Beek, 2005), acknowledging the need to explore it in childhood and its ramifications for policy and practice (Flynn et al., 2004: 65). The differing components that are seen to enhance resilience are split into those directed to the child, the family, interpersonal relationships and community, distinguished by the components developed by Bronfenbrenner (highlighted above) (Bronfenbrenner, 1979; Flynn et al., 2004: 66). The likelihood of resilience increases with experiences of a secure base (a sense of belonging and security),
self-esteem (an internal sense of worth and competence), good education, prosocial relationships and attachments to family and/ or peers, expectations from others, self-efficacy (a sense of mastery and control, along with an accurate understanding of personal strengths and limitations), talents and interests, positive values and social competencies (Rutter, 2006). The importance here is the presence of such experiences to protect from offending (Houston, 2010). However, it is important to note that the process of resilience is a social process, as much as an individual one. Research has moved beyond understanding resilience as a set of qualities within the individual and towards acknowledging the importance of the social environment’s ability to facilitate resilience (Ungar, 2011). This is particularly important when studying the impact of the care system on an individual and their outcomes of offending. Therefore, this central development will be discussed in detail in section 2.5.3, presenting both individual and social definitions of resilience within care populations.

2.4 Methods

The RPFP and the related RFR utilise quantitative methodologies in order to define factors related to offending. These methods allow measurements of the predominance of certain areas in a young person’s life, such as educational experiences and family relationships. The measurement of ‘risk’ or ‘protection’ has been facilitated by a process called ‘factorisation’, whereby numerical or ordinal values are allocated to real world observations to produce variables which can be statistically measured (Case and Haines, 2009: 12). These are then analysed to determine their relationship with the dependant variable: offending. However it is important to note that risk factors are probabilistic in nature, due to the difficulty in achieving the conditions from which causality can be inferred in developmental research.
The most influential RPFP research within England and Wales has been longitudinal in design, using regression analysis which specifies the direct magnitude of the relationship between the risk factor ‘coefficients’ in an overall model measuring offending. Crawford and Newburn (2003) highlight how the study of young offenders in the UK has been drawn from empirical longitudinal studies of risk factors. This type of design incorporates correlation research through repeat measurement. Longitudinal data is required to establish the ordering of risk factors that are associated with being causal and predictive of offending.

There are two main types of longitudinal study. The first is retrospective and consists of looking back at the individual’s life (either an offender or non-offender), seeking to gain information on risk and protective factors experienced at different stages of their life (through records and interviews, for example) and mapping them to offending (if an offender). Although these studies are used due to their ability to collect rich biographical data relatively quickly, they are flawed due to the known inability for full memory recall. The main purported advantage consists of the utility of such measures. Farrington (2006) states that the typically retrospective prediction is better, highlighting that hindsight is better than foresight, although the applications of the RPFP within prevention are by definition designed to predict offending. However, it is important to note that retrospective designs generally focus on offenders, inflating the importance of shared risk factors, with little reference to the individuals who also shared those risk factors but did not go on to offend.

Second, prospective longitudinal studies are prominent in developing knowledge for the onset, persistence, escalation, duration and desistance of risk and protective factors (Liberman, 2008; Leschiedl et al., 2008). After locating a suitable sample, the researcher
will follow an individual’s life experiences in terms of risk and protective factors and map them with rates of offending or absence of offending. Most of the influential pieces of research highlighted through the history of the RFR and the RPFP are prospective longitudinal studies, with retrospective and cross sectional research also adding to the paradigm (O’Mahony, 2009). Sampson and Laub (2005) highlight the importance of prospective longitudinal research due to its ability to trace back from the adult outcomes that could not have being predicted via precursors or risk variables.

Resilience studies mirror such methodological choices, with the importance of life span trajectories being prevalent (Rutter, 2006).

In addition, there are variations of prospective longitudinal studies, with both ‘high risk’ and ‘representative’ samples being compared and followed up to map differences. This method could be used, for example, to draw upon the RPFP and its implications to ‘in care’ offending and the general population.

2.5 The RPFP as an Explanatory Tool

2.5.1 RPFP Explanations for Care Populations: Examining System Failings

Few attempts have been made to explicitly explain the criminogenic themes within the care system. Within the last fifteen years, theorists including Gilligan (2001), Schofield and Beek (2005), Rutter (2006), Jones et al. (2011) and Schofield et al. (2014; 2015) have carried out studies with a basis drawn from Farrington’s earlier work alongside West in ‘The Cambridge Study’, with the addition of a resilience focus for those in care. Such studies allow detailed acknowledgement of the variables of risk and protection, either experienced as a product of pre-care experiences or through experiences within care itself, and their importance within the process of resilience and offending outcomes.
The ability to link understanding, explanation and prevention measures to offending offers the potential for application to aid developments to reduce offending by looked after children.

Using the theoretical guidance offered through the RPFP and the mechanics and processes of resilience is seen as a useful method, for example in Meltzer et al.’s (2003) study into mental health and behavioural outcomes of looked after children in England and Wales, which measured contextual factors of lifestyle behaviours and risk factors (Meltzer et al., 2003: xi).

This framework of investigation offers a good example of how links can be made within aspects of health, lifestyle, use of services, placement type and length, educational achievement and social networks, alongside the prevalence of their offending. Their findings concluded that of the 2,500 participants, children in residential care were far more likely than those in foster care or living with their natural parents to have behavioural and conduct disorders related to the levels of risk experienced during care (56% compared to 33% and 28%). The RPFP suggests that the predictors of offending identified in longitudinal research, that is, the risk and protective factors, are promising targets for preventive intervention (Arthur et al., 2002). The robust nature of the relationship between exposure to risk factors, processes of resilience and likelihood of offending is apparent, with the number of risk factors that are present being more powerful than protective factors and possession of resilience (Marsh, 2008).

The RPFP has potential for explaining offending in ‘in care’ populations, as risk and protection are found across different circumstances, with the availability of resilience processes differing between individuals (Schofield and Beek, 2005).
It is important to identify the ways in which the care environment may heighten these risks through their inability to address pre-care concerns and by presenting further risk, causing vulnerabilities (e.g. poor attachments, low achievement), and the extent they offer protective factors and mechanisms to allow the process of forming possible resilience (e.g. good attachments, stability and encouragement) (Rutter, 1987; Gilligan, 2001; McCarthy, 2004), allowing care leavers to ‘work well, love well and expect well’, free of criminality (Marsh, 2008: 15).

2.5.1.1 Individual and System Explanations

As highlighted within Chapter One, there are both individual and system explanations of care and criminality. This chapter incorporates the risk associated with both pre-care ‘individual’ level explanations and those risks or ‘adverse influences’ as a consequence of system failings. Therefore, the measurement of criminogenic influence of care is measured through both the inability to compensate for prior negative influences related to offending (noted within the RPFP as risks), and through the risks experienced as a direct consequence of an individual’s experiences within care.

2.5.2 Outcomes within Different Care Environments

2.5.2.1 Residential Care

Although only 8% of those in care are in residential settings at the time of writing (DfE, 2015a), it is the most widely researched type of care environment, and has been both a prevalent and recurrent theme in studies of offending behaviour (Schofield and Beek, 2005; Taylor, 2006; Schofield et al., 2014). The literature highlights many problems within this placement; ‘low educational attainment’, ‘lower attendance at school’, ‘living with criminals’, ‘alienation’, ‘disruption’, ‘lack of attachment’, ‘high placement movements’
and ‘high staff turnover’ (Home Office, 2004; Hayden, 2010). These experiences during care, all noted as risk factors for offending, are often linked to concerning outcomes after leaving care, such as high rates of unemployment, with research reflecting the importance of employability in reducing crime (Dixon and Stein, 2005; Mendes and Moslehuddin, 2006; Hayden, 2007; Hannon et al., 2010; Stein, 2012). Evidence has suggested that the placement itself is a direct cause of offending either through adding to pre-existing risk (Howe, 1997; Darker et al., 2008) or by introducing new risks posed through the environment itself (Sinclair and Gibbs, 1998; Taylor, 2006; Hayden, 2010). In addition, as highlighted within Chapter One, individuals living in children’s homes “are being criminalized at excessively high rates compared to all other groups of children, including those in other types of care” (Howard League for Penal Reform, 2016: 1). Therefore, not only does this placement type fail to address the concerns of risk, there is embedded structural criminalisation, which exaggerates the behavioural concerns within this placement type.

Residential care is provided in non-family based group settings. It should be well regulated and as family-like as possible, and only used in a purposeful and time-limited way. Residential care, while appropriate for some children who require rest breaks from foster placements, for instance, should never be the first resort (McGhee and Francis, 2003). In addition to the criminogenic influences above, there have been deep concerns with this placement type’s ability to appropriately safeguard looked after children, with both historical and current abuse being reported at high levels (Hicks et al., 2009). In 2014, the National Police Chiefs Council [NPCC] presented 75 children’s homes under investigation for historical child sex abuse within residential homes. Despite the developments of the care system and importance of safeguarding looked after children, as highlighted with
section 1.3.1.2, these concerns are still prevalent in residential settings today. Biehal et al. 
(2014) carried out an examination into abuse and neglect within residential care from 2009 
to 2012, showing between 2-3% of children in residential care each year are falling victim 
to the care system’s failures, either through serious abuse or neglect. These numbers are 
likely to be lower than the overall experiences of abuse or neglect, with individuals often 
feeling they are unable to report it, for fear they will not be listened to or taken seriously 
(Jay, 2014).

Residential settings often have high ratios of children to staff and high staff turnover, with 
the staff “limited in their capacity to provide children ongoing and meaningful affection, 
attention, and social connections needed to grow and prosper”. Consequently, “young 
children raised in institutions frequently have poor health, development, and behaviour 
outcomes” (BCN, 2009: 4).

Not only has research focused on the practical limitations of residential settings, evidence 
has also suggested that the placement itself is seen as direct cause of offending. Feelings of 
difference are highlighted through restrictions on what the young people can be involved 
in, hindering experiences that contribute to personal development, which in turn promotes 
protection from crime (Milligan and Stevens, 2006). Higher levels of residential 
movements are apparent compared to other care environments, which is a concerning 
outcome, as placement movements are a clear indicator of the abilities of an individual to 
form attachments (Munro, 2001; Oosterman et al., 2007; Darker et al., 2008). Those in 
stable placements are still likely to experience many care givers due to high staff turnover 
(Holland et al., 2005; Marsh, 2008: 5). Stein (2008: 289) suggested that enhancements of 
attachments in residential care can be made if there is reduction of staff turnover, allowing
the young people in care to be in receipt of warm and redeeming relationships, which in turn will aid educational achievement (Darker et al., 2008).

Attendance at school is lower compared to those in alternative placements, with a higher prevalence of offending to ‘fit in’ with other residents, who as noted above are more likely to be within an environment which includes criminals or others with challenging behaviour (Taylor, 2006). The absence of emotional, social and educational protective factors hinders the development of resilience needed to avoid offending.

Sinclair and Gibbs (1998: 178) showed that 40% of people with no convictions prior to entering care had a conviction six months after living in a residential placement, suggesting offending to be a direct consequence of being in residential care. However, as discussed in section 1.5.1.2.2, it is important to recognise the influence of structural criminalisation on these findings, with police interactions being more likely in residential care than they would be for the same behaviours in a family setting (Fitzpatrick and Williams, 2016). Furthermore, it is also important to note that such conclusions need to be considered in relation to Moffitt’s adolescence – limited type (within the context of the developmental taxonomy and alternative life course of persistent offenders). Thus, such a conclusion as that offered by Sinclair and Gibbs (1998) must be understood with acknowledgement of the general ‘age effect’, resulting in expectations of offending patterns relating to age (e.g. a large amount of teenagers do not commit crime in their early teens, but do so when they reach their mid-teen years) (see Moffitt, 1993). This said, one could acknowledge that the risk presented within residential care could amplify the effects presented within Moffitt’s theories of age and prevalence of offending.
The residential placement is often seen as a ‘last resort’, fuelled with impeded protections, which in turn limit the availability of the process of resilience to offending, and thus highly criminogenic (Rutter, 1987; Darker et al., 2008; Marsh, 2008). However, acknowledgement of its effectiveness is often overtaken by research into its faults (Houston, 2010: 367). Houston (2010) highlighted through research into resilience in residential homes that this type of care should be seen as a ‘positive choice’.

2.5.2.2 Kinship and Foster Care

Kinship placements are generally viewed by social work professionals and policy makers as the most preferred type of placement (Broad et al., 2001). Long term foster care that provides an alternative family life is seen to promote resilience and protect individuals from crime (Taylor, 2006; Darker et al., 2008; Pritchard and Williams, 2009). Kinship and foster care are seen as offering good insights into how improvements can be made within the residential care system (Monck et al., 2003; Holland et al., 2005; Stein, 2006). However, there are aspects of kinship care which present concern, with lower levels of discipline (Marsh, 2008) and financial support (Flynn, 2000; Richard and Tapsfield, 2003).

Kinship care contributes to and promotes relationships, reducing separation trauma and multiple placements, and enhancing the child’s sense of identity, areas emphasized within the RPFP (Broad et al., 2001; BCN, 2009). In addition, placements with relatives are less disruptive and tend to last longer than non-relative placements, allowing greater stability and increasing protection from offending (Chamberlain et al., 2006). Such protective factors have also been referenced whilst investigating offending as an outcome. The Who Care’s Trust (2010: 1) showed that around half of children go into kinship care with behavioural and emotional difficulties, but around 80% improve after placement.
Foster care is where children are placed by a local authority into the domestic environment of a family other than the children’s own biological family, that has been selected, qualified, approved and supervised for providing such care (BCN, 2009: 4; Parrish, 2010). Schofield (2003) also highlights the importance of long term foster care in providing an alternative to family life, drawing on the importance of attachment and stability. Schofield and Beek (2009) added to this, and stated that long term foster placements enable quality care that that helps children and young people towards success and fulfilment of their potential in life. However, this placement type is not without its faults, with an estimation of between 450 and 550 confirmed cases of abuse or neglect each year within foster placements (Biehal et al., 2014: 10).

Research has also focused on offending as an outcome for those placed in foster care. Taylor (2006), Krinsky (2010) and Schofield et al. (2014) found that individuals who received foster placements were less likely to offend than those in residential settings due to longer placement lengths and the related enhancement of stability and attachments. As mentioned above, it must be noted that the levels of preexisting risk will be different for each placement type and the individuals involved.

Evidence suggests that placements with extended families, such as grandparents, aunties, uncles and older siblings, are likely to promote better welfare for a child’s progression into adulthood (Ritchie, 2005). Alternatively, Flynn (2000) shows that although kinship may be the most preferred placement, it often faces barriers of economic hardship due to the predominance of older carers. The carers have also been noted to receive less assessment, training and financial support than non-kinship carers (Richards and Tapsfield, 2003). Therefore, although kinship care is referenced to be protective in terms of stability and attachments, practical risks are of concern.
While foster care can provide a positive family based placement for children in need of alternative care, it is not without potential problems. For example, serial and short term foster placements have been shown to be harmful to children when there is a lack of permanency and consistency of care and support (BCN, 2009: 4). Such factors raise the risk of behavioural problems.

Thus, the issue of stability and permanency is central in understanding experiences within placement types, with even the best interventions being disruptive in ways that enhance risk, including living arrangements, relationships, education, mental health and lifestyle. All of these are vital as positive experiences in order to promote prosocial behaviour (James et al., 2004; Leathers, 2006). These studies highlight the problematic nature of frequent placement moves, and have led to a greater interest in promoting permanency in foster care through prospective longitudinal studies of planned long term placements (Garrett, 1999a; Schofield and Beek, 2009: 256). It is important to note here the context of the foster placement at the time of writing. Through the professionalization of the care system and shift from foster parents to foster carers, the ease of building attachments within foster placements has been replaced by a need to commit to parenting on a professional level, which can discourage closeness between the carer and young person (Wilson and Evetts, 2006; Kirton, 2007). Although this aims to avoid further rejection and attachment concerns, there is still a strong need to further develop foster care “that more nearly approaches a ‘family for life’ which is not seen as ‘second best’ and [in] which carers can act as parents” (Sinclair, 2005: 123; Schofield and Beek, 2012). Such developments will allow responsive parenting, built on love and trust, to enable young people to have emotional stability, self-esteem and behavioral boundaries (Wilson et al., 2003).
2.5.3 Resilience within Care Populations

Resilience is a principle that is vital whilst planning for young people who may require to be looked after away from home (Gilligan 2001; Flynn, 2004: 65). This concept recognises that although it may not always be possible to protect a young person from further adversity or to provide an ideal environment for them, boosting resilience should enhance the likelihood of better long term outcomes. Through the detailed acknowledgments of areas such as poor stability and low educational attainment, it is evident straight away that the abilities to develop resilience may be impeded. This suggests a need to look more closely at the areas of resilience experienced in care, to formulate further understandings of the defined areas, or alternatively introduce areas of further interest.

Schofield and Beek (2005) report and analyse a longitudinal study of children in long term foster care, examining the levels of risk and resilience available. Their study aimed to focus on the different levels of progress and outcomes for individuals who experienced this placement type. All participants were high risk in all aspects, including their age at placement. Promoting resilience in the context of multiple adversities was a primary goal for this placement type, exploring how the needs of the looked after children could be met. It draws upon Rutter’s argument of thinking in terms of processes and mechanisms, rather than focusing simply on lists of characteristics which may counteract risk factors (Rutter, 2006). Such concepts and processes fit in and complement other developmental theories by providing a language and a framework for understanding processes and mechanisms of coping over time. Understanding such resilience allows carers and social workers to produce turning points that can lead to positive outcomes.
The research looked at the extent to which the children progressed in three key areas of their lives: a secure base, including behaviour and relationships in the foster family, social functioning outside the foster family and a sense of permanence. Two time points were pertinent: measurement of resilience at the initial stage of placement and then again three years later, noting the potential links to experience of care. Success in each of these areas would be indicative of and suggest contribution to resilience (Schofield and Beek, 2005).

The study found that there were three groups: ‘the good progress’ group, ‘the uncertain progress’ group and ‘the downward spiral’ group. All of the groups fared differently regarding the process of resilience, with some starting within phase 1 in the good progress group and slowly moving towards the downward spiral within phase 2, and others moving in the opposite direction, sometimes only gaining the uncertain status with progress. The exact results are not pertinent here; instead, the application and presentation of the process of resilience is key. This small study highlights the processes that can take place and the diverse outcomes that can occur even with the same scaled level of risk, with some children making good progress despite high levels of adversity. Using the resilience framework allows the incorporation of inner and outer worlds, taking a psychosocial and developmental approach which aids the explanations of the complex histories of the looked after children (Gilligan, 2001).

Stein (2006) researched care leavers in a resilience framework, showing them to fall into three groups. First was a ‘moving on’ group, which possessed stability, attachments, educational and transitional successes, and whose existence was interpreted as reflecting resilience enhanced by being in care. The second group, the ‘survivors’, possessed instability, movements and disruptions leading to fewer qualifications and early transitions affecting their life chances. The third group, the ‘victims’, experienced high levels of
instability, no qualifications and had profoundly compromised transitions into adulthood resulting in poor life chances. Not being able to overcome the difficulties faced in care leads to an increased likelihood of offending (Wade and Dixon, 2006). There are different pathways for care leavers directly related to the quality of care they experience (Stein, 2008). It is important to examine the extent to which young people who offend are ‘victims’ of the care system, and what can be done to reduce these poor outcomes. Rutter, Giller and Hagell (1998) showed protective factors aiding young people in care to be resilient to crime, such as the promotion of self-esteem through secure and supportive relationships and the availability of positive opportunities through education and careers (Bynner, 2001; Osterling & Hines, 2006). Flynn et al. (2004: 78) show that those in care display similar levels of resilience to those in non-state care, and although they often face challenges within education, there is positive adaption in areas such as self-esteem and prosocial behaviour. However, although there are positive messages, attachments are seen to be a concerning issue for those in care. Clearly, individuals are all subjected to differing experiences; however, there is a need to see how those who have experienced care see their experience in its entirety. Linking areas of ‘protection’ within a resilience-focused perspective allows better judgement of offending as an outcome. Evidence suggests that “children who ‘make it’ have basic human protective systems operating in their favour. Resilience does not come from rare and special qualities, but from the everyday magic of ordinary human resources in the minds, brains and bodies of children, in their families and relationships, and in their communities” (Masten, 2000: 4). The key question here is whether Masten’s (2000; 2001) idea of promoting resilience is available at the expected level for that of general youth and for those who have been looked after. The resiliency perspective is not only academically focused, it is also incorporated within local authority action plans relating to corporate parenting. ‘Looking after Children’ is a developmental
approach incorporating the concept of and need for resilience, alongside monitoring progress and welfare of those young people who are looked after (Flynn et al., 2004: 67).

Although some mention that plans such as ‘Looking after Children’ only merely touch upon resilience, there is evidence to suggest that even when implicitly shown there are three overall areas that promote resilience for those in receipt of state care. Firstly, the development of competence for those who have experienced adversity is at the forefront within corporate parenting, derived from the very definitions of resilience. Secondly, through the developments of corporate parenting and ‘what works’, local authority teams seek to strengthen attachments, motivation, self-regulation and educational systems that underpin resilience (Flynn et al., 2004: 67). Finally, the overall principles directed to the different types of care environments are instilled with a resilience perspective that aims for looked after children to achieve success and positive wellbeing, with the same parenting standards of those in stable non-state care, and to achieve the same outcomes as this group.

The targets are in acknowledgment of the young people’s possible difficulties, but state that resilience is possible even in less than desirable circumstances. Thus, in addition to the need to highlight if there are the available protective factors needed for resilience within care, there is a need to see how those who have left care view their experiences in relation to their life chances, and the outcome of offending. Research needs to go beyond simply determining where resilience is available, and move towards understanding how care leavers become resilient (Benzies and Mychasiuk, 2009: 109).

As highlighted above, the study of resilience has been popular, but the popular discourse is surrounding the resilience of an individual and their ability to respond to adverse experiences (Keck and Sakdapolrak, 2013). This is particularly interesting when the
evidence suggests that an individual’s positive outcomes are actually predominately an outcome of the environments that they are placed in. Thus, the stability of a placement can predict the looked after child’s ability to develop coping strategies, rather than the child’s coping ability being dependent on the stability provided within the placement. However, it is vital for the study of resilience to look at the context or ‘social environment’ first, and the ‘individual’ second.

The context or environment in which an individual exists will play a vital role in determining which resources are accepted as mechanisms to assist resilience. Therefore, resilience research based on the ‘individual’ fails to understand the importance of the function of external components. Therefore, there is a need to place greater emphasis on the importance of the roles social and physical ecologies play in positive developmental outcomes when individuals encounter significant amounts of stress. Ungar (2011) proposes four key principles to better understand resilience: decentrality, complexity, atypicality and central relativity, all of which produce a definition of resilience that puts emphasis on the importance of the environment in ensuring positive outcomes.

Each of the principles, to be briefly introduced below, highlight how individual qualities associated with dealing with adversity are only present when there is the capacity in the individual’s social and physical ecologies to facilitate processes, which in turn assist their ability to cope and promote positive development (Ungar, 2011: 4).

Decentrality: This is a concerning aspect in the study of resilience, as the academic must focus on the individual (including the changes that occur within the individual’s life) and the nature of the mechanisms that interact with adverse experiences or ‘risk factors’ to alleviate their impact. This focus tends to be centred on outcomes of individuals caused by
the environment. Through focusing on the changes of the individual, the environment then becomes secondary to the study of resilience. Although we already know that the environment is important, it is only seen as important in terms of the extent to which it provides an arena in which resilience building can take place. Therefore, the responsibility for resilience is incorrectly placed on the victim of the negative environments, with the level of change presented by the individual hypothesised as a measure of how well the child is individually able to take advantage of the resources provided by the environment. However, children change not because of what they do, but as a consequence of what their environment provides (Wyman, 2003). Therefore, in order to better inform interventions, including for those in care, research needs to shift its focus from the changes apparent within an ‘individual’ to placing a greater emphasis on the environment, “making social and physical ecologies facilitative” (Ungar, 2011: 6).

Complexity: Social and physical ecologies can be complex, and therefore it is seen to be counterproductive to create specific processes which assist resilience. It is important to understand that positive adaptation in the face of adversity and the protective processes that cause it to occur are extremely complex, and therefore it is impossible to predict trajectories. Contexts will change over time, individuals will change schools, change placements and gain new relationships, and therefore the influences of resilience will change, dependant on their environment. Therefore, the principle of complexity highlights the need to develop “contextually and temporally specific models to explain resilience related outcomes” (Ungar, 2011: 7). Through development of these specific models, there will be a move away from general predictors of resilience, towards an understanding that resilience can be reached through many potential means related to the social and physical ecologies experienced.
Atypicality: There is an important need to move away from the individual traits linked to resilience and towards processes apparent due to the environments available. Furthermore, resilience needs to focus less on “predetermined outcomes to judge the success of growth trajectories and [place] more emphasis on understanding the functionality of behaviour when alternative pathways to development are blocked” (Ungar, 2011: 8). Therefore, the principle of atypicality is crucial to argue that resilience will be apparent in ways which the care system might not want to promote, but are vital due to the social environments in which a looked after child survives. It is hoped that changes to the environment that the looked after person experiences will assist them in utilising more appropriate ways of coping, but again, these choices will be more dependent on the quality of the environment than the individual traits of the looked after person.

Cultural Relativity: The processes of coping in the face of adversity are both culturally and temporally rooted. It is vital that the study of resilience accounts for cultural relativity, ensuring that an individual’s beliefs, values and activities are understood by others in terms of that individual’s own culture. Understanding resilience as a process that reflects cultural influences will allow the study of resilience to understand coping in the face of adversity as a process which is culture specific and not generic. Such understandings will provide a clearer analysis of resilience as a multifaceted construct with varying outcomes, accounting for the cultures of the looked after child.

These four principles provide a definition of resilience that accounts for the “disequilibrium between vulnerable individuals who lack opportunities for growth and the influence of social and physical ecologies that facilitate or inhibit resilience-promoting processes” (Ungar, 2010: 3). The importance of shifting the focus away from the ‘individual’ and towards the individual’s ‘social environment’ and the extent to which it
provides the individual with the resources they need to become resilient, is crucial. If the resources provided are insufficient, or lack meaning, then it is more likely that the particular environment will fail to facilitate resilience (Ungar, 2011). It is therefore important to recognise the critical focus of the resources available for looked after children within their placements and wider social environments. Not only will this allow a better theoretical understanding of resilience amongst looked after children, but will also assist the design of interventions that promote well-being among looked after children who experience environments that inhibit resilience-promoting processes (Ungar, 2011: 1).

2.6 Overall Critiques of the RPFP

2.6.1 Political Context

Although the paradigm attempts to explore areas of life that are known to be poorer in outcomes for the care population compared to general youth, one must acknowledge the context in which this exploration is situated. The RPFP offers an attractive mechanism for political leaders, highlighting clear causes of delinquency which can be presented as preventable (O’Mahony, 2009). However when these factors are noted, the blame is shifted in line with the pursuit of responsibilisation, rather than towards the broader concerns of social exclusion to reposition the management of risk to the government’s interests (France, 2008).

The ideologies highlighted within the political agendas and prominent responsibilisation are a great concern within the explorations of offending by care leavers, as they leaves little room for unbiased interpretations of the exclusion faced within care populations and the failure of the claimed legislative developments highlighted within Chapter One (Gray, 2005). The RPFP and related risk factor analysis is crucial for the government, as it shows
that they are addressing the issues of offending, without having to tackle the fundamental concerns of the care system and broader social and economic equality (France, 2008).

2.6.2 Superficial Understandings

Research including that of Case and Haines (2009) and O’Mahony (2009) highlights that the predominance of the RPFP is in many ways an obstacle to a fuller understanding of, and more effective response to, youth offending. The RPFP holds one of the most technically sophisticated and challenging areas of study within criminology, but such detailed and statistically developed research is often fuelled with over simplified assumptions and exaggerated claims. There is a lack of understanding of the risk factor influences on any level (whether that be descriptive, exploratory or explanatory) other than the statistical. Many of the risk factors have been factorised, aggregated and generalised in order to ascribe causality, but without stating a credible mechanism linking the proposed cause and effect (Case and Haines, 2009).

In addition, the reluctance of the risk focussed researchers to push critiques forward is noted to be of concern due to the interrelated interests of both the RFR and the RPFP. Without such critiques, the prevention programmes made through the RPFP allow the RFR to enhance their research on causal inferences. Thus, such a process is referenced to spread bad practice within the management of risk, through the absence of clear mechanisms that link risk to offending (France, 2008). Although such a simplified translation makes the research appeal to the public and policy makers, it does so at the price of the validity of the claims. Such processes de-professionalize and mute practitioners, robbing them of their ability to use discretion and experience when accessing risk and possible interventions (Case, 2007).
2.6.3 Evidence Based Concerns

Case (2007) and Case and Haines (2009) focus their critical concerns towards the evidence of the RPFP. Both authors highlight their concerns with the comprehensiveness, validity and appropriateness of the evidence of defined risk factors which underpin the evidence based prevention and intervention within the Youth Justice Board [YJB]. Goldson and Muncie (2006) show concern with the lack of critical engagement and methodological rigour in both the gathering of the evidence and its application. Through this uncritical lens, the RPFP and RFR tend to accept a certain ideological assumption, or ‘regime of truth’, and therefore do little to challenge or develop understandings of the link between risk and offending. Instead, the evidence gathered is noted to remain self-fulfilling (House, 2007; Case and Haines, 2009).

The application of evidence based research to risk assessment is noted to be one without understanding, being ambiguous, contradictory and uncritical in its transfer from RFR into assessment. In addition, the claimed definitive conclusions of predictive utility and its ability to inform effective interventions, is one that is merely based on the perpetuation of uncritical and narrowly understood understandings of the RPFP (Case and Haines, 2009).

The evidence based rationale, which upholds many of the RPFP applicability, is self-referenced to focus on targeting ‘at risk’ children and related risk factors. Thus, it is seen to be self-evidently beneficial because it prioritises the obvious links within social and personal harms (O’Mahony, 2009). Such evidence is derived at different times and from distinctive samples of people (not often care populations) in different social environments, which in turn include different definitions, perceptions and meanings. Thus, not only does
the evidence base prioritise areas of concern that fit ideologies, but the methods employed to gather them do not offer a basis for sound comparison.

2.6.4 Methodological Concerns

2.6.4.1 Causality

The issues of causality are prominent within the critiques the RPFP and related RFR. Rutter (2005: 2) presents the criteria to present clear causality as follows: “Is the association valid?; if valid, does it represent a causal effect?; if there is a causal influence, what element in the experience or circumstance provides the risk and by what mechanism does it operate?; and does the risk operate in all people in all circumstances or is it contingent on either particular individual characteristics or a particular social context?” However Rutter, amongst others, states that these very questions are not only often left unanswered, but no attempt is made to answer them (France, 2008; Case and Haines, 2009).

A critique drawn from a researcher focusing on risk prevention, Hinshaw (2002: 436), states that “there is distressingly little evidence for the causal status of nearly all the entries (in the typical risk factor list)”, with any causality being claimed on the basis of preconceptions rather than new discovery, a lack of comparative causal significance and the misuse of terming causality with mere correlations (Rutter, 2006). O’Mahony (2009) states that the RPFP is mostly based on correlates of vague proxies for offending, rather than explaining causality. Such correlations do not help to answer the important question of ‘why’, which is vital within aims to reduce offending by looked after children.
Thus, such elision between the correlations and causations through the RPFP and related RFR actually obscure rather than clarify the issues surrounding causality, encouraging the ‘blunderbuss’ approach (Farrington, 2002: 661).

### 2.6.4.2 False Positives and Negatives

The RPFP predicts people who are likely to offend and those who are not. Common errors appear when these assumptions are wrong, with false positives referring to individuals predicted to offend based on a risk profile, who do not, and false negatives describing the process whereby individuals are not predicted to offend, who do (Soothill et al., 2009). Huizinga et al. (2003: 86) state that “identifying future serious delinquents at an early age is likely to be inaccurate. Thus targeting problematic children for various ‘treatments’ although done with the best of motives and intentions, may through labelling and other processes be counterproductive and potentially increase the number of future serious delinquents”. Although there is no such thing as a ‘risk free’ decision in assessing the likelihood of offending, the RPFP is widely criticised for its methodological and ethical flaws in presenting both false positives and negatives (France, 2008). As Case (2006: 173) concludes, “stigmatising, marginalising and criminalising young people through risk based targeting should be avoided”. Such stigmatisation has a negative effect on offending as an outcome, with young people who are labelled as deviant being more likely to act in a subsequent delinquent manner (Hayden, 2007). Although not focused on offending as a sole outcome, Stein (1994) highlights the detrimental effects of labelling looked after children as low achievers within education, resulting in lower overall achievements, poorer transitions into adulthood and overall behavioural problems. Thus, to marginalise those in care and those who have left care as ‘at risk’ of offending could lead to deviancy amplification within the care population.
2.6.5 Theoretical Shortcomings

2.6.5.1 Risk Factor Concerns

Hinshaw (2002: 432) expresses concern that “the sheer size of the list (of risk factors associated with aggressive and anti-social behaviour) betrays the field’s lack of ability to synthesize or to tell a fully coherent story about the development and maintenance of externalising behaviour”. The very process of factorisation is paramount within the critique of the RPFP, due to the use of crude reductionist conversions of potentially complex and dynamic experience into static risk and protective factors (Case and Haines, 2009). This process cannot measure risk within an individual’s life in any valid, meaningful or comprehensive way, as too much meaning is lost from the data at each step.

The perspective also assumes that ‘risk factors’ are social facts that are measurable and objective. Armstrong (2004) highlights how risk factors are difficult to measure and identify, with meanings and consequences being unclear and their relationships being limited in evidence. One cannot say that behaviour is dichotomous or that there is a causal primacy to offending, yet still the RPFP makes these claims and therefore takes criminology in unproductive directions (France, 2008).

In addition, the interrelation of risk factors are also deemed a concern. Hayden (2010) shows that the mix of risk factors that are associated with care can be deemed part of the problem of using the RPFP as an assessment of offending. The interconnections of risk factors, such as school exclusion, poor educational outcomes/achievement, mental health problems, special educational needs, offending and being unemployed are all too obvious. Therefore, the RPFP as an investigative tool may cause problems in assessing looked after
children at high risk, when it may be one aspect of their life that would deem them to be likely to commit crime (Marsh, 2008).

2.6.5.2 False Claims

The RPFP claims to be based on the premise of the utilisation of predicting serious offending behaviour, especially explaining offending which continues after the transition to adulthood. Such claims are flawed, as the RPFP tends to focus on the risk factors and precursors linked to youth offending, and not crimes which typically have an adult onset, such as corruption, fraudulent activities and paedophilia (O’Mahony, 2009).

In addition, it fails to explain crimes that are often committed by individuals who are not noted to have a history of adverse personal experiences or anti-social behaviour, reiterating the concerns of false negatives highlighted above (Soothill et al., 2009). Further explorations into such precursors could expand the present widespread risk factors, increasing the model’s validity.

2.6.5.3 Freewill and Agency

The conviction of offenders is concerned with the moral issues of responsibility and the role the individual’s agency plays in this, relying on the doctrine of free will. The RPFP is totally preoccupied with the search for causal determinants that it loses such focus. The RPFP fails to incorporate the concept of free will and agency and their relationship to offending trajectories, which is undoubtedly a major limitation (O’Mahony, 2009).
2.6.5.4 Atheoretical Nature

Although risk factors are gathered from explorations into a breadth of domains and analytical considerations, the RFPF fails to seek precise causal mechanisms and relate them to one another (although arguably causality is problematic for all major camps of criminological thought). However, such lack of direction reflects an atheoretical reputation, failing to account properly for key facets of youth justice, including the place of human agency, context issues and psychological motivations (O’Mahony, 2009).

2.7 Alternative Doctrinal Criminological Approaches: Attachment Theory as a Critique

2.7.1 Overview of Attachment Theory

Attachment Theory was developed from the work of Bowlby and Ainsworth, with Main and Solomon expanding on the categories of attachment (Ainsworth and Bell, 1970; Main and Solomon, 1986; Ainsworth & Bowlby, 1991). The main categories are as follows: secure; avoidant (distance between child and caregiver); ambivalent (inconsistent behaviour from caregiver causing anxiety and insecurity to the child); and disorganised (extreme behaviour from caregiver which is often erratic and frightening, causing depression and anxiety to the child).

The key component of the theory describes the need of infants to form emotional bonds and attachments with a primary caregiver (or attachment figure) as a function of psychological and biological survival (Bowlby, 1988). Experiences in childhood have an important influence on development and behaviour later in life, with broken attachments being linked to delinquency (Hirschi, 1969). Although Bowlby’s earlier work on
attachment focused on attachment styles developed within infancy, recent research challenges this, and highlights how relationships with experiences throughout our lives, including relationships with others and our wider environment, continue to alter throughout life (Mendes et al., 2014).

‘Secure’ attachments are known to set the foundations of prosocial behaviour and make us accountable to the people we love (Hirschi, 1969). In contrast, those who experience ‘insecure’ attachments (either avoidant, ambivalent or disorganised) are more likely to experience low self-esteem, lack of self-control and difficulty with genuine trust, intimacy and affection. These consequences are known to lead to inabilities to deal with adversity, negative views of the self, family and society and a lack of empathy, compassion and remorse, all of which are strongly linked to antisocial attitudes and behaviours.

Although early studies within attachment theory have been noted to be deterministic, recent work has moved away from this and towards the understanding of attachments developing throughout the life course. These developments allow a clearer understanding of both attachment and resilience, acknowledging the ability of an individual to develop mechanisms of dealing with adversity beyond childhood. Neither attachment nor resilience are fixed traits, and instead can be enhanced by positive experiences facilitated by supportive environments. Therefore, the likelihood of resilience increases with attachments and their ability to assist a young person’s sense of belonging, self-esteem, self-efficacy, positive values and social competencies (Rutter, 2006). Thus, with a well-resourced environment, there is an increased likelihood of the development of attachments, which is a driving force in assisting resilience. The research within this thesis will therefore examine the extent to which concerns relating to attachments, due to the environment a
child is placed in, will impede resilience and cause vulnerabilities in relation to the risks experienced.

2.7.2 Attachment Disorders and Behaviour

Lieberman and Pawl (1988) define attachment disorders and the implications to adult life. Those who have not experienced secure attachments are more at risk of impairments in three areas: interpersonal relationships, impulse control and regulation of aggression. This leads a young person to have a long term inability to develop positive emotional connections, due to their inexperience in reciprocating attachments.

These risks are noted to be reduced in structured environments, rather than those which are permissive and relaxed, with a young person feeling more comfortable with distance. However, more exposure to such environments will further escalate the attachment disorders and increase interpersonal and behaviour concerns.

Therefore, it is interesting to see the extent to which different care environments are able to address attachment disorders in both family based and institutional settings. Millward et al. (2006) researched the prevalence of reactive attachment disorders and found that those in care were four times more likely to have reactive attachment disorders than those who were not in care. This presents firm evidence of the need to ensure there are positive interactions within a stable and nurturing environment.

2.7.3 Attachment in Care

Joseph et al. (2014) examined the attachment patterns of 62 young people who had been placed in foster care and compared them to 50 young people in normal risk families. The patterns of attachments were measured through current observations of relationship quality
and the duration of the placement. Of those in foster care, 90% had insecure attachments with their birth mother and 100% with their birth father. However, just under a half had secure attachments with their foster mothers (46%) and foster fathers (49%). These rates were not significantly different to rates in normal risk families. Furthermore, the attachment quality for both sample groups was linked to fewer behavioural concerns. Such findings highlight the potential for attachments to be formed within stable environments.

2.7.4 Attachments, Behavioural Concerns and Offending

It is vitally important to develop secure attachments within care in order to teach prosocial values (Ryan, 2007; May et al., 2014). Hoeve et al. (2012) carried out a meta-analysis of 74 published and unpublished manuscripts (n = 55,537 participants) and found that poor attachments to parents was significantly linked to criminal behaviour in both males and females. Such findings reinforce the need to focus on attachment as a target for intervention to reduce or prevent offending amongst those in care.

Children in care tend to have previous difficulties with attachments, behaviour and self-esteem (Wilson et al., 2003). Therefore, it is vital carers handle attachment carefully in order to reinforce self-esteem and handle behaviour appropriately. In order to reduce behavioural concerns, carers must ensure they provide responsive parenting at all times. This includes ensuring the young person is aware of their importance, provided with a secure base and remaining near the young person when they are badly behaved.

It is vital that carers understand that behaviour is often a response to previous negative experiences, and ensure attachments are not shaken when dealing with concerning behaviour (Wilson et al., 2003). Mendes et al. (2014) highlighted the vital importance of attachments to reduce pre-care concerns of trauma and improve behavioural outcomes. In
order to reduce behavioural concerns the following components are needed: safety, stability, connection, understanding, healing (access to case files and therapeutic interventions) and ongoing interventions. With such provisions in place, the risk of offending amongst the care population is predicted to reduce.

The majority of research surrounding care and criminality is carried out under the RPFP framework, and has been discussed above. However Taylor (2006) and Krinsky (2010) highlighted the significance of attachments as an indicator of offending, and both conclude that individuals who received foster placements were less likely to offend than those in residential settings, due the presence of attachments.

Anderson (2005) carried out a prospective longitudinal study of 26 looked after children placed in residential care in Sweden in the 1980s. The children were seen three and nine months after leaving the children home, and then at five year intervals, up to twenty years later. The last follow up showed very different outcomes, with those who experienced attachments being categorised as either ‘good’ or ‘moderate’ in terms of social adjustment and wellbeing. However, those who experienced a lack of attachment were linked to ‘bad’ outcomes, with a higher prevalence of substance misuse and criminal behaviour.

2.7.5 Applicability and Importance of Attachment Theory

Attachment Theory offers us a way of understanding offenders (Ansbro, 2008). It underpins Social Control Theory, with an individual’s attachments, commitment, involvement and beliefs acting as key mechanisms to deter them from criminality (Hirschi, 1969). Furthermore, the importance of relationships and related attachments have a varying presence within developmental theories of crime.
The theories of attachment and risks are not incompatible. The RPFP shows objective markers, which predict outcome variables that are centred on what is known to predict offending, including the importance of family and personal relationships (Leschied et al., 2008; Schofield et al., 2014).

However, Attachment Theory allows an investigation into the process of relationships, which are fluid and interactive, in the various aspects of a young person’s life, with the quality of the bond being paramount. Therefore, the process of forming attachments and their subsequent status provides a mechanism that explains why people in care experience these variables, or ‘risks’. Thus, attachment plays a vital role in understanding the cause of risk, and therefore assists in providing the improvements needed in order to reduce risk. Therefore, focusing on attachments has the potential to provide an explanation of the experiences of risk within care.

Using Attachment Theory builds on the critiques presented above, by highlighting the importance of gaining theoretical guidance to acknowledge and understand the processes which lead to the experience of risk. Focusing on attachment provides evidence of a plausible mechanism to link the cause (quality of environment and ability to facilitate relationships) and effect (presence of risk or resilience and offending outcome). Focusing on attachment as a mechanism which predicts risk, moves away from the vague proxies for offending, and actually assists with the understanding of causality, providing responses to the important question of ‘why’, which is vital to reduce adverse experiences within care and reduce offending by looked after children (Armstrong, 2004; O’Mahony, 2009).

This is not to state that Attachment Theory should replace the use of the RPFP, as measuring attachment alone will give disproportionate understandings of its influence. Instead, the aim is to examine the extent to which attachment is seen as an ‘overarching
influence’ upon risk, with the attachment being the focus of influence and the RPFP highlighting the outcomes of risk, either related to attachment or other external factors. Using the RPFP alone would not allow explanations as to ‘why’, whilst Attachment Theory alone would be unable to show the full outcomes of risk across the twelve aspects of life. However using both could assist the understanding of the adverse influences of the care system, targeting the importance of attachments within prevention of risk and the accountability of the care system to provide the appropriate environments to gain attachments and develop resilience when risk is present.

In summary, the extent to which the RPFP neglects underlying mechanisms leading to risk, such as a lack of attachment, is of critical concern. It is therefore vital to examine the extent to which this monocausal theory assists with the understanding of criminality amongst the care population.

2.8 Reducing Behavioural Concerns: Interventions within Care

2.8.1 Treatment Foster Care Oregon UK

Treatment Foster Care Oregon UK [TFCO-UK], originally known as Multi Treatment Foster Care [MTFC], both being referenced, developed at the Oregon Social Learning Centre, and is based on Social Learning Theory (TFCO, 2016). It is an intensively structured behavioural programme which provides multi agency assistance to a child or young person (Biehal et al., 2012a).

There are three types of TFCO-UK: TFCO-UK-P, focusing on pre-schoolers aged three to six; TFCO-UK-C, focusing on middle childhood, and covering ages seven to eleven; and TFCO-UK-A, which covers the period of adolescence from ten to seventeen years. Due to
the majority of children entering care at aged ten years and over (45% of all care entrances in the year ending 31 March 2015) the focus of TFCO-UK-A is crucial (DfE, 2015a).

TFCO-UK-A aims to help the child increase prosocial behaviour, make the most of relationships, achieve in school and enjoy leisure activities. In order to achieve this, the following provisions need to be in place: consistent environments, allowing an individual to be encouraged and mentored, clear behavioural boundaries with specified consequences, close supervision, a shift from anti to prosocial peers and celebrations of achievements (Biehal et al., 2012b; TFCO, 2016). The secure and consistent environment, belief in the child and the understanding of the deeper reasons for the child or young person’s behaviour are vital for successful therapeutic placements.

In order to achieve these elements, foster carers are given high levels of support and training to ensure all young people are able to address emotional and behavioural concerns and build on the positive experiences of everyday life. The young person will have skills coaching to assist then with both relationships and overall life skills. The overall aim is to return the young person to their birth family or a long term foster placement (TFCO, 2016).

Biehal et al. (2012a) and Green et al. (2014) examined the extent to which MTFC-A enhanced positive outcomes compared with usual care (including foster care, residential care, residential schools and others) in England. The majority of the participants had experienced abuse or neglect and a high volume of placement moves, with two thirds having mental health concerns.

The study looked at 219 young people (including 63% of young people placed nationally in MTFC-A between 2005 and 2009) and examined the impact MTFC-A had on the Child
Global Assessment Scale [CGAS] (measuring the general functioning of a child under the age of eighteen) in terms of educational attendance, achievement and offending behaviour. Looking at the sample as a whole, there was no evidence that the MTFC-A sample achieved better outcomes than those in usual care.

However, when analysing a subgroup of young people with high levels of antisocial behaviour, those in the MTFC-A sample showed a bigger reduction of behavioural concerns. The young people who did not exhibit such behavioural concerns did better within a ‘usual’ placement.

TFCO-UK-A presents a positive approach to addressing the emotional and behavioural concerns for young people in care. The above evidence only shows the ability of treatment programmes to assist those with extreme behavioural concerns, and little difference to non-TFCO-UK-A placements in terms of education, achievement and general functioning of the child. Furthermore, Schofield et al. (2014) acknowledged the strength in this program, but saw additional concerns with the time limited approach, particularly when there was not a suitable placement to return to.

The key focus within this thesis is to reduce the prevalence of offending amongst those in care, with TFCO-UK-A offering insights into how improvements can be made for this secondary outcome. However, the extent to which it can address the primary outcomes raises concerns, and is need of further research.

2.8.2 Therapeutic Children Homes

In order to address the behavioural concerns amongst those in care, and in particular those already in residential settings, some young people are placed in Therapeutic Children
Homes [TCH] (Bullock, 2009). These placements are normally private, and provide an environment where children can address previous trauma and its overall impacts on their emotional development and behavioural outcomes. Staff are highly trained in attachment theory, child development theory and trauma and its impact on a child.

Gallagher and Green (2013) looked at the outcomes of sixteen young adults who had been placed in therapeutic homes as children (mean age of 8.4 years at entrance). The narratives of these participants highlighted good outcomes in emotion and behavioural wellbeing, overall health and living arrangements. Furthermore, the participants did not reflect on experiences of early parenthood or substance misuse.

Some of the participants also showed good outcomes in terms of success within education (GCSEs obtained by n=11) and absence of offending behaviour (n=9). However, a small number of the participants had less educational success and experiences of offending (n=2 received cautions), with a very small amount showing particularly poor outcomes in terms of education and offending profiles (n=5 received convictions). Contact with family was limited, with 44% having no contact with family. Although, one cannot eliminate the impact of family and family settings on these outcomes, as 35% of the participants experienced foster placements after their TCH placement and 6% lived with their family.

Although this offers positive insight into the experiences within TCH, it is important to acknowledge that children within these private homes “are being criminalized at excessively high rates compared to all other groups of children, including those in other types of care” (Howard League for Penal Reform, 2016: 1). Therefore, there are mixed representations of this type of placement. However, the above findings offer insights into the ability of residential settings to produce good outcomes when offering specialist care.
2.9 Conclusion

This chapter has provided discussions of the importance of the RPFP in explaining the outcomes of looked after children and care leavers. The RPFP can be assessed as highly influential but conceptually and evidentially imperfect, due to its failure to allow investigations into the underlying mechanisms which influence the experiences of risk, such as attachments. Therefore, the RPFP will be utilised to present the care leaver’s journey of ‘risks’ from before care until the time of interview, with insufficient attachments as a central focus of influence upon the presence of risk, as explored within the qualitative data collection. It is hoped that by using both theories this research will be able to show the levels of risk experienced by each placement type and the mechanisms which lead to these outcomes. With such understanding, it will provide clearer recommendations of what needs to be put in place in order to reduce levels of risks within care and the outcome of offending.
Chapter Three
The Research in Practice: Methods of Data Collection and Analysis

3.1 Methodological Approaches

Before offering justifications for the methodological approaches used within the study, it is important to highlight the interpretive framework in which the research is developed. This framework comprises of the ontological beliefs and epistemology that influence the methodology chosen, as the researcher “Is bound within a net of epistemological and ontological premises which – regardless of ultimate truth or falsity – become partially self-validating” (Bateson, 1972: 314). Therefore the basic set of beliefs held by the researcher need to be addressed as they influence the action of the research (Denzin and Lincoln, 2008).

The interpretivist framework is closely linked with the researcher’s beliefs, holding relativist ontology through her assumptions that there are multiple realities that are constructed through meanings and understandings which are developed through social experiences and methods of enquiry. These realities are socially constructed and fluid and negotiated within cultures, social settings and relationships with other people (Denzin and Lincoln, 2008). Such a framework allows the researcher to explore the care environments through each unique experience of the participants, whilst acknowledging the differences that will be in place due to diverse realities.

The researcher acknowledges a subjectivist epistemology as she cannot separate herself from what is already known and therefore is aware that all of her values are inherent within the research process and truth can only be negotiated through the dialogue apparent within the research. This subjectivism allows the research to be based on the logic of
interpretation, understanding that each participant could offer differing interpretations of whether their experience of care is criminogenic.

Through such negotiations there can be multiple, valid claims to knowledge (Angen, 2000). This standpoint compliments the research design, with subjectivist researchers developing knowledge by collecting primarily verbal data through the intensive study of cases and then subjecting these data to analytic induction. However, one could assume a degree of scientific realism due to the observations of theories to play a part in the analysis of the research within a non-deterministic standpoint acknowledging causal explanations. This realist approach within this study, allows understandings of theories as they apply to the particular cases of the given sample in a way which compliments the field of criminology to a more secure scientific basis (Banister et al., 1994).

It is important to note the secondary part of the research of quantitative enquiry adding positivist objectivism. This standpoint assumes that features of the social environment constitute an independent reality and are relatively constant across time and settings, through collecting numerical data on observable behaviors of samples and then subjecting these data to numerical analysis (Gall et al., 1996: 30). Such a standpoint underpins the use of risk assessments, as used within ASSET, to see the extent to which the care experience impacts on these risk factors, which can be seen to increase the likelihood of offending (DfE, 2014a).

3.1.1 Why a Qualitative Approach?

When deciding upon a research approach, one must be clear on the level of detail needed in order to address the research questions, enabling a methodology that has the potential to offer the most reliable and valid exploration of the topic with flexibility of gaining the
information required (Babbie, 2012). The following research questions informed the researcher’s decision to carry out qualitative enquiries: are different types of care environment criminogenic? To what extent does attachment to significant others help answer this question? And, what if anything, can be done to reduce criminogenic risk in care? Such research questions are in need of descriptive statements, opinions and feelings of both the care environment and its possible criminogenic factors (Silverman, 2005).

The researcher was aware from the starting point of the research, that the study would be small scale to offer insights into the potential concerns within differing care environments and at no stage developed aims to provide generalisability which a large quantitative study could offer (Noaks and Wincup, 2004).

In addition, the researcher was aware of the ability for coded responses to the research questions in the form of a questionnaire. However, it was felt this quantitative method would limit the room for unanticipated responses, with qualitative methods having the ability to be quantified for analysis through coding and qualitative survey responses having little room to be expanded (Babbie, 2012).

Before going into discussions of the reasons why specific qualitative methods were employed for the primary research, the issues of validity and reliability were forefront in the debate whilst deciding on the most appropriate option to compliment the research questions.

The very nature of the research questions emphasises the importance of gaining valid responses from individuals who had experienced care as a care leaver or through their work as a carer or as a member of the LCT. Such observations allowed the researcher to be critical of quantitative methods and the drawbacks of limited validity and often superficial
nature found within questionnaires or surveys (Babbie, 2012). This is not to say the method of surveys was one to be dismissed, in fact the ability to categorise responses in a time efficient and clear way was a procedure that would become important in the first two parts of the interview. However, the importance of being there is a powerful technique for gaining insights in the rich complexity that can be gained even from short survey style questions (Babbie, 2012). Therefore, the use of such questions was warranted to be of good use in the overview questions, but within an interactive forum to allow rich data to be gained by providing illustrations limiting the constraints of a survey approach.

When looking at reliability, qualitative methods have the tendency to be less reliable, especially when offering flexibility within unstructured or semi structured questions (Noaks and Wincup, 2004). That said, research aiming for micro understandings of lived experiences has a higher level of validity over reliability and offers awareness of all participants’ responses being different (Babbie, 2012).

3.1.1.1 Interviews as a Qualitative Approach

To ensure a method of enquiry that would allow exploration of issues too complex to investigate through quantitative means, a qualitative interview was used, comprising of three parts; structured survey styled questions for part one and two, with part three presenting semi structured open ended questions (Noaks and Wincup, 2004). The interview ‘a conversation with purpose’ allowed greater depth in responses than self-administered questionnaires, exploring informant’s stories and perspectives with rich responses and flexibility rather than unchangeable question formation which would limit information (Arksey and Knight, 1999). The precise aim of using this semi structured approach was to allow the interviewee to highlight their perceived direction of the questions, allowing the
questions to be tailored to the interviewee rather than being bound by standardisation irrespective of how the interviewees discussion were to be portrayed (Banister et al., 1994).

Not only does this method allow a more appropriate experience for the interviewee, it also aids the quality of the research gained, with unanticipated responses that could highlight undocumented perspectives, in turn offering empowerment to disadvantaged groups by validating and publishing their views (Noaks and Wincup, 2004). Thus, in contrast to a structured approach which asks key questions which are used to respond to the needs of the research questions, the semi structured approach to questions allows a matter of negotiation (Banister et al, 1994). This approach fits well within the interpretivist framework, allowing the researcher to confront one’s own participation within the research and in turn allows acknowledgements of differences in place, due to the diversities within each of the participant’s narratives (Angen, 2000).

Part two of the interview however, did not allow such flexibility and in depth responses, as there needed to be fixed alternatives to allow categorisations of risk to be apparent (Hagan, 2000).

3.1.2 Quantitative Data

In order to fully answer the research questions, a quantitative method of enquiry was chosen to measure the usefulness of the Risk and Protective Paradigm, alongside offering input to answer the remaining research questions. The use of a risk assessment based on ASSET (Appendix A), a tool used by the YJB to find out the levels of risk experienced by each participant (either from own experiences or experiences witnessed throughout the carers or LCT roles). Each participant was asked the following, in response to the 12 aspects of life shown in Appendix A, based on their experiences before, during and after care:
If the participants scored 2 or 3 for risk, this factor would be referenced as negative experiences, thus scored as a presence of risk. They were then asked to state whether this impacted on their behaviour, if the participant stated ‘yes’ then this was noted to be of an influence to the participants offending or a perceived influence from experiences of carers, staff or the LCT. The assessments were based on retrospective and current subjective judgments. Finally, whilst measuring offending profiles of the care leavers, an offence was noted for cautions, convictions, reprimands or final warnings for an offence. The offences were not pertinent to the analysis, with the focus of research being based on the overall impact of the care experience to offending.
This process allowed data and method triangulation, whilst addressing the research questions (DfE, 2014a). The data triangulation is a means of collecting different types of data on the same topic, using the same or different methods (Noaks and Wincup, 2004). The triangulation apparent within this research used differing methods on the same topic; with the quantitative method categorising risk factors measured within section two and three of the interviews. This allowed a greater overview of the possible links of risk factors to both the type of care environments and the likelihood of offending.

It was felt that this addition to the research allowed the concerns of merely using qualitative enquiry to be minimised whilst offering a comparative element of perceived risk and protective factors offered through both the qualitative and quantitative methodologies. Thus, utilizing multiple sources of evidence to answer the research questions (Jupp, 2013).

3.2 Research Procedures

3.2.1 Access and Recruitment

My personal experiences of being in care within this LA, allowed the process of access to be supported and well guided. After researching the latest Ofsted inspection, showing the safeguarding services to looked after children and leaving care services being scored from adequate to outstanding, (Appendix B) I approached the LCT, who have previously supported me, and presented them with my research aims, as shown within the Participant Information Sheet [PIS] (Appendix C).

After careful consideration and advice from research staff, it was felt that carers would be best approached through informal channels as approaching access through Social Services [SS] or the LCT could result in a conflict of interest when discussing the level of service support.
After receiving ethical clearance, this process of access was finalised and resulted in 95 potential participants being contacted through the recruitment process discussed below, with 21 care leaver participants making up the final sample. The remaining participants were accessed through the LCT.

After initial discussions with a worker within the LCT, agreement was made that the team could act as gatekeepers and also become participants once Research Governance Approval [RGA] was awarded for the project. Having the LCT as gatekeepers allowed them to make the decisions on who would be appropriate for the research with the interests of protecting the participants potential vulnerabilities and also to make decisions of the risk the care leavers posed to the researcher, therefore withdrawing potential participants who are known to be unpredictable (Noaks and Wincup, 2004).

Although all of the care leaver sample was to be over eighteen, such use of gatekeepers is recommended within research of any population in which local authorities have responsibility and was unquestionably required in this case due to the vulnerable nature of the group of care leavers who may have offended (Noaks and Wincup, 2004). The researcher then circulated inclusion criteria (discussed later) to the gatekeepers, allowing them to formulate a long list of potential interviewees (who match the criteria for each care environment). The researcher then randomly selected seven potential participants from this list (through picking random numbers) to make a short-list. The designated gatekeepers then made initial contact with these people, either via face to face monthly contact, phone or email; filling in a permission to contact sheet, allowing the researcher to have the preferred methods of contact (Appendix D). Where there were non-responses, the researcher picked additional random numbers until the sample was complete: following the above process.
The next part of this section highlights how the entire process of recruitment was carried out within the above access frameworks. The below table will highlight the main processes of identifying and approaching participants alongside the processes of recruitment:

**Table 1: An Overview of Access: Identifying, Approaching and Recruiting Participants**

<table>
<thead>
<tr>
<th></th>
<th>Care Leavers</th>
<th>Carers</th>
<th>LCT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identifying and Approaching Participants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gatekeepers made</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inclusion criteria circulated to gain a short list</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inclusion criteria used by the researcher</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Gatekeepers make initial contact</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Researcher makes initial contact</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Permission to Contact Form signed (Appendix D)</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recruiting Participants (documents presented to potential participants)</strong></td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Autobiography (Appendix E)</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Participant Information Sheet (Appendix C)</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Consent Form (Appendix F)</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

The only differences were the starting point of contact; with the care leavers that possessed the required inclusion criteria receiving initial contact through the gatekeepers, who gained permission for the researcher to contact the potential participants through the preferred means and the researcher, then contacted each of these participants.

The carers and members of the LCT who possessed the required inclusion criteria were contacted directly by the researcher. The remainder of the procedure with recruitment was the same for all three of groups of participants.
Once the researcher had gained contact with the potential participants, full information on the study was given and the researcher talked through her *autobiography* in order to aid rapport by highlighting the researcher’s experiences in care, interest and the importance of the research area.

In addition, a *participant information sheet* was talked through: allowing the participants to be familiar with the research intentions and what it entails, highlighting the content that would be explored at each stage of the research. Finally, the participants were introduced to the content of the *consent form*. If the potential participant was then happy after all this information has been exchanged (via telephone and/or email or post) the participants were then asked about suitability of times available in order to schedule the interviews. In addition to the convenience of timing, the interview environment was also talked through with each of the groups of participants, allowing them to feel comfortable with the decision. It must be noted here, that although the interests of the participants had upper most importance, the locations had to fit into ethical guidelines to ensure safety for both parties and confidentiality for the participant.

After the interview was scheduled, the researcher then took their time to run through the information sheet and consent forms again face to face to ensure that the participant was happy whilst giving an opportunity to ask any questions. The very process of introducing the research information prior to the interview allowed this process to be a time to revisit the purpose of the research rather than be introductory, thus a process of double checking understanding and consent (Noaks and Wincup, 2004).

Once the participants had asked questions and were fully informed, they signed the consent forms and the interview commenced.
3.2.2 Sampling Approach and Inclusion Criteria

3.2.2.1 Care Leavers

Purposive sampling was used to select participants who illustrated sufficient variety in care and related backgrounds in order to maximise the richness of the information obtained pertinent to the research questions (Babbie, 2012). However, it is important to note the diversity available within this rural LA. The majority of children looked after within this LA are from a White British background, the same proportion as the general population and in line with the national average for looked after children (74%). Specific breakdowns of ethnic groups are not currently mapped for this looked after children population due to the low numbers, but there is a steady increase of unaccompanied asylum seekers (Earney and Gould, 2015). Therefore, it was expected that a largely White British sample group would be gained, representative of this rural population.

Nationally there are higher levels of males in care. This is true for this LA, however, there is a more even split with 221 males and 172 females. Therefore, the inclusion of a mixed gender response was deemed likely.

Finally, a variation in Social Economic Status [SES] was not part of the inclusion criteria. This decision was made due to the difficulty in measuring care leavers’ SES, with conflicts between basing this on birth parents, foster parents or the participant’s position at the time of interview (for example, their employment status).

The sample and overall research focus does not aim to be representative of experiences attributed to ethnicity, gender or SES; instead, the sample and overall aims are in place to provide an investigation into experiences within different placement types within this rural LA, to inform changes for all young people.
The criterion presented at the beginning of the research was as follows:

The inclusion criteria MUST include:

- 4 -7 care leavers from each type of placement (kinship, foster and residential), with a mix of behavioural outcomes.

The inclusion criteria will AIM to include the follow:

- A mix of genders (within placement type and behavioural outcomes)
- A mix of ages between 18 – 24yrs (the age brackets will be [18 – 21yrs] and [22 – 24yrs] with a mixture within placement type and behavioural outcomes)
- Variability in age at first placement (the ranges will be [0 – 5yrs], [6 – 10yrs] and [over 10] again with a mixture within placement type and behavioural outcomes)
- A range of time spent in care (the ranges will be [under 1 year], [1 – 3yrs] and [over 3 years] again a mixture within each placement types and behavioural outcomes)
- A variability within the number of placements experienced (the ranges will be [Under 3], [3 – 5] and [6 or more] this will also be varied within each placement types and behavioural outcomes)
- And a variability of ethnic groups.

In addition, the care leavers sample excluded those under the age of eighteen due to the potential vulnerabilities presented to this group and the research interests including transitions into adulthood and its relation to behavioural problems and offending.
3.2.2.2 Carers

The sampling technique was also purposive to ensure carers from each type of environment were gained to allow a variation in experience and perspectives on care. Although limited variation would be apparent for n=9, the following criterion was put together:

The inclusion criteria MUST include:

- 3 carers from each type of placement (kinship, foster and residential – the main type of care offered will allow categorisation into each of these groups).

The inclusion criteria will AIM to include the follow:

- A mix of genders (within placement type)
- A mix of ages ([under 30yrs], [40 – 50yrs] and [over 50yrs] within placement type)
- Range of age groups they care for ([under 5yrs], [6 – 10yrs] and [over 10yrs] within placement type)
- A range of time children and/or young people spend in their care (the ranges will be [under 1 year], [1 – 3yrs] and [over 3 years] again a mixture within each placement types
- And a variability of the number of care placements given (the ranges will be [Under 10], [10 – 50] and [50 or more] this will also be varied within each placement type).

3.2.2.3 Leaving Care Team

Finally, the LCT sample was also gathered through a purposive method to ensure different overviews were given in relation to the research questions. The following criterion guided the recruitment of the sample, again being aware of the extremely limited variability available within n=3.
The inclusion criteria MUST include:

- 3 member(s) or manager(s) from the Leaving Care Team whose job role fit within/include these areas:
  - Specialist in Education, Employment and Training (allow a focus on protective factors)
  - Specialist in Behaviour/Offending Management (allow a focus on risk factors)
  - Local Authority Manager (provide an overview).

The inclusion criteria will AIM to include the follow:

- Age of children/young people they work with ([16 – 20yrs], [21 -24yrs], and [over 2yrs])
- A range in the time they have worked with children/young people ([under 1 year], [1 – 3yrs] and [over 3 years])
- A range of type of placement(s) the children/young people they work with have experienced
- A range of number of placement(s) the children/young people they work with have experienced ([Under 3], [3 – 5] and [6 or more]).

3.2.3 Interview Schedules

The main stage interview schedules were developed after a pilot interview. This allowed the researcher to test interview techniques with the addition of checking the ability of the participants to understand the questions asked. The piloting stage involved testing all three of the interview schedules and gaining feedback on the clearness of the interview questions, interest and the overall levels of comfort experienced by the participants. An important part of this process was ensuring that each section did not inhibit the
participant’s ability to disclose information within the structured survey components. After reflecting on these pilots, it became apparent that the researcher should take an active role in talking through the structured elements if appropriate and thus the first two parts of the interview were offered to be spoken through, or answered independently by the participant if they were more comfortable with that option. Finally, the researcher became aware that the flexibility of asking the questions within part three of the interview was crucial and further practice was made to ensure this skill was available through detailed interview training. After developing this flexibility, the researcher became confident in dealing with unanticipated and unexpected responses, whilst still remaining in control of the interview schedule (Robson, 1993).

3.2.3.1 Care Leavers

The interviews with the care leavers consisted of three parts. The first part of the interview consisted of a short survey where the participant was asked by the researcher about some basic information about themselves, for example the researcher asked about the type(s) of placements in which they had experiences and details of their wider life, including their experiences of crime as a victim and offender.

After the participant had disclosed their basic information and asked any questions, the interview went to the second phase which comprised of a short survey on twelve different aspects of their life in care, including living arrangements, relationships and education. The participant was asked to state if any of the risk related aspects had been present in their life, before, during and after care. In addition they were asked if they felt any of these aspects influenced any behavioural concerns and/or offending.
Finally, a short and informal set of open ended questions were asked dealing retrospectively with the participants experiences before entering care, drawing upon both positives and negatives to allow an insight into the levels of pre-existing risk and protection each participant had experienced. The questions then moved on to exploring the participant’s experiences within care, before then reflecting on their present circumstances with reflections of the overall care experience.

### 3.2.3.2 Carers

The interviews with each of the carers consisted of a similar three part structure. The first part also took the form of a short survey, allowing the participant to give some basic information about their role as a carer, including the type(s) of placements they had given, duties, durations of stay and any experience they had in looking after young offenders. Once the background of the carers experience was established, the second part followed the same structure as presented for care leavers but shifting the focus on to the perceived aspects of risk they had gathered through their experience of being a carer and if they felt this had linked to behavioural concerns or offending. After the categorisation of potential risks and perceived links to behaviour concerns and/or offending, the interview went on to its final stages of discussing the participant’s experiences of being a carer through open ended questions.

The questions started by asking about the participants experiences of being a carer and how the pre-existing experiences of those who they had looked after affected the young people in their care. The questions then went on to address both the positive and negative experiences the participants had whilst looking after young people and how they perceived each aspect of care and how they could aid protection from offending or heighten the risk.
It was felt that this allowed reflections on the participants own experience, welcoming examples of both successes and problems within the carer role and outcomes of those looked after. The questions then moved to perceptions of the process of care and how this may aid or hinder transition into adulthood and life after for those who have been looked after.

Finally the questions shifted focus towards the practicalities of being a carer, drawing upon the participants perceptions of the government’s developments of the care system, working relations with social services and how the professionalization of acting as a carer has impacted on relationships with those looked after.

3.2.3.3 Leaving Care Team

The LCT interview schedules also consisted of three parts but again shifting the focus towards a broader reflection of those ‘in care’ and ‘after’. Again, taking the survey styled set of questions, the participants were asked by the researcher about their experiences of working with those in care and/or leaving care.

Information was gathered around their roles within the care system, placements the young people they have assisted had experienced and the demographics of these young people alongside experience of working with young offenders.

After the experiences of the LCT members had been recorded, they were also asked to state whether they perceived any of the twelve aspects of life in care to be a risk and if they felt any of these aspects influenced behavioural concerns and/or offending from their experience.
Finally, following the same structure as both the care leavers and carer’s interviews, open-ended questions were used to discuss the participant’s experiences of working with those in care and/or care leavers. The questions started with a focus of the participants’ experiences of working with looked after children and/or care leavers and how the pre-existing experiences of those who have been looked after affected individuals experiences of care. The questions then mirrored those asked to carers, asking the LCT members about their reflections of both positive and negative experiences of working with young people and how they perceived each aspect of care and how they could aid protection from offending or heighten the risk. Again, this allowed reflections of the participants own experiences, welcoming examples of both successes and problems within their role and outcomes of those looked after. Perceptions of the process of care and how this may aid or hinder transition into adulthood and life after for those who have been looked after were discussed before shifting the focus of the questions towards the practicalities as highlighted above within the carers interviews. All of the interview schedules can be found within Appendix G.

3.2.4 Ethics

To enable to above research procedures to be carried out, two ethical procedures were apparent: University Recognised Ethics Committee [UREC] on research of humans being and Research Governance Approval [RGA], both of which included applications that were put in front of a panel. In addition to the standard ethics applications, the RGA needed justifications of the research’s use within the local authority to ensure its purpose was beneficial and had the participant’s needs at the heart of the investigation. Therefore the researcher had to justify its applicability in line with the Children and Young People's Plan
2011 – 2014 [CYPP]: a single, strategic, overarching plan for all local services for children and young people, highlighting which priorities would be addressed in order to gain RGA.

The areas proposed and granted approval on include the importance on enhancing: resilience, educational achievement, attachments, and positive contributions. In addition the need of lowering gaps of care leaving populations alongside offering empowerment and successful transitions and lifestyles allowed the research to be deeply qualified in aiding the CYPP 2011 – 2014.

3.2.4.1 Informed Consent

Gaining informed consent to carry out research with human participants is a task which should be carried out carefully, alongside voluntary participation “a responsibility on the part of the researchers to explain as fully as possible, and in terms meaningful to participants, what the research is about, who is undertaking and financing it, why it is being undertaken, and how any research findings are to be disseminated” (BSC, 2015:3). The detailed access plans of identifying, approaching and recruiting participants, allowed the process of gaining consent to be carefully carried out, with the PIS being talked through at the stage of initial contact and prior to the interview commencing. Thus the participants had two opportunities to talk through this information and ask questions, before signing the consent form which had also been presented to the participants at both the initial contact stage and prior to commencement of the interview.

The form asked the participant to confirm they understand their participation would be voluntary with the right to withdraw at any time and their awareness of the confidentiality of all information given (except if current or planned offending was disclosed).
Finally they were asked to give permission for their interviews to be recorded and that the information they shared could be used within anonymous quotes. All of the above was then signed off, stating that they agreed to take part in the study.

Although this process can be seen as straightforward in the case of interviews with clearly identified and informed participants, it can actually be quite complex (Mason, 1996). One of the main issues Mason recognises is the limits on how far all interviewees can be adequately informed, noting how some participants may not be interested in internalising the information given within the PIS and others not being able to understand the context of the research; either through unfamiliarity with the academic debate or the information not being presented in a way appropriate for them. The researcher was conscious of these concerns at the time of writing the PIS forms for the care leavers, carers and the LCT and adapted the presentation of the information to fit the perceived knowledge base, e.g. keeping informed academic or policy debates details within the LCT who possess specialist knowledge and rewording these for the other participants who may not recognise specialist terms.

**3.2.4.2 Sensitive Information**

Due to the nature and content of the research involving sensitive topics of care and possible offending, a key ethical concern was to ensure that all participants and the researcher did not experience physical, psychological or emotional distress from the nature of the research (Hayden and Shawyer, 2004).

The care leavers sample posed the most concern around this ethical issue due to questioning around their experiences of care and offending. However, the *interview schedule* was carefully developed to ensure that information was only gained at the
discretion of the participant, ensuring participants only added information they felt comfortable with. In addition through the detailed PIS and consent form, the participants were aware of their confidentiality and right to withdraw at any stage of the research (BSC, 2015). Finally the PIS also informed the participant of the researcher’s role in guiding them to a relevant contact if they are upset and a list of contact details for help, advice and support were given to the participants at the time of the interview (Appendix H).

The carers and LCT were noted to be in need of protection from possible conflicts of interest when disclosing views on the systems in which they worked. However the interview schedule ensured the researcher did not probe for such information, to eliminate distress (Babbie, 2012). Thus they only added information they felt comfortable with and were aware of their right to withdraw at any stage of the research.

3.2.4.3 Confidentiality and Anonymity

Confidentiality and Anonymity is one of the most important concerns within research with human participants and care should be taken to ensure that all participants are informed of how this will be carried out. Protecting individual’s details is of crucial importance as the informed consent given by the participants is based on the researcher’s ability to uphold this agreement. Therefore to ensure these ethical criteria were adhered to the following procedures were put into place.

After confirmation participant status was made, each participant was given a unique ID number. This was then used in all documentation relating to that individual including hard copies, recordings and computer saved files. All of which were then stored on encrypted files on a password protected encrypted drive and remained at the site of the university to reduce the risk of the accidental loss. In addition, a separate password encrypted file linked
participant’s unique ID number to a pseudonym, reducing the risk of compromising analysis by loss of meanings if the links were severed (Aldridge et al., 2010: 8). Through these protections, participants details were not recognisable at any point within the fieldwork, analysis, write up or storage of the data.

Hard copies of information relating to each of the participants unique id number were stored in a secure filing cabinet until the data was fully coded into a password protected file. Once the process of coded was complete, the hard copies were destroyed.

The researcher was also aware of the issues of confidentiality apparent with recording interviews. Therefore voice recordings gathered in the field were heavily secured from the onset with each recording being linked to a pseudonym (as highlighted above). As soon as the recordings were made, care was taken by the researcher to transfer them into an encrypted file on a portable password protected drive (remaining coded) before travelling with the data. Backups were also be made to portable media (USB drives) that had been encrypted and were carried separately in case of loss or theft (Aldridge et al., 2010: 7). Finally, the original recordings were permanently deleted from the device as soon as the above process had been carried out. It must be noted here, that ‘AbsoluteSheild File Shredder’ was used to permanently delete files so that there is no possible way of them being retrieved (Aldridge et al, 2010: 7).

The final concern whilst ensuring confidentiality and anonymity were kept was apparent within the writing up and presenting the research. All quotes that have been used have been anonymised so that the participants were not easily recognisable, this was crucial as the researcher gave reassurance that information disclosed would not be linked back to the particular participant (Babbie, 2001). This process was by far the most difficult for the care
leavers and LCT, with the former being recruited through the LCT gatekeepers and the LCT being a known sample of n=3. Therefore extra care had to be taken as within these groups of participants, their participation within the study could be known and therefore could enhance the chance of their quotes being recognised.

3.2.4.4 Data Protection

Closely linked to the importance of the above confidentiality and anonymity, data protection was an extremely important ethical concern to address. Through the RGA application process, the entire study had to fit within the Data Protection Act (1998) following the eight guiding principles (Appendix I).

3.2.4.5 Disclosure

An important ethical concern rose within the topic of offending is disclosure. After careful consideration and discussions with supporting staff at The University of Manchester, the participants were informed that they should not disclose to the researcher any present or planned offending, as the researcher has an ethical obligation to report it to the police if there is a possibility it could present harm to others.

The researcher was aware that she is under no legal obligation to inform authorities about past offending, therefore guidance to the participants around these disclosures were not noted to be of concern. In addition, the participants were aware that details of offending were not needed in detail, as the exploration within the interviews were based on the participants life experiences and how this may or may not link to their behavioural/offending outcomes.

There were no issues of disclosure apparent within the fieldwork that had not already been shared with the relevant authorities.
3.3 The Sample

3.3.1 Sample Achieved

The study consisted of conducting research with the following participants:

- Care leavers who mainly experienced a kinship placement n=4
- Care leavers who mainly experienced foster placements n=11
- Care leavers who mainly experienced residential placements n=6
- Carers whose main experience is within the kinship setting n=3
- Carers whose main experience is within the foster setting n=3
- Carers whose main experience is within the residential setting n=3
- Leaving Care Team Local Authority Manager n=1
- Leaving Care Team Specialist in Education, Employment and Training Manager n=1
- Leaving Care Team Specialist in Behaviour and Offender Management n=1

The total number of participants equated to n=33.

The length of interview was expected to be approximately 1 hour per participant. However, the length ranged from twenty minutes to 1 hour forty minutes, with the total interview time being just under 40 hours.

The number and type of participant was designed to answer the principle research question and to reflect the variation in experience and perspective on care. In addition, a secondary consideration was to restrict total participants to a number both manageable and appropriate for the purposes of a PhD. With permission, each of the interviews was recorded to allow a focus on the interviewee and engagement in eye contact and nonverbal communication (Blaxter et al., 1996).
In addition it allowed the researcher to have a word for word account of the interview, in turn providing the material for a full transcription which increases the quality of the analysis (Babbie, 2012). It must be noted here that the researcher was aware of the potential for individuals not to be happy with recordings at all times, so note taking equipment was used in addition to the MP3 recorder.

3.3.2 Care Leaver Sample Characteristics

This section will provide a brief overview of the characteristics of the sample of care leavers used for this study (n=21). 95% of the sample were White British (n=20), with one unaccompanied asylum seeker who did not specify his particular ethnicity. Although there are slightly more males coming through the care system within this LA, the final sample showed slightly more females (n=13) than males (n=8). Although not exact, the sample is similar to the overall levels of variation in race and gender as shown nationally and within this rural LA.

In addition, the sample was reflective of the care system, with more foster participants than kinship and residential participants. It is important to note, due to the last resort status of those within residential placements, that these participants had also experienced kinship and/or foster placements. However, throughout the analysis, care was taken to ensure the placement type being referred to was made clear.

3.3.2.1 Overall Reasons for Entering Care

- Abuse/Neglect (n=17)
- Death of Parent(s) (n=3)
- Asylum (n=1).
The reasons for entering care were representative of the national data (DfE, 2015a).

### 3.3.2.2 Age Entered Care

- A range from birth to fifteen years old
- Average of nine years across placement types
- Average of ten years eight months for foster participants
- Average of four years five months for kinship participants
- Average of nine years nine months for residential participants.

### 3.3.2.3 Age, Gender and Ethnicity of Participants

- A range from eighteen to twenty eight years at time of interview
- Average age across all placement types was twenty years and eight months
- Average age of kinship participants was twenty four years and five months
- Average age of foster participants was nineteen years and five months
- Average age of residential participants was twenty years and six months
- Care leavers consisted of males (n=8) and females (n=13)
- Foster participants consisted of males (n=4) females (n=7)
- Kinship participants had equal split of males (n=2) females (n=2)
- Residential participants consisted of males (n=2) females (n=4)
- The majority of care leavers were White British (n=20).

### 3.3.2.4 Amount of Placements

- A range of one to thirty six
- Average of eight placements across all participants
- Average of four placements for foster participants
• Average of two placements for kinship participants
• Average of eighteen placements for residential participants
• Total of 170 placements across the care leaving sample.

3.3.2.5 Time in Care

• A range from one to eighteen years
• Average of seven years and two months across all participants
• Average of five years and five months foster participants
• Average of thirteen years for kinship participants
• Average of six years and four months for residential participants.
3.3.2.6 Offending Patterns

Table 2: Participants Offences Carried Out: Before Care, During Care, After Care

<table>
<thead>
<tr>
<th></th>
<th>Age Entered Care</th>
<th>Before Care</th>
<th>During Care</th>
<th>After Care</th>
<th>Total Offences</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>F2</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>F3</td>
<td>13</td>
<td>9</td>
<td>14</td>
<td>12</td>
<td>35</td>
</tr>
<tr>
<td>F4</td>
<td>13</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>F5</td>
<td>15</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>F6</td>
<td>4</td>
<td>0</td>
<td>16</td>
<td>15</td>
<td>31</td>
</tr>
<tr>
<td>F7</td>
<td>6</td>
<td>0</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>F8</td>
<td>14</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>F9</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>F10</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>F11</td>
<td>11</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Foster Total</td>
<td>15</td>
<td>47</td>
<td>38</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>K1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>K2</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>K3</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>K4</td>
<td>7</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Kinship Total</td>
<td>0</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>R1</td>
<td>11</td>
<td>1</td>
<td>12</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>R2</td>
<td>13.5</td>
<td>2</td>
<td>6</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>R3</td>
<td>11</td>
<td>2</td>
<td>11</td>
<td>8</td>
<td>21</td>
</tr>
<tr>
<td>R4</td>
<td>5</td>
<td>0</td>
<td>18</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>R5</td>
<td>14</td>
<td>2</td>
<td>10</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>R6</td>
<td>5</td>
<td>0</td>
<td>15</td>
<td>16</td>
<td>31</td>
</tr>
<tr>
<td>Residential Total</td>
<td>7</td>
<td>72</td>
<td>36</td>
<td>115</td>
<td></td>
</tr>
<tr>
<td>Total Offences</td>
<td>22</td>
<td>125</td>
<td>77</td>
<td>224</td>
<td></td>
</tr>
</tbody>
</table>

The participants were randomly selected, with a wide range of offending profiles. The above illustration has been taken from Chapter Four, and presents the overall offending rates: before, during and after care. Just under ¼ of the participants did not offend, all of which were placed either within foster or kinship placements. All offending profiles went up during care, but this was predicted due to The Age Crime Curve (Moffitt, 1993).
224 offences were carried out, throughout the twenty one care leaver’s lifetimes, with an overall mean of just over ten offences per care leaver. Residential participants were shown to have both the highest rates of offending and the biggest changes throughout each transition: showing an increase of mean from one to twelve, and then a sharp decrease to six on exit from the care system. The remaining figures were lower and did not reflect such dramatic changes in offending profiles, and therefore as concerning images of the care system and criminality.

3.3.3 Carers Sample Characteristics

The carers were gathered through informal channels, using a purposive sampling technique. It is important to note that these carers are not known to have worked with the care leaving sample, therefore their narratives are not analysed directly in response to the narratives of the care leavers cohort.

3.3.3.1 Foster Carers

- All females (n=3)
- Age range of forty two to sixty nine years
- Average age of fifty seven years three months
- Range of placements given from ten to forty
- Average placements given twenty five
- Experiences of: emergency, short term, long term and intensive placements
- Range of placement duration from three days to ten years
- Experiences of working with new born to eighteen years.
3.3.3.2 Kinship Carers

- All females (n=3)
- Age range of thirty six to seventy eight years
- Average age of fifty four years three months
- All participants had only given one placement each
- Age(s) of child(ren) entering their care ranged from five to eleven years old
- One participant had finished her placement of thirteen years, the remaining were hopeful to continue their placements to adulthood.

3.3.3.3 Residential Staff

- Males (n=2) females (n=1)
- Age range of thirty seven to thirty six years
- Average age of thirty years three months
- Participants had seen between twenty and one hundred young people go through their care homes
- Age(s) of child(ren) entering their care ranged from ten to sixteen years old
- Range of placement duration from under one day to six years.

3.3.4 LCT Sample Characteristics

The LCT were also gathered through a purposive sample, allowing one overview of the care system, one specialising in education and the final participant working directly with care leavers who have offended.
• All participants were female (n=3)
• An age range of thirty four to fifty five years
• Average age of forty three
• A broad range of experiences were covered: roles in social services, leaving care services and YJB.
• A range of experiences with young people in EET, those who are NEET and those with and without behavioural concerns.

3.5 Methods of Data Analysis

3.5.1 Qualitative Analysis

All interviews were recorded, evaluated and transcribed by the researcher and initially analysed thematically in relation to key hypotheses using the Computer Assisted Qualitative Data Analysis Software [CAQDAS] programme ‘Atlas Ti’. After careful consultation within an independent review of my research, it was suggested to do all analysis by hand, due to the relatively manageable data set. Thematic analysis was used, a process which presents a coherent way of organising interview data in relation to the overall research questions. The themes were made to group together both the elements of the research questions and the preoccupations presented by the interviewees (Noaks and Wincup, 2004). Open coding was used to establish the themes, then axial coding provided links and finally selective coding highlighted the key themes to be used for the final analysis. This interpretive and flexible coding practice reflected the key patterns in the participants responses from all three samples, informing full discussion of the extent to which different types of care environments may be criminogenic (Robson, 1993).
The attachment status of the care leavers was noted for each phase of their lives: before, during and after care. The analysis categorised the attachment type before care, recording the categories as: secure, avoidant, ambivalent or disorganised. The attachment categories were not made to make formal psychological retrospective judgement, instead they were made to establish the level of attachment concerns faced on entry to the care system, with some participants showing evidence of one or more attachment types. Such observations were crucial in order to establish the extent to which the care system was able to address these concerns and provide a clear understanding of the complex differences each young person faced in terms of attachments. These categories were made after consulting key developmental theorists on attachment and combined Ainsworth and Bell’s (1970) work of children in strange situations, with Main and Solomon’s (1986) introduction of disorganised attachments.

Chapter Eight provides an overview of the attachment patterns across the care leavers experiences: before, during and after care. The broader categories included overall observations to include negative experiences of attachments: lack of attachment/non-secure; lack of attachment/non-secure/further damage and good attachments but problematic (subjective assessments highlighting positive attachments, but with evidence of ambivalent, avoidant or disorganised elements through analysis. The positive attachment trajectories were categorised as a care leaver being able to form new secure attachments. These final analyses of attachments remained in broad terms, to allow an overview of the extent to which the care system assisted the development of new attachments and/or allowed positive changes for pre care attachments. This analysis allowed conclusions on the extent to which the care system allowed protective factors towards offending, through
the presence of attachments or the failure to provide these foundations and the influences to criminality.

3.5.2 Quantitative Analysis

The analysis was carried out by using the statistical software, SPSS. Basic descriptive statistics were used, alongside inferential statistics; allowing both observations of the data alone and predictions in relation to the placement type (Agresti and Finlay, 2014). As highlighted within 3.1.2 the use of ASSET categories of risk (Appendix A) were used to establish the levels of risk: before, during and after. With a no risk experienced scoring 1, slight risk scoring 2 and definite risk scoring 3. The main body of analysis presented in Chapter Four, presents the experiences of risk for those who scored 2 or 3, with the SPSS mean scores presented within Appendix J. These risk ratings were used to establish the extent to which levels of risk changed whilst in care and through the care leavers transition to adulthood, allowing clear understandings of the extent to which each placement type is criminogenic due to presenting new risks and the failure to reduce the experiences of risk within each placement type.

The subjective influences to behavioural and/or offending of each risk factor were also noted, to establish the area’s most in need of development and to conclude on the most criminogenic influences each placement type presents. Both experiences of risk and influences to behavioural concerns and/or offending were made by all participant groups. Finally, the offending profiles were analysed, alongside the levels of risk, in order to establish the changes in offending rates before, during and after care, whilst acknowledging the importance of age.
3.6 Reflexivity and Positionality

It is crucial to reflect on the extent to which the researchers' background and position “affects what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions” (Malterud, 2001, p. 483-484). The overall process of research went well, with extremely detailed narratives and full risk assessments for all care leavers, with predicted missing data within the carers and LCT (due to their roles not always having overviews of the care experience in its entirety). A good rapport was made with all participants, with adjustments in terminology to match the participant group. Such interview skills allowed a huge amount of data, which allowed strong concluding points of the impact of attachment on risk and offending. The overall sample size (n=33) allowed limited quantitative data, however the aim of this was to provide an insight and at no stage was this research aiming to provide generalisability within its data constructs. However this sample size produced approximately forty hours of audio, with a larger amount of data than anticipated. Therefore, instead of being able to produce qualitative analysis of both the direct influence to offending and the secondary influences, highlighting attachment to be the underlying cause for all risk factors except physical health, the latter was unable to be used for this research. This decision was made, to allow the most poignant themes to be established, with the remaining data being held for further research.

Further reflections are apparent within the methodology used, with two key limitations being apparent. The retrospective nature of the research, in particular within the quantitative risk assessments, were seen to limit the validity and reliability of the data in some instances, with the risk ratings of family and personal relationships not being shown to be consistent across all participants. However, this was not seen to be an overall
concern, instead it adds the emphasis of the need to see this risk domain, to be one that underpins all other risks, findings which were clear within the interview data. Although it was anticipated that the LCT and carers/staff would hold back on their critiques of the system and services which they provide, this was not the case. Instead, their honest accounts of their own limitations, alongside the system constraints, added clearer conclusions in the expectations one can have of the care systems ability to undo pre care risk and attachment concerns.

In addition to the procedural and methodological reflections, my positionality as a researcher and care leaver are of central importance. As a care leaver, who was placed into care at the age of five years, I went into the research with my own experiences. Although these experiences were the main reasons I have dedicated my study and work experiences to improving the life chances of those in care and after, this also meant there was an enhanced emotive response to the research content. Although my supervisory team anticipated some emotional responses from the research, and ensured I was in contact with a counsellor, we did not expect the direct emotional impact it had on me. The research triggered past experiences and resulted in me taking an interruption of study to have in-depth counselling and taking time to address my own experiences before care and its impact on my adult life. After taking nine months out, I was able to commit fully to the full analysis of my data, with an extra drive to ensure all the narratives of the research were fully shown, with the aim of improving experiences for those who enter care in the future. Despite this very difficult emotional journey, these experiences have allowed an invaluable level of personal development as a researcher and care leaver.
Chapter Four

Quantitative Analysis of Risk Experienced and Offending by Placement Type: Before, During and After Care

4.1 Introduction

This chapter sets the scene for later qualitative analyses and analyses the quantitative risk assessments carried out with the care leaver sample. It assesses self-reported levels of criminogenic risk and offending behaviour before, during and after care and compares both dimensions across placement types: foster, kinship and residential. Although SPSS was used to analyse the data, percentages have been used to clearly present the presence of each factor. However, for further reference, appendices are cited next to the relevant data.

4.1.1 Rationale for Risk Assessments

As highlighted in Chapter One and Chapter Two, there are wide bodies of literature which focus on both the risks experienced before entry into care and the adverse influence or ‘risks’ experienced as a direct consequence of a young person’s placement within the care system (Staines, 2016). However, as highlighted within section 2.6, there are many concerns with this approach, such as its inability to provide clear conclusions of causation. The extent to which care leavers’ circumstances appear to improve or worsen as a function of their care experiences is at the heart of this thesis. Therefore, the presentation of risks is important for setting the scene and presenting the overall journey for the participants within this study.

In addition to highlighting the journey of a young person in care, the use of this risk assessment will provide evidence of the extent to which the use of the RPFP can illuminate the levels of criminogenic influence apparent within each placement type. It will therefore
address research questions i (whether care environments are criminogenic) and ii (the extent to which the RPFP successfully measures this), and potentially provide the information needed in order to reduce risk and improve life chances for looked after children and care leavers, assisting research question iv (what, if anything, can be done to reduce criminogenic risk in care). Therefore, the central intention of this chapter is to examine the extent to which patterns of risk, as experienced throughout a care leavers journey, can go beyond variables correlated to offending and provide explanations of the processual mechanisms which lead to each risk experienced.

### 4.2 Overall Impact of the Care Experience: Highlighting Concerns

#### Table 3: Overall Risk Experienced*

<table>
<thead>
<tr>
<th>Overall Risk Experienced*</th>
<th>Before Care</th>
<th>During Care</th>
<th>After Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Arrangements</td>
<td>81% (n=17)</td>
<td>71.4% (n=15)</td>
<td>47.6% (n=10)</td>
</tr>
<tr>
<td>Family and Personal</td>
<td>81% (n=17)</td>
<td>61.9% (n=13)</td>
<td>33.3% (n=7)</td>
</tr>
<tr>
<td>Relationships</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EET</td>
<td>47.6% (n=10)</td>
<td>66.7% (n=14)</td>
<td>42.9% (n=9)</td>
</tr>
<tr>
<td>Neighbourhood</td>
<td>66.7% (n=14)</td>
<td>42.9% (n=9)</td>
<td>66.7% (n=14)</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>42.9% (n=9)</td>
<td>61.9% (n=13)</td>
<td>47.6% (n=10)</td>
</tr>
<tr>
<td>Substance Use</td>
<td>42.9% (n=9)</td>
<td>71.4% (n=15)</td>
<td>57.1% (n=12)</td>
</tr>
<tr>
<td>Physical Health</td>
<td>61.9% (n=13)</td>
<td>47.6% (n=10)</td>
<td>33.3% (n=7)</td>
</tr>
<tr>
<td>Emotional and Mental</td>
<td>66.7% (n=14)</td>
<td>90.5% (n=19)</td>
<td>81% (n=17)</td>
</tr>
<tr>
<td>Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceptions of Self and</td>
<td>38.1% (n=8)</td>
<td>71.4% (n=15)</td>
<td>57.1% (n=12)</td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking and Behaviour</td>
<td>38.1% (n=8)</td>
<td>71.4% (n=15)</td>
<td>42.9% (n=9)</td>
</tr>
<tr>
<td>Attitudes to Offending</td>
<td>33.3% (n=7)</td>
<td>47.6% (n=10)</td>
<td>33.3% (n=7)</td>
</tr>
<tr>
<td>Motivation to Change</td>
<td>23.8% (n=5)</td>
<td>52.4% (n=11)</td>
<td>38.1% (n=8)</td>
</tr>
</tbody>
</table>

* Overall n =21 (Appendix J SPSS Mean Risk Levels and Appendix K Breakdown of Risk Factors: Across Placements)
The participants were asked if each of these twelve factors were of concern in each of the following three assessment periods: before, during and after care. If the participant felt a risk factor was of concern, they were asked to score it.

On first glance, one can see that care leavers overall had a high level of risk, as demonstrated through all of the twelve risk factors, before entering care, ranging from just under 25% (n=5) to over 80% (n =17) of the sample. As highlighted within Chapter One and Chapter Two, individual risk experienced before care is used as a justification for the higher rates of criminality within the looked after population (Staines, 2016). However, it is important to note that the interpretations here are presented to acknowledge the individual’s journey, and not to eliminate the care system’s links to criminality. Instead, such findings highlight problematic elements of the young person’s life, and by doing so, present the areas of life the care system should address in line with their duty of care and legislative commitments as a corporate parent.

Therefore, although this observation shows criminogenic influences before individuals enter the care system, highlighting the vulnerable nature of this group of participants in relation to the likelihood of offending (findings reflective of national data), it does not suggest the young people entering care are criminal, and instead presents the need for the care system to address these vulnerabilities (DfE, 2015a).

Table 3 shows pre care risk to be lower within the risk factors directly related to the act of offending: Perceptions of Self and Others (38.1% n=8), Thinking and Behaviour (38.1% n=8), Attitudes to Offending (33.3% n=7) and Motivation to Change (23.8% n=5). This result was anticipated due to the age in which the young people entered care being from birth and the average age of entrance being at 9years 4months; ages below criminal responsibility. Lifestyle (42.9% n=9) and Substance Use (42.9% n=9) also show lower
levels as anticipated, due to the age of the sample group and access to freedom in choosing peers and accessing drugs and alcohol. Furthermore, the high levels displayed within the remaining risk factors; Living Arrangements (81% n=17), Family and Personal Relationships (81% n=17), Neighbourhood (66.7% n=14), Emotional and Mental Health (66.7% n=14), Physical Health (61.9% n=13) and EET (47.6% n=10) are all linked to the process of being put into care, therefore these high levels were also predicted, with the exception of care entrance through bereavement, which will be discussed in detail in further chapters.

Overall, the participants who have experienced care shows an average prevalence of 52.4% (n=11) across the risk factors, with a range of 23.8% (n=5) and 81% (n=17) before they entered care. Therefore across the participants, there is a high level of experienced risk, with Living Arrangements and Family and Personal Relationships being of critical concern. The clear establishment of the concerns young people have that lead them into care allows us to move forward and analyse the extent to which they are reduced in care.

Once the participants had entered the care system, they were asked to reflect on the same twelve risk factors and the extent to which they were still present. The risk factors directly linked to offending showed a marked increase in this assessment period; Motivation to Change (23.8% n=5 to 52.4% n=11), Attitudes to Offending (33.7% n=7 to 47.6% n=10), Thinking and Behaviour (38.1% n=8 to 71.4% n=15) and Perceptions of Self and Others (38.1% n=8 to 71.4% n=15), these increases were anticipated due to the increase in age and the predicted offending levels which will be explored further on in this chapter. In addition, both Lifestyle (42.9% n=9 to 61.9% n=13) and Substance Use (42.9% n=9 to 71.4% n=15) also showed a sharp increase, again a risk factor which would be predicted to increase due to the participants being in care within their adolescence.
The remaining risk factors are all aspects of life in which the care system have embedded in their local authorities safeguarding principles, and for most there is an improvement: Physical Health (61.9% n=13 to 47.6% n=10), Neighbourhood (66.7% n=14 to 42.9% n=9), Living Arrangements (81% n=17 to 71.4% n=15) and Family and Personal Relationships (81% n=17 to 61.9% n=13). The striking concern here is although there is a decrease reflected in the care system overall, the biggest improvement is shown to still have over 40% of the participants experiencing these risks within care. Such observations, although showing a reduction, highlight concerns of the care system in offering a minimal improvement and with still high levels for each of the risk factors. Thus, one may not be able to say that the overall risk levels increase due to the care system, but it remains at a high level and therefore shows an initial insight to the inability of the care system to eradicate or minimise these risk levels to have allowed the participants to be of low risk to offending. The inability of care to provide the basic safeguarding principles, and therefore failing to reduce pre-care risk, provides evidence of the care system’s direct criminogenic influence through their inability to provide appropriate and stable placements (Shaw, 2012). Whilst looking at the final two risk factors, EET (47.6% n=10 to 66.7% n=14) and Emotional and Mental Health (66.7% n=14 to 90.5% n=19), the truly concerning nature of the participants’ experiences are prominent.

In particular, the increase experienced for Emotional and Mental Health shows all but two participants experienced these concerns during care, the highest level of risk presented within the study. Furthermore, whilst offering a comparison to the risk levels before and during care, the average prevalence across the risk factors has risen from 52% (n=11) to 63% (n=13), with the lower range increasing from 23.8% (n=5) to 42.9% (n=9) and the higher range from 81% (n=17) to 90.5% (n=19). Again, such findings provide evidence of
the system’s failures to the young person through the inability to provide suitable foundations, and to allow positive outcomes of educational achievement, helping to explain why young people within care do not achieve the same educational outcomes as their peers (DfE, 2015b). These findings show 66.7% (n=14) of the sample to have not been supported by the safeguarding promises of achievement, and present a direct failure of the care system to address their pre-care risks associated with EET, in some cases providing further upheaval (DfES, 2003).

Evidently, Emotional and Mental Health concerns are expected before care, due to the abuse and neglect experienced through the process of individuals separating from their family environments, and individuals entering care are predicted to show an increase in concerns (Staines, 2016). However, the assessment of the during care period included the overall care experience, and through this analysis the care system is seen to further impact on the young person’s emotional and mental health. In turn, this shows a direct failure in addressing the concerns of the young person, neglecting to uphold the basic safeguarding principles outlined in *Every Child Matters* (2003), and allowing the young person to be healthy and enjoy their life within care. Such failures not only undermine the legislative commitments, they provide further risk of criminality, as outlined within the RPFP.

Before looking in more detail at the risk levels experienced within each assessment period, the risk analysis of the aftercare period needs to be highlighted. These statistics show a marked reduction within all risk factors, except that of Neighbourhood (42.9% n=9 to 66.6% n=14). This highlights the positive impact the care system had in regard to where young people lived, showing a sharp increase on their exit from the care system. This provides evidence of the ability of the care system to provide accommodation in areas which may be unlikely when a young person exits care. This finding is not unsurprising,
with high rates of homelessness apparent within the care leaver population (between 20% and 30%), and 7% of care leavers (n=1,840) in 2015 referencing their accommodation as unsuitable (CSJ, 2014; DfE, 2015a). However, such findings do not eradicate the system’s failures, with the leaving care services failing to provide suitable accommodation during a care leaver’s transition to adulthood (Stein, 2012). Not only does this failure impact upon the overall life chances of a young person, it directly increases the likelihood of offending.

The striking finding on exit from the care system shows that the risk factors predicted to be heightened due to age within care decrease on exit. In particular, the decreased concern with substance misuse (42.9% n=9 to 71.4% n=15 to 57.1% n=12) contrasts with national findings, which show increased risk of substance misuse after care (CSJ, 2014). Although only a small decrease, this can be interpreted as a success for substance misuse interventions, or provide evidence of a young person’s successful desistance from drug taking. However, this finding can also provide evidence of the heightened level of substance misuse within care, showing a direct concern with the system’s ability to protect the health and wellbeing of 71.4% (n=15) of the sample. This finding is significantly higher than expected, with national figures showing that only 3.5% of looked after children identified as having a substance misuse problem (DfE, 2015b). It is important to note that experience of substance misuse was self-assessed, and this could offer an explanation as to the higher levels of concerns within this sample group. Nevertheless, the retrospective self-assessments are critically important, with the risks being reflective of the problems the participants had within care, and thus the areas in need of improvement.

The risk factors directly related to the act of offending also show a marked decrease. The most prominent change was shown in Perception of Others (38.1% n=8 to 71.4% n=15 to 57.1% n=12) and Thinking and Behaviour (38.1% n=8 to 71.4% n=15 to 42.9% n=9).
Although this analysis is based on a small sample size, these findings offer challenging presentations of the overall care system, showing that the thoughts and feelings towards others and one’s own behaviour improve once the young person has left care. It is not clear if this can be attributed to successful interventions during these participants’ time in care, or the care system not providing the participants with suitable placements that encouraged relationships, setting the foundations of prosocial behaviour and making the young person accountable to their carers, these instead being provided after leaving care (Hirschi, 1969).

Living Arrangements (81% n=17 to 71.4% n=15 to 47.6% n=10), Family and Personal Relationships (81.7% n=17 to 61.9% n=13 to 33.7% n=7) and EET (47.6% n=10 to 66.7% n=14 to 42.9% n=9) show a huge improvement after leaving the care system. Such observations provide evidence for the inability of the care system to lower the risk experienced, with particular concerns linked to the direct protection of Living Arrangements which the care system objectives are based upon. Not only do these observations highlight the concern regarding the ability of the care system to reduce the risk of offending, they also show the direct failures of the ability of the care system to uphold the basic safeguarding principles and legislative developments outlined in Chapter One, with local authorities failing to ensure stable and suitable placements crucial in assisting an individual’s foundations to make prosocial choices. These key concerns will be explored in detail throughout the remaining chapters.

Overall, the average prevalence across the risk factors after the participants had left care was at 48% (n=10), a lower level of risk in comparison to both before and during care. These individuals, despite having problematic transitions into adulthood, look back at their experiences within care as worse than their current situation. This is highly concerning considering what we already know about the problems many care leavers face, including
high levels of NEET, substance misuse, homelessness and emotional and mental health concerns (Mendes and Moslehuddin, 2006; Wade and Dixon, 2006; CSJ, 2014; DfE, 2015b; DfE, 2016a). In addition, research shows that there are different pathways for care leavers directly related to the quality of their experiences within care. So, why are these individuals’ lives suggested to have improved after leaving a system which is there to protect and care for them? This analysis will be presented within Chapter Eight, with a consultation of the qualitative data (Stein, 2006).

4.2.1 Prominent Risk Factors

Before moving onto the detailed analysis across assessment periods, for each placement type, it is important to note the overall high level of risk factors experienced by the participants. For the purpose of this analysis, Table 4 highlights the risk factors that were reported in each of the assessment stages, this will allow an overview of any persistent risk factors that are present before, during and after care.
As highlighted in Chapter One, the majority of individuals who are placed in care have been exposed to traumatic experiences, and in turn have experienced a high level of pre-care concerns/risks. This group of participants is no exception, with 81% (n=17) of the sample being placed into care due to abuse and/or neglect, 14% (n=3) due to a death of a parent(s) and 5% (n=1) for asylum. Although this finding was expected, it merely presents the starting point of the participants’ care journeys, highlighting the vulnerability of the sample and the need to closely examine the care system’s ability to reduce these risks, upholding safeguarding principles and the legislative commitments which the system is based upon.

Both Living Arrangements (81% n=17) and Family and Personal Relationships (81% n=17) are incredibly high, with over 80% of the these participants experiencing

<table>
<thead>
<tr>
<th>Before Care</th>
<th>During Care</th>
<th>After Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Arrangements</td>
<td>Emotional and Mental Health</td>
<td>Emotional and Mental Health</td>
</tr>
<tr>
<td>81% (n=17)</td>
<td>90.5% (n=19)</td>
<td>81% (n=17)</td>
</tr>
<tr>
<td>Family and Personal Relationships</td>
<td>Living Arrangements</td>
<td>Neighbourhood</td>
</tr>
<tr>
<td>81% (n=17)</td>
<td>71.4% (n=15)</td>
<td>66.7% (n=14)</td>
</tr>
<tr>
<td>Neighbourhood</td>
<td>Substance Use</td>
<td>Substance Use</td>
</tr>
<tr>
<td>66.7% (n=14)</td>
<td>71.4% (n=15)</td>
<td>57.1% (n=12)</td>
</tr>
<tr>
<td>Emotional and Mental Health</td>
<td>Perceptions of Self and Others</td>
<td>Perception of Self and Others</td>
</tr>
<tr>
<td>66.7% (n=14)</td>
<td>71.4% (n=15)</td>
<td>57.1% (n=12)</td>
</tr>
<tr>
<td>Physical Health</td>
<td>Thinking and Behaviour</td>
<td>Lifestyle</td>
</tr>
<tr>
<td>61.9% (n=13)</td>
<td>71.4% (n=15)</td>
<td>47.6% (n=10)</td>
</tr>
</tbody>
</table>

*Overall n =21
concerns surrounding their home environment, interestingly Family and Personal Relationships are no longer in the highest level of risk after entrance to the care system but still remain high at 61.9% (n=13), Living Arrangements remain high and only shows a reduction of risk to 71.4% n=15, thus remaining at the second highest concern for the in care period. Emotional and Mental Health is a relative concern before care at 66.7% n=14 and increases to an incredibly high 90.5% n=19, being the overall highest level of risk experienced being present during care. In addition Emotional and Mental Health remains the highest level of risk on exit from care, showing a slight reduction to 81% n=17 and is the only risk factor to be prominent at all assessment periods. The remaining high level of risk reported from the participants are those predicted to increase with age, and offer a small variance between the time in care and after. It is important to highlight that the care system does not offer striking increases within many of the risk factors, instead it highlights the absence of decreasement of such factors. These findings show the inability of the care system to address pre-care concerns, and through such failures, the overall care system is shown to be unable to improve the experiences of the young people interviewed. The criminogenic nature of care, as analysed within this study, is measured through the inability to address pre-care risk and through increases in risk. With this in mind, the sample present overall failures, which need to be investigated further.

To allow a clearer analysis of this data, it is important to not only look at the trends offered for the care system overall, but to add a detailed observation of the patterns between the assessment periods and how the care system impacts on the risk factors.
### 4.2.2 Foster Placements: Overall Risk

#### Table 5: Foster Placements: Overall Risk Experienced

<table>
<thead>
<tr>
<th></th>
<th>Before Care</th>
<th>During Care</th>
<th>After Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Living Arrangements</strong></td>
<td>90.9% (n=10)</td>
<td>81.8% (n=9)</td>
<td>45.5% (n=5)</td>
</tr>
<tr>
<td><strong>Family and Personal</strong></td>
<td>81.8% (n=9)</td>
<td>72.7% (n=8)</td>
<td>27.3% (n=3)</td>
</tr>
<tr>
<td><strong>Relationships</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EET</strong></td>
<td>72.7% (n=8)</td>
<td>63.6% (n=7)</td>
<td>36.4% (n=4)</td>
</tr>
<tr>
<td><strong>Neighbourhood</strong></td>
<td>63.6% (n=7)</td>
<td>36.4% (n=4)</td>
<td>45.5% (n=5)</td>
</tr>
<tr>
<td><strong>Lifestyle</strong></td>
<td>54.5% (n=6)</td>
<td>54.5% (n=6)</td>
<td>45.5% (n=5)</td>
</tr>
<tr>
<td><strong>Substance Use</strong></td>
<td>54.5% (n=6)</td>
<td>72.7% (n=8)</td>
<td>45.5% (n=5)</td>
</tr>
<tr>
<td><strong>Physical Health</strong></td>
<td>72.7% (n=8)</td>
<td>54.5% (n=6)</td>
<td>36.4% (n=4)</td>
</tr>
<tr>
<td><strong>Emotional and Mental</strong></td>
<td>90.9% (n=10)</td>
<td>81.8% (n=9)</td>
<td>72.7% (n=8)</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Perceptions of Self and</strong></td>
<td>54.5% (n=6)</td>
<td>81.8% (n=9)</td>
<td>63.6% (n=7)</td>
</tr>
<tr>
<td><strong>Others</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Thinking and Behaviour</strong></td>
<td>45.5% (n=5)</td>
<td>63.6% (n=7)</td>
<td>36.4% (n=4)</td>
</tr>
<tr>
<td><strong>Attitudes to Offending</strong></td>
<td>27.3% (n=3)</td>
<td>27.3% (n=3)</td>
<td>27.3% (n=3)</td>
</tr>
<tr>
<td><strong>Motivation to Change</strong></td>
<td>27.3% (n=3)</td>
<td>36.4% (n=4)</td>
<td>36.4% (n=4)</td>
</tr>
</tbody>
</table>

* *n=11 (Appendix J SPSS Mean Risk Levels and Appendix K Breakdown of Risk Factors: Across Placements)*

Before the care experience, the foster participants present a very similar concern as shown in Table 3. Living Arrangements and Emotional and Mental Health both show ten out of the eleven participants to have reflected concerns of this nature and are the highest level of concern in this placement type (90.9% n=10). Furthermore, the risk factors directly linked to the act of offending show just over a quarter of the foster participants to have experienced this risk (27.3% n=3), the lowest experienced risk reflected at any point of the participants care experience.
Interestingly, the concerns expressed in Table 3 showed Emotional and Mental Health (90.5% n=19) to soar within the ‘in care’ assessment period; however within this group there is a slight decrease (90.9% n=10 to 81.8% n=9). In addition, five out of the twelve risk factors start to reduce in care and continue to do so after exiting the care system. Such reflections show foster placements to be less criminogenic than the overall portrayal of the care system, findings which are often attributed to foster care, due to the longer placement lengths and the related enhancement of stability (Schofield et al., 2014).

However, one third of all risk factors increase after entering care, with three quarters of these risks reducing after care and a quarter remaining the same. These latter statistics present an overall concern, seeing the biggest decreases in risk to be on exit from the care system. Although individuals will be exposed to differing levels of risk throughout their adolescents and overall care journey, these stark differences on exit do lend support to the concerning set up of some of the foster placements.
### 4.2.3 Kinship Placements: Overall Risk

#### Table 6: Kinship Placement: Overall Risk Experienced*

<table>
<thead>
<tr>
<th></th>
<th>Before Care</th>
<th>During Care</th>
<th>After Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Living Arrangements</strong></td>
<td>50% (n=2)</td>
<td>0% (n=0)</td>
<td>25% (n=1)</td>
</tr>
<tr>
<td><strong>Family and Personal Relationships</strong></td>
<td>50% (n=2)</td>
<td>0% (n=0)</td>
<td>0% (n=0)</td>
</tr>
<tr>
<td><strong>EET</strong></td>
<td>25% (n=1)</td>
<td>25% (n=1)</td>
<td>50% (n=2)</td>
</tr>
<tr>
<td><strong>Neighbourhood</strong></td>
<td>75% (n=3)</td>
<td>50% (n=2)</td>
<td>75% (n=3)</td>
</tr>
<tr>
<td><strong>Lifestyle</strong></td>
<td>25% (n=1)</td>
<td>25% (n=1)</td>
<td>50% (n=2)</td>
</tr>
<tr>
<td><strong>Substance Use</strong></td>
<td>25% (n=1)</td>
<td>25% (n=1)</td>
<td>50% (n=2)</td>
</tr>
<tr>
<td><strong>Physical Health</strong></td>
<td>50% (n=2)</td>
<td>0% (n=0)</td>
<td>0% (n=0)</td>
</tr>
<tr>
<td><strong>Emotional and Mental Health</strong></td>
<td>50% (n=2)</td>
<td>100% (n=4)</td>
<td>100% (n=4)</td>
</tr>
<tr>
<td><strong>Perceptions of Self and Others</strong></td>
<td>0% (n=0)</td>
<td>50% (n=2)</td>
<td>50% (n=2)</td>
</tr>
<tr>
<td><strong>Thinking and Behaviour</strong></td>
<td>0% (n=0)</td>
<td>50% (n=2)</td>
<td>25% (n=1)</td>
</tr>
<tr>
<td><strong>Attitudes to Offending</strong></td>
<td>25% (n=1)</td>
<td>50% (n=2)</td>
<td>50% (n=2)</td>
</tr>
<tr>
<td><strong>Motivation to Change</strong></td>
<td>0% (n=0)</td>
<td>50% (n=2)</td>
<td>50% (n=2)</td>
</tr>
</tbody>
</table>

*n=4 (Appendix J SPSS Mean Risk Levels and Appendix K Breakdown of Risk Factors: Across Placements)

Although a small sample, it is important to provide a context of the risk experienced within a family setting. Kinship participants were the only group to have risk domains not present in any of the sample, of the risk domains, one third of all risk factors decreased during care, half of these then increased after care. In addition, Family and Personal Relationships and Physical Health reduced to no risk during and after care. Such data lends support to the positive impact kinship placements had on young people, findings which support the preference of kinship care within social services (Broad et al, 2001; Stein, 2006; BCN, 2009). However, like foster placements, five of the twelve risk domains increased in care, with only one decreasing after care and four remaining the same. In addition, a quarter of
risk factors remained the same within care, before increasing on exit of the care system. Therefore, although this placement offers a more positive view of the care system, it still provides evidence of the presence of risk domains increasing whilst in care and in turn heightening the likelihood of offending.

### 4.2.4 Residential Placements: Overall Risk

**Table 7: Residential Placement: Overall Risk Experienced***

<table>
<thead>
<tr>
<th></th>
<th>Before Care</th>
<th>During Care</th>
<th>After Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Arrangements</td>
<td>83.3% (n=5)</td>
<td>100% (n=6)</td>
<td>66.7% (n=4)</td>
</tr>
<tr>
<td>Family and Personal Relationships</td>
<td>100% (n=6)</td>
<td>83.3% (n=5)</td>
<td>66.7% (n=4)</td>
</tr>
<tr>
<td>EET</td>
<td>16.7% (n=1)</td>
<td>100% (n=6)</td>
<td>50% (n=3)</td>
</tr>
<tr>
<td>Neighbourhood</td>
<td>66.7% (n=4)</td>
<td>50% (n=3)</td>
<td>100% (n=6)</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>33.3% (n=2)</td>
<td>83.3% (n=5)</td>
<td>50% (n=3)</td>
</tr>
<tr>
<td>Substance Use</td>
<td>33.3% (n=2)</td>
<td>100% (n=6)</td>
<td>83.3% (n=5)</td>
</tr>
<tr>
<td>Physical Health</td>
<td>50% (n=3)</td>
<td>66.7% (n=4)</td>
<td>50% (n=3)</td>
</tr>
<tr>
<td>Emotional and Mental Health</td>
<td>33.3% (n=2)</td>
<td>100% (n=6)</td>
<td>83.3% (n=5)</td>
</tr>
<tr>
<td>Perceptions of Self and Others</td>
<td>33.3% (n=2)</td>
<td>66.7% (n=4)</td>
<td>50% (n=3)</td>
</tr>
<tr>
<td>Thinking and Behaviour</td>
<td>50% (n=3)</td>
<td>100% (n=6)</td>
<td>66.7% (n=4)</td>
</tr>
<tr>
<td>Attitudes to Offending</td>
<td>50% (n=3)</td>
<td>83.3% (n=5)</td>
<td>33.3% (n=2)</td>
</tr>
<tr>
<td>Motivation to Change</td>
<td>33.3% (n=2)</td>
<td>83.3% (n=5)</td>
<td>33.3% (n=2)</td>
</tr>
</tbody>
</table>

* *n=6 (Appendix J SPSS Mean Risk Levels and Appendix K Breakdown of Risk Factors: Across Placements)*

Residential placements present a very different view to that of foster and kinship, with ten of the twelve risk factors going up whilst in care before sharp reductions after exiting the care system.
In contrast, only one of the risk domains, Family and Personal Relationships, reduced from 100% (n=6) before care to 83.3% (n=5) during care, and continued to decrease after exiting the care system 66.7% (n=4). The remaining risk domain, Neighbourhood, reduced from 66.7% (n=4) before care to 50% (n=3) during care, before rising to 100% (n=6) after care. What really sets residential care apart from foster and kinship placements is that five of the twelve risk domains are reported to have been a problem for all residential placement participants. Although this presents a depressing view of this type of care, it is not unexpected, with residential care’s ‘last resort’ status and its recurring link to offending behaviour being prevalent within both academic and policy debates (Hayden, 2010; Schofield et al., 2014). This coupled with the direct increase in risk after entrance to the care system allows a clear distinction between placements, and indeed the extent to which they may be deemed criminogenic, both in terms of failing to address pre-care risk and the increase of risk as expressed by the young person.

Interestingly, a low proportion of the residential sample expresses concern with their Emotional and Mental Health before care, yet this concern soars to 100% during care, alongside the four other risk domains which were rated as a risk by all participants in this sample. This group of participants are the only sample which has had all participants experiencing a risk domain, reflecting this type of placement to be that of most concern.

The inability of the care system to address pre-care risk and the clear increase of risk produced within care, particularly within residential placements, is evident. However, the RPFP and the related risk variables only highlight the areas of life in need of assistance, and fail to allow an analysis based on the mechanisms which influence these risk factors. The next section will attempt to build on the above findings by providing an analysis of the
levels of risk and presence of offending, before analysing the subjective assessment of the most influential risk factors to a young person’s offending rates.

### 4.3 Risk and Offending

#### Table 8: Participants Offences Carried Out: Before Care, During Care, After Care*

<table>
<thead>
<tr>
<th></th>
<th>Age Entered Care</th>
<th>Before Care</th>
<th>During Care</th>
<th>After Care</th>
<th>Total Offences</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>F2</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>F3</td>
<td>13</td>
<td>9</td>
<td>14</td>
<td>12</td>
<td>35</td>
</tr>
<tr>
<td>F4</td>
<td>13</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>F5</td>
<td>15</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>F6</td>
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<td>16</td>
<td>15</td>
<td>31</td>
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<tr>
<td>F7</td>
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<td>8</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
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<td>14</td>
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<td>5</td>
<td>10</td>
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<tr>
<td>F9</td>
<td>16</td>
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<td>0</td>
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<td>1</td>
</tr>
<tr>
<td>F10</td>
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<tr>
<td>F11</td>
<td>11</td>
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<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Foster Mean Offences</td>
<td>1.36</td>
<td>4.27</td>
<td>3.45</td>
<td>9.09</td>
</tr>
<tr>
<td>K1</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>K2</td>
<td>5</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>K3</td>
<td>6</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>K4</td>
<td>7</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Kinship Mean Offences</td>
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<td>1.5</td>
<td>0.75</td>
<td>2.25</td>
</tr>
<tr>
<td>R1</td>
<td>11</td>
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<td>12</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>R2</td>
<td>13.5</td>
<td>2</td>
<td>6</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>R3</td>
<td>11</td>
<td>2</td>
<td>11</td>
<td>8</td>
<td>21</td>
</tr>
<tr>
<td>R4</td>
<td>5</td>
<td>0</td>
<td>18</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>R5</td>
<td>14</td>
<td>2</td>
<td>10</td>
<td>5</td>
<td>17</td>
</tr>
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<td>R6</td>
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<td>15</td>
<td>16</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>Residential Mean Offences</td>
<td>1.17</td>
<td>12</td>
<td>6</td>
<td>19.17</td>
</tr>
<tr>
<td></td>
<td>Total Offences</td>
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<td>77</td>
<td>224</td>
</tr>
<tr>
<td></td>
<td>Overall Mean</td>
<td>1.05</td>
<td>5.95</td>
<td>3.67</td>
<td>10.67</td>
</tr>
</tbody>
</table>

*With placement and overall means.
You will see that before care the mean levels of offending were low; 0 for kinship, 1.17 for residential and 1.36 for foster placements thus reflecting more offences to be carried out for those who were in the foster placement sample. Out of the twenty one participants, twenty two offences were carried out before care; a low level of offending. During care shows a very different story, with kinship care remaining low with a mean of 1.5 offences but foster increasing to a mean of 4.27 and residential having a mean ten times higher, at 12. The volume of offending increased by six times, resulting in a final record of 125 offences for this assessment period. Finally, after exiting care all levels of offending decreased, with the biggest change being that of residential care; showing a decrease by half, a mean of 6 offences. Overall 224 offences were carried out and 115 of those offences were by those who had been in residential, with 72 of them happening during the care period. The remaining participants do not show such a link, with residential care being the only placement type that presents concerning offending rates during care. This finding is in line with a large body of literature, which presents residential care as a ‘last resort’ placement due to its inability to address pre-care risks, the adverse influences/risks experienced as a direct consequence of this placement type and the increased likelihood of structural criminalisation, as highlighted within Chapter One (See Staines, 2016; Fitzpatrick and Williams, 2016). However, the decrease in risk and offending rates for those who leave residential placements offers a different portrayal to the wider academic and political debate. These findings do not provide evidence of the current plans to extend residential placements with ‘Staying Close’, in order to improve transitions to adulthood and overall life chances. However, due to the quantitative nature of this analysis, it is unclear why the risk is reduced, and this will therefore be discussed within Chapter Eight.
Table 9: Participants Risk Levels and Offences: Before, During and After Care

<table>
<thead>
<tr>
<th></th>
<th>Age Entered Care</th>
<th>Risk Before Care</th>
<th>Offences</th>
<th>Risk During Care</th>
<th>Offences</th>
<th>Risk After Care</th>
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<th>Overall Mean Risk Level</th>
<th>Total Offences</th>
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<td>F1</td>
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<td>5</td>
<td>0</td>
<td>3</td>
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<tr>
<td>F2</td>
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<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>F3</td>
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<tr>
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<td>5</td>
<td>7.66</td>
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<tr>
<td>F9</td>
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<td>Foster Mean</td>
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<td>1.36</td>
<td>7.36</td>
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<td>5.18</td>
<td>3.45</td>
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<td>10</td>
<td>1</td>
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<tr>
<td></td>
<td>Kinship Mean</td>
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<td>0.75</td>
<td>4.41</td>
<td>2.25</td>
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<td>R1</td>
<td>11</td>
<td>11</td>
<td>1</td>
<td>11</td>
<td>12</td>
<td>6</td>
<td>1</td>
<td>9.33</td>
<td>14</td>
</tr>
<tr>
<td>R2</td>
<td>13.5</td>
<td>5</td>
<td>2</td>
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<td>6</td>
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<td>R3</td>
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<tr>
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<td>6</td>
<td>7.33</td>
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<tr>
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<td>10</td>
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<td>17</td>
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<td>R6</td>
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<td>0</td>
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<td>15</td>
<td>12</td>
<td>16</td>
<td>9.33</td>
<td>31</td>
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<tr>
<td></td>
<td>Residential Mean</td>
<td>5.83</td>
<td>1.17</td>
<td>10.16</td>
<td>12</td>
<td>7.5</td>
<td>6</td>
<td>7.83</td>
<td>19.17</td>
</tr>
<tr>
<td></td>
<td>Overall Mean</td>
<td>6.04</td>
<td>1.05</td>
<td>7.71</td>
<td>5.95</td>
<td>5.9</td>
<td>3.67</td>
<td>6.55</td>
<td>10.67</td>
</tr>
</tbody>
</table>

Overall the mean risk level shows risk to move from 6.04 to 7.71 in care, before reducing to 3.67 after care. In regards to the offending rates, the overall mean amount of offences is of course low before entrance to care (based on the age of criminal responsibility often being higher than their age at the onset of care). However, the mean overall offences made increases when in care, from 1.05 to 5.95 and then decreases after care to 3.67.

Foster placements have a mean level of risk, higher than the overall mean at 7.36 and remains the same in care; becoming lower than the overall mean risk level of 7.71 for in care. The mean risk level then decreases after care to a low 5.18, again a lower level of risk.
than the overall mean. Whilst looking at offending, the foster placements mean level of offences is 1.36 before care, a figure slightly higher than the overall mean offence level. This increases to 4.27, but remains lower than the overall mean and then further decreases after care to 3.45, again slightly lower than the overall mean number of offences at 3.67.

Whilst looking at kinship placements, the analysis shows extremely different levels of both risk and offences. Before entering the care system, the mean level of risk is that of 2.75 compared to 6.04 as expressed for the overall mean risk levels. Although this risk increases during care to 5, it is still relatively low compared to the overall mean of 7.71. Finally on exit from care, the risk level goes up slightly from 5 to 5.5 and still remains lower than the overall mean level 5.5 compared to 5.9. The pattern of offending means presents the same findings, showing there to be 0 offences carried out before care and therefore a mean of 0 compared to the 1.05 expressed for the overall mean of the sample. On entering the care system, the mean level of offences had risen to 1.5, again lower than the overall mean of 5.95 offences during care. After care, the mean number of offences carried out for the kinship placement participants reduced again to 0.75, again lower than the average 3.67 displayed for the overall sample.

Finally, residential placements present with further contrasting evidence. Although the levels of risk expressed through the residential mean was lower than the overall mean level of experienced risk, at 5.83 compared to 6.04, it remains the highest thereafter. During care, the mean level of risk nearly doubled to 10.16 a staggeringly high level compared to the already high average of 7.71. After care, this mean reduced to 7.5 but still remained higher than the overall sample mean which was presented at 5.9. The most striking output here is the offence levels presented, with a mean level of 1.17 being higher than the overall average of 1.05, the initial assessment stage showed a higher level of criminal
involvement. Furthermore, the mean level of offences carried out were over double of the mean expressed at 5.95 resulting in residential participants presenting a concerning average of 12 offences during care. Finally, on exit from care the levels of offences lowered substantially and halved the level of offending displayed in care at a mean of 6, although substantially higher than the overall mean of 3.67.

4.4 Subjective Assessment of Risk factor Influences on Care Leavers’ Offending

This section allows the analysis to move away from the experienced risk, as established throughout the different placement types, and allows the participants to further explore the impact of such risks and the extent to which they actually influenced their bad behaviour and/or offending behaviour. The aim of this section is to contrast the reported prevalence of risk with the subjective sense of whether those risk factors influenced the participants offending. For the purpose of this analysis the experienced risk is analysed on the basis of a ‘slightly’ and ‘definite’ status of risk, alongside the ‘yes’ or ‘no’ status of subjective influence. Thus the analysis extends beyond the established predominant risk factors and allows a clearer picture of the extent to which these high risk factors are indeed the expressed influences to criminality or if lower areas of risk are linked to their offending.
### 4.4.1 Foster Placements: Influences of Risk Factors to Behavioural Concerns and Offending

Table 10: Percentage of Risk Experienced and Influences to Offending Expressed by Risk Factor for Foster Placement Participants: Before, During and After Care*

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Before Care: Subjective Influence (Yes) and Prevalence</th>
<th>Before Care: Risk</th>
<th>During Care: Subjective Influence (Yes) and Prevalence</th>
<th>During Care: Risk</th>
<th>After Care: Subjective Influence (Yes) and Prevalence</th>
<th>After Care: Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Arrangements</td>
<td>54.5% (n=6)</td>
<td>90.9% (n=10)</td>
<td>54.5% (n=6)</td>
<td>81.8% (n=9)</td>
<td>27.3% (n=3)</td>
<td>45.5% (n=5)</td>
</tr>
<tr>
<td>Family and Personal Relationships</td>
<td>63.6% (n=7)</td>
<td>81.8% (n=9)</td>
<td>36.4% (n=4)</td>
<td>72.7% (n=8)</td>
<td>27.3% (n=3)</td>
<td>27.3% (n=3)</td>
</tr>
<tr>
<td>EET</td>
<td>45.5% (n=5)</td>
<td>72.7% (n=8)</td>
<td>36.4% (n=4)</td>
<td>63.6% (n=7)</td>
<td>9.1% (n=1)</td>
<td>36.4% (n=4)</td>
</tr>
<tr>
<td>Neighbourhood</td>
<td>45.5% (n=5)</td>
<td>63.6% (n=7)</td>
<td>18.2% (n=2)</td>
<td>36.4% (n=4)</td>
<td>27.3% (n=3)</td>
<td>45.5% (n=5)</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>54.5% (n=6)</td>
<td>54.5% (n=6)</td>
<td>63.6% (n=7)</td>
<td>54.5% (n=6)</td>
<td>45.5% (n=5)</td>
<td>45.5% (n=5)</td>
</tr>
<tr>
<td>Substance Use</td>
<td>45.5% (n=5)</td>
<td>54.5% (n=6)</td>
<td>63.6% (n=7)</td>
<td>72.7% (n=8)</td>
<td>27.3% (n=3)</td>
<td>45.5% (n=5)</td>
</tr>
<tr>
<td>Physical Health</td>
<td>36.4% (n=4)</td>
<td>72.7% (n=8)</td>
<td>36.4% (n=4)</td>
<td>54.5% (n=6)</td>
<td>27.3% (n=3)</td>
<td>36.4% (n=4)</td>
</tr>
<tr>
<td>Emotional and Mental Health</td>
<td>54.5% (n=6)</td>
<td>90.9% (n=10)</td>
<td>45.5% (n=5)</td>
<td>81.8% (n=9)</td>
<td>36.4% (n=4)</td>
<td>72.7% (n=8)</td>
</tr>
<tr>
<td>Perception of Self and Others</td>
<td>36.4% (n=4)</td>
<td>54.5% (n=6)</td>
<td>63.6% (n=7)</td>
<td>81.8% (n=9)</td>
<td>36.4% (n=4)</td>
<td>63.6% (n=7)</td>
</tr>
<tr>
<td>Thinking and Behaviour</td>
<td>45.5% (n=5)</td>
<td>45.5% (n=5)</td>
<td>54.5% (n=6)</td>
<td>63.6% (n=7)</td>
<td>36.4% (n=4)</td>
<td>36.4% (n=4)</td>
</tr>
<tr>
<td>Attitudes to Offending</td>
<td>27.3% (n=3)</td>
<td>27.3% (n=3)</td>
<td>27.3% (n=3)</td>
<td>27.3% (n=3)</td>
<td>18.2% (n=2)</td>
<td>27.3% (n=3)</td>
</tr>
<tr>
<td>Motivation to Change</td>
<td>27.3% (n=3)</td>
<td>27.3% (n=3)</td>
<td>36.4% (n=4)</td>
<td>36.4% (n=4)</td>
<td>18.2% (n=2)</td>
<td>36.4% (n=4)</td>
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</tbody>
</table>

*Overall n=11 (Appendix L. Mean Level of Influences to Offending Expressed by Risk Factor for Foster Placement Participants and Overall Care System: Before, During and After Care)
Before care, shows the foster placement to present the high influences to behavioural concerns and offending, with: Family and Personal Relationships (63.6% n=7), Living Arrangements (54.5% n=6) and Emotional and Mental Health (54.5% n=6) referenced as the most influential risk factors to behaviour. The highest risk experienced shows Emotional and Mental Health and Living Arrangements to be reflective of ten out of the eleven foster care participants, but just over half perceive this to be of influence to their behavioural concerns. In addition, EET and Physical Health is shown to be a huge concern with 72.7% n=8, experiencing this risk, but with only half of these experiencing this risk stating it as an influence. Thus, this group of participants are reflective of high risk, but lower influences are evident within this further analysis.

Lifestyle, Substance Use and Perceptions of Self and Others are presented to be the biggest influences to offending within care, with 63.6% (n=7) stating this to be linked to their criminality. The highest levels of risk shown within this placement type: Living Arrangements (81.8% n=9) and Emotional and Mental Health (81.8% n=9) were not referenced to be of a high influence, with only 54.5% (n=6) reflecting their living conditions to be linked to their offending within care and a lower 45.5% (n=5) seeing their emotional and mental health concerns to influence behaviour. The prevalence of emotional and practical concerns is echoed across the overall analysis, but again the link between such high risks and offending is challenged. After care, shows the most concerning influence to be that of Lifestyle, with just under half of this placement sample expressing this as a link to their offending (45.5% n=5), followed by Emotional and Mental Health and Perceptions of Self and Others (36.4% n=4). Again, such high rating influences are only expressive of half of the participants who experienced this risk.
4.4.2 Kinship Placements: Influences of Risk Factors to Behavioural Concerns and Offending

Table 11: Percentage of Risk Experienced and Influences to Offending Expressed by Risk Factor for Kinship Placement Participants: Before, During and After Care*

<table>
<thead>
<tr>
<th></th>
<th>Before Care:</th>
<th>Before Care:</th>
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<th>During Care:</th>
<th>After Care:</th>
<th>After Care:</th>
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<td>Subjective Influence (Yes) and Prevalence</td>
<td>Risk</td>
<td>Subjective Influence (Yes) and Prevalence</td>
<td>Risk</td>
<td>Subjective Influence (Yes) and Prevalence</td>
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</tr>
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<td>Living Arrangements</td>
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<tr>
<td>Family and Personal Relationships</td>
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<td>EET</td>
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<td>25% (n=1)</td>
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<td>50% (n=2)</td>
<td>75% (n=3)</td>
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<tr>
<td>Lifestyle</td>
<td>0% (n=0)</td>
<td>25% (n=1)</td>
<td>25% (n=1)</td>
<td>25% (n=1)</td>
<td>50% (n=2)</td>
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<td>Substance Use</td>
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<td>Physical Health</td>
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<td>0% (n=0)</td>
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<tr>
<td>Emotional and Mental Health</td>
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<td>50% (n=2)</td>
<td>25% (n=1)</td>
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<td>25% (n=1)</td>
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<td>Perception of Self and Others</td>
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<tr>
<td>Attitudes to Offending</td>
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<td>50% (n=2)</td>
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<tr>
<td>Motivation to Change</td>
<td>0% (n=0)</td>
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<td>25% (n=1)</td>
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</table>

*Overall n =4 (Appendix L: Mean Level of Influences to Offending Expressed by Risk Factor for Kinship Placement Participants and Overall Care System: Before, During and After Care)
Before care, shows the kinship placement to present the highest influences to behavioural concerns and offending with Living Arrangements (50% n=2). The remaining influences, however, are very small with only a quarter of the participants showing influences to their bad behaviour within: EET, Substance Use and Emotional and Mental Health. The remaining factors were not presented to influence any of this group.

The highest risk experienced is that of Neighbourhood, showing 75% (n=3) of the sample expressing this as a risk; however none of the sample showed this to be an influence to their behavioural concerns. Of the remaining high risk factors; Family and Personal Relationships and Physical Health, both at 50% (n=2), were not linked to be an influence to offending in any case.

Perceptions of Self and Others, Thinking and Behaviour, Attitudes to Offending and Motivation to Change; all showed 50% (n=2) to deem this as an influence to their behaviour during care, reflecting 100% of those who rated this as a risk factor. In contrast 100% (n=4) referenced Emotional and Mental Health to be a high risk factor, the only aspect of life to be of universal concern; with only 25% (n=1) of the participants seeing this as influential to their behaviour.

Finally, after care shows the most concerning influence to be EET, Neighbourhood and Lifestyle; all showing 50% of the sample to link it to their behavioural concerns.
4.4.3 Residential Placements: Influences of Risk Factors to Behavioural Concerns and Offending

Table 12: Percentage of Risk Experienced and Influences to Offending Expressed by Risk Factor for Residential Placement Participants: Before, During and After Care*

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Before Care: Risk</th>
<th>Before Care: Subjective Influence (Yes) and Prevalence</th>
<th>During Care: Risk</th>
<th>During Care: Subjective Influence (Yes) and Prevalence</th>
<th>After Care: Risk</th>
<th>After Care: Subjective Influence (Yes) and Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Arrangements</td>
<td>66.7% (n=4)</td>
<td>83.3% (n=5)</td>
<td>100% (n=6)</td>
<td>100% (n=6)</td>
<td>33.3% (n=2)</td>
<td>66.7% (n=4)</td>
</tr>
<tr>
<td>Family and Personal Relationships</td>
<td>100% (n=6)</td>
<td>100% (n=6)</td>
<td>83.3% (n=5)</td>
<td>83.3% (n=5)</td>
<td>33.3% (n=2)</td>
<td>66.7% (n=4)</td>
</tr>
<tr>
<td>EET</td>
<td>16.7% (n=1)</td>
<td>16.7% (n=1)</td>
<td>66.7% (n=4)</td>
<td>100% (n=6)</td>
<td>33.3% (n=2)</td>
<td>50% (n=3)</td>
</tr>
<tr>
<td>Neighbourhood</td>
<td>33.3% (n=2)</td>
<td>66.7% (n=4)</td>
<td>33.3% (n=2)</td>
<td>50% (n=3)</td>
<td>50% (n=3)</td>
<td>100% (n=6)</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>33.3% (n=2)</td>
<td>33.3% (n=2)</td>
<td>83.3% (n=5)</td>
<td>83.3% (n=5)</td>
<td>50% (n=3)</td>
<td>50% (n=3)</td>
</tr>
<tr>
<td>Substance Use</td>
<td>16.7% (n=1)</td>
<td>33.3% (n=2)</td>
<td>100% (n=6)</td>
<td>100% (n=6)</td>
<td>66.7% (n=4)</td>
<td>83.3% (n=5)</td>
</tr>
<tr>
<td>Physical Health</td>
<td>33.3% (n=2)</td>
<td>50% (n=3)</td>
<td>50% (n=3)</td>
<td>66.7% (n=4)</td>
<td>16.7% (n=1)</td>
<td>50% (n=3)</td>
</tr>
<tr>
<td>Emotional and Mental Health</td>
<td>33.3% (n=2)</td>
<td>33.3% (n=2)</td>
<td>83.3% (n=5)</td>
<td>100% (n=6)</td>
<td>83.3% (n=5)</td>
<td>83.3% (n=5)</td>
</tr>
<tr>
<td>Perception of Self and Others</td>
<td>33.3% (n=2)</td>
<td>33.3% (n=2)</td>
<td>66.7% (n=4)</td>
<td>66.7% (n=4)</td>
<td>50% (n=3)</td>
<td>50% (n=3)</td>
</tr>
<tr>
<td>Thinking and Behaviour</td>
<td>50% (n=3)</td>
<td>50% (n=3)</td>
<td>100% (n=6)</td>
<td>100% (n=6)</td>
<td>66.7% (n=4)</td>
<td>66.7% (n=4)</td>
</tr>
<tr>
<td>Attitudes to Offending</td>
<td>50% (n=3)</td>
<td>50% (n=3)</td>
<td>83.3% (n=5)</td>
<td>83.3% (n=5)</td>
<td>50% (n=3)</td>
<td>33.3% (n=2)</td>
</tr>
<tr>
<td>Motivation to Change</td>
<td>33.3% (n=2)</td>
<td>33.3% (n=2)</td>
<td>100% (n=6)</td>
<td>83.3% (n=5)</td>
<td>16.7% (n=1)</td>
<td>33.3% (n=2)</td>
</tr>
</tbody>
</table>

*Overall n = 6 (Appendix L Mean Level of Influences to Offending Expressed by Risk Factor for Residential Placement Participants and Overall Care System: Before, During and After Care)
Before care, shows the residential placement to present the same high influences to behavioural concerns and offending, with Family and Personal Relationships (100% n=6), Living Arrangements (66.7% n=4) showing the higher concerns as expressed for the care environment overall. Both of these high influences are also the highest experienced risk with Family and Personal Relationships showing 100% (n=6) and Living Arrangements showing 83.3% (n=5) to have concerning reflections. During care, both the influence to offending and related risk sees 100% (n=6) of the residential participants to reference Living Arrangements, Substance Use, Thinking and Behaviour and Motivation to Change as high concerns. In addition, risk experienced showed 100% of responses for EET and Emotional and Mental Health; with 66.7% (n=4) and 83.3% (n=5) also seeing this as an influence. Such findings echo the concerns for the overall system but at a higher prevalence. Finally, after care, shows the most concerning influence to be that of Emotional and Mental Health at 83.3% (n=5); reflecting 100% of those who deemed it to be a risk. Substance Use and Thinking and Behaviour were shown to influence the behaviour of two thirds of the sample. Although showing a decrease in overall risk, after exiting the care system, this placement type significantly increases both the risk levels and consequential influences during care and in turn pinpoints the criminogenic influences to be centred on the residential placement.

4.5 LCT and Carers: Perceived Risk and Influence to Offending

The following section provides an overview of the highest perceived risks and their influences to offending. Although, the sample is small it important to provide to examine the perceptions of risk, and its influence to offending, throughout the care journey. Brief overviews will be given, by the LCT (providing an overview of the system) and carers/staff from each placement type.
### 4.5.1 Before Care

Table 13: Highest Perceived Influences* to Offending Expressed by LCT**, Foster Carers, Kinship Carers and Residential Staff: Before Care***

<table>
<thead>
<tr>
<th>LCTs Perceived Influences to Offending</th>
<th>Foster Carers Perceived Influences to Offending</th>
<th>Kinship Carers Perceived Influences to Offending</th>
<th>Residential Staff Perceived Influences to Offending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Arrangements 100% (n=2)</td>
<td>Living Arrangements 100% (n=3)</td>
<td>Living Arrangements 100% (n=3)</td>
<td>Living Arrangements 100% (n=3)</td>
</tr>
<tr>
<td>Family and Personal Relationships 100% (n=2)</td>
<td>Family and Personal Relationships 100% (n=3)</td>
<td>Family and Personal Relationships 100% (n=3)</td>
<td>Family and Personal Relationships 100% (n=3)</td>
</tr>
<tr>
<td>Emotional and Mental Health 100% (n=2)</td>
<td>Emotional and Mental Health 100% (n=3)</td>
<td>Emotional and Mental Health 100% (n=3)</td>
<td>Emotional and Mental Health 100% (n=3)</td>
</tr>
<tr>
<td></td>
<td>Neighbourhood (n=2) 75%</td>
<td>Neighbourhood 75%(n=2)</td>
<td>Neighbourhood 75%(n=2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attitudes to Offending 75%(n=2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Motivation to Change 75%(n=2)</td>
<td></td>
</tr>
</tbody>
</table>

* categorised by risk factors which were perceived as ‘Yes Definitely’ and perceived to ‘yes’ influence offending, in two or more cases.**The LCT scored the perceived influences on the care experience overall***LCT n=2 (one participant did not feel they could accurately reflect) Foster Carers n=3, Kinship Carers n=3 and Residential Staff n=3.

All of the participants (n=12) highlighted: Living Arrangements; Family and Personal Relationships and Emotional Health to be a strong influence to offending. Foster carers showed a concern of neighbourhood to influence offending, with residential carers showing all but Physical Health to link to offending. These findings show the highest risk of offending, to be attributed to those in residential care.
### 4.5.2 During Care

Table 14: Highest Perceived Influences* to Offending Expressed by LCT**, Foster Carers, Kinship Carers and Residential Staff: During Care***

<table>
<thead>
<tr>
<th>LCTs Perceived Influences to Offending</th>
<th>Foster Carers Perceived Influences to Offending</th>
<th>Kinship Carers Perceived Influences to Offending</th>
<th>Residential Staff Perceived Influences to Offending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family and Personal Relationships 100% (n=2)</td>
<td>Family and Personal Relationships 100% (n=3)</td>
<td>Emotional and Mental Health 100% (n=3)</td>
<td>Family and Personal Relationships 100% (n=3)</td>
</tr>
<tr>
<td>Emotional and Mental Health 100% (n=2)</td>
<td>Emotional and Mental Health 100% (n=3)</td>
<td></td>
<td>Emotional and Mental Health 100% (n=3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Substance Use 100% (n=3)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Perceptions of Self and Others 100% (n=3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Thinking and Behaviour 100% (n=3)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Attitudes to Offending 100% (n=3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Motivation to Change 100% (n=3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lifestyle 75% (n=2)</td>
</tr>
</tbody>
</table>

* categorised by risk factors which were perceived as ‘Yes Definitely’ and perceived to ‘yes’ to influence offending, in two or more cases. **The LCT scored the perceived influences on the care experience overall. ***LCT n=2 (one participant did not feel they could accurately reflect) Foster Carers n=3, Kinship Carers n=3 and Residential Staff n=3.

For all placement types, Living Arrangements and Neighbourhood were no longer deemed to be an influence to offending. All participants, except residential staff, show the influence of offending to be solely allocated to: the Family and Personal Relationships and Emotional and Mental Health. Residential care is shown to be the most criminogenic, with seven out of twelve risk factors being referenced as a high risk factor and perceived influence to offending.
### 4.5.3 After Care

**Table 15: Highest Perceived Influences* to Offending Expressed by LCT**, Foster Carers, Kinship Carers and Residential Staff: After Care***

<table>
<thead>
<tr>
<th>LCTs Perceived Influences to Offending</th>
<th>Foster Carers Perceived Influences to Offending</th>
<th>Kinship Carers Perceived Influences to Offending</th>
<th>Residential Perceived Influences to Offending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Arrangements 100% (n=3)</td>
<td>Family and Personal Relationships 100% (n=3)</td>
<td>Emotional and Mental Health 100% (n=1)</td>
<td>Family and Personal Relationships 100% (n=3)</td>
</tr>
<tr>
<td>Family and Personal Relationships 100% (n=3)</td>
<td>Emotional and Mental Health 100% (n=3)</td>
<td></td>
<td>Emotional and Mental Health 100% (n=3)</td>
</tr>
<tr>
<td>Emotional and Mental Health 100% (n=3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighbourhood 100% (n=3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifestyle 100% (n=3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use 100% (n=3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceptions of Self and Others 100% (n=3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking and Behaviour 100% (n=3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitudes to Offending 100% (n=3)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* categorised by risk factors which were perceived as 3 ‘Yes Definitely’ and perceived to ‘yes’ to influence offending, in two or more cases. ** The LCT scored the perceived influences on the care experience overall***LCT n=3 Foster Carers n=3, Kinship Carers n=1 (as one is n/a) and Residential Staff n=3.
This final overview presents some insightful trajectories of risk, with the LCT showing a massive increase to criminogenic influences after care and residential staff showing a huge decline in high risk levels and influences to offending. However, Emotional and Mental Health and Family and Personal Relationships remain prominent influences to offending, a contrast to the risk assessments above.

Using the RPFP and the associated risk assessment, allowed an illustration of the care leavers journey from before care to their transition to adulthood, but was unable to explain the processual mechanisms that underpin their experiences of risk. Although, the analysis of subjective and perceived influences of risk on offending, assisted in understanding the areas of care deemed more problematic, it is unable to offer explanations as to why that is the case and in turn, what can be done to reduce these negative experiences.

The penultimate section of this chapter, will present the need to understand foundations which shape these levels of risk and therefore influences to offending.

4.6 Attachment as a Critique

This chapter looks in depth at the levels of risk and influences which lead to offending, as experienced by those whom have been looked after, and the perceived links of risk to offending by both carers/staff and professionals. The above findings do provide evidence of the extent to which different types of care may be criminogenic, but these findings do not present the areas which are specifically in need of change, instead providing many variables, and not the mechanisms which underpin their existence. Therefore, although the risk assessments show patterns of risk and adverse influences throughout the participants’ care journeys, which will be summarised below, there are many areas in need of expansion in terms of investigation and analysis.
This section will set out the justifications for such expansions, highlighting the need to bring attachment to the forefront of the analysis. Although Family and Personal Relationships and Emotional and Mental Health are of central concern for those in non-familial settings, the attachment focus is limited, despite the crucial element of this foundation to all other risk factors. Thus, although the RPFP shows attachments to be problematic if Family and Personal Relationships is scored as a risk factor, little more is known on the influences of attachments to the remaining risk domains. Taking into consideration the importance of attachments (Bowlby, 1952; Ainsworth and Bell, 1970; Main and Solomon, 1986), the importance of attachments for positive development demonstrated within Maslow’s Hierarchy of Needs (1943) and the crucial elements of attachment for protection from offending Social Control Theory (Hirschi, 1969), more attention needs to be devoted to analysing the extent to which attachment influences the overall levels of risk and the ability of the care system to reduce such concerns. With this in mind, the remaining analysis chapters (Chapter Five to Chapter Eight) will provide an investigation into the reasons for the negative experiences in care and the importance of attachment in determining such outcomes.

4.7 Conclusion

Participants with experience of residential care generally report increased levels of risk during care relative to entry. The experiences of risk were high, with five of the six residential participants stating they had experienced ten of the twelve risk factors, influencing their behaviour. The risk levels mostly drop after care, but are mostly higher than on entry, again showing the concerning experiences of residential placements. Foster placement risk remains constant, both before and during care, showing risk factors associated with emotions and relationships being areas of concern. The risk levels show a slight reduction after care, indicating concerns with the ability of foster care to reduce risk. Finally, kinship placements show an increase during care, but are seen to be the least
criminogenic, with the lowest level of risk factors during the care experience, and half of the kinship participants only experiencing one risk domain *during* care.

Offending rates increase during care relative to entry, and then fall on exit for *all* placement types; however, the relative increase is much higher for residential care and remains at a relatively high level even after falling.

Although this data set is limited due to the small sample size and the methodological limitations apparent due to retrospective self-assessments of risk, the findings present clear evidence that care in institutional settings is more criminogenic than in family settings. The following chapters will build on this whilst investigating the extent to which attachment influences levels of risk and offending behaviour, allowing a clearer understanding of what needs to change in order to improve life chances of looked after children and care leavers, and keep them free from offending.
Chapter Five

Attachments Before Care: Care Leavers’ Experiences

5.1 Introduction: Influence of Attachments to Risk Factors and Offending

The previous chapter provided a nomothetic perspective on the RPFP as it applies to risk and offending within the cohort as a whole. This chapter presents an in-depth idiographic analysis of the influences of the risk factors, centred on attachments. The chapter will ‘set the scene’ and present excerpts from each placement, providing an analysis of the participants’ attachment status before care. The attachment categories were not made to make retrospective psychological judgements; instead, they were formulated to establish the level of attachment concerns faced before entrance to the care system. These categories were made after consulting key developmental theorists on attachment and combining Ainsworth and Bell’s (1970) work of children in strange situations with Main and Solomon’s (1986) introduction of disorganised attachments. It is important to note that although earlier views within Attachment Theory are noted to be deterministic, this analysis acknowledges the ability of attachments to develop throughout an individual’s life, and therefore this chapter aims to present the starting point of the sample’s care journey (Mendes et al., 2014).

Through clearly stating the attachment status experienced before care, the analysis will allow a clearer measurement of the extent to which care assists the development of resilience towards offending, both as a system as a whole and in terms of individual care types. Therefore, the analysis within this chapter does not seek to conclude the level of resilience a young person experiences before care, but rather focuses solely on the pre-care attachment status of the sample, with Chapter Six critically analysing the ability of residential, kinship and foster care to assist with resilience, with the formation of attachments and non-offending outcomes being measurements of success.
Chapter Seven provides an analysis of the carers and LCT perceptions of attachments and the influences on emotional stability and its link to offending. Chapter Eight presents all participants’ experiences and perceptions of attachments after care and the impact this has on their offending, alongside the concerns experienced during a young person’s transition to adulthood. Finally, Chapter Nine will provide concluding remarks on the ability of attachment research and literature in order to aid the theoretical underpinnings of the RPFP, provide multi-theoretical approaches to understand the link between care and influence a model of intervention that builds on the safeguarding basis of the leaving care services in the UK.

5.2. Residential Participants

Participant: R1

Age Entered Care: 11

Attachment Status: Avoidant and Disorganised

“I can’t remember anything positive before care, everything about it really, was negative, everything. They should just have not had children, my mum should not have had children, my dad and my step dad shouldn’t of”.

“My step dad died at nine and he had made sure that my dad buggered off basically and my dad left when I was three. My Mum couldn’t control me I suppose, mum just didn’t care. Like when I would run off she didn’t report it, she didn’t report me missing. She just didn’t care pretty much. I didn’t want to live with my mum and she didn’t want me there either so yeah. It all stopped when I ended up in hospital, that’s when they took me away and I was glad my plan worked, finally I would be looked after and loved”.

This young woman had been at home with her primary caregiver for nine years. However, the clear lack of positive parenting from mother to child, are of deep concern, with a concerning lack of connection between them both. The rejection is undeniable, with this participant reflecting back on a clear mutual dissatisfaction for her mother. These
prolonged negative exposures to emotional neglect, shows the increased risk of anti-social behaviour (Farrington and Welsh, 2007).

Through such exposures, it is clear that no secure attachment has been presented. However, the young woman states “I didn’t want to live with my mum and she didn’t want me there either”; this lack of harmony between the mother and child is clearly a feeling that is mutual between them both. Therefore, whilst looking at the use of a care order on this child, the child is in favour of this, with the participant reflecting back on when she went into care “It all stopped when I ended up in hospital, that’s when they took me away and I was glad my plan worked”.

At this stage, although exposed to insecure attachments for the duration of her childhood, she shows her reasons for wanting to get away from her mum “finally I would be looked after and loved”. This young woman is aware of the need for attachment and such reflections allow us to look back and see the process through her eyes, the hope and need for a sense of belonging and love. This very awareness allows potential for the young person to not only be aware of the need for attachment but also shows that this young woman did not allow the abnormal to become normal. Therefore, although no attachment was apparent in the first eleven years of this participant’s life, this young woman entered care with a strong conscious need for love.
Participant: R2
Age Entered Care: 13
Attachment Status: Avoidant Attachment

“My mum never liked me and treated me badly. My sisters would get fed first and I would have to wait, she wouldn’t let me play and I would have to stand by the wall. Once she gave my sisters three hundred pound each and me nothing, even though I had no clothes or clothes that were too small. I would then get stick from school and everything, I just thought it was normal and would just sit and pretend to be someone else. It’s hard to ever get over that, so to a certain extent that must have been boiling up inside and making me lash out at things. I was glad to go into care to get away from that”.

This young woman entered care at the age of thirteen, showing a prolonged exposure to damaging relationships. The details presented show high levels of neglect and no reflections of love and belonging.

Although we have no evidence of the early attachments between mother and child, we can clearly see the participants reflections of her childhood to be absent of affection and receipt of her primary needs.

As Harlow (1958) clearly presents, there is a strong need for affectionate ties to a mother, however this participant does not display evidence of this lifelong, unrelenting persistent attachment. Instead, due to the participant’s mother, there is a clear insecure, avoidant attachment. As highlighted within attachment research, the avoidance of the mother to respond to her child’s needs, will lead to changes in the way the participant can cope with stress and develop resilience.

Through this analysis, it is evident that the participant has been subjected to concerning parenting practices, and this had its impact: “it must have been boiling up inside and making me lash out at things”. Thus, the damaging attachment style is directly shown to
link to the participant’s behaviour, a finding that fits with the body of literature that
surrounds attachments and consequences of non-secure attachments. The concerning
aspect of this participant’s experience is the length of exposure to this attachment type. As
discussed earlier, we cannot determine the attachment type in her earlier years, but the
above excerpt shows clear evidence of an insecure avoidant attachment for a considerable
length of time. Similarly to R1, this participant shows their relief, being “glad to go into
care to get away from that” again. The participant is therefore aware of what is needed,
and attributes positive feelings to going into care. The desire for normality and settling is
present; therefore, the residential placement offered to this participant will be of central
focus, allowing a full analysis of the extent to which this placement type has the ability to
provide the tools to assist the development of attachments and resilience.

Participant: R3
Age Entered Care: 11
Attachment Status: Ambivalent Attachment

“I went into care when I was eleven as I was witness to domestic violence and things were
pretty tough. I do think though that I had a good family life, they were my family and I was
used to them, it was all I had known for eleven years. Yes, there were problems and
violence and that but they were my family”.

This young person shows reflections of his childhood to be of a mixed experience. There
are key negative terms; however, in the same commentary the participant highlights how
they had experienced a “good family life”. Although attachment literature has a strong
focus on the presence of closeness, it also shows a strong need for a positive attachment
void from abnormal practices (Ainsworth and Bell, 1970). Therefore, although this
participant shows some positivity towards their birth family, the acceptance of violence is a
concern. In terms of the influence of care towards this participant, one is filled with hope
that the removal of the young person from this environment, could allow the attachments to be built on with positive influences.

**Participant: R4**

**Age Entered Care: 5**

**Attachment Status: Avoidant Attachment**

“I was taken from my mum when I was five. I don’t remember much at all, but know she loved me. She just had problems with drugs and had a breakdown. My mum and social services decided it was best to be moved into care and looked after properly. My mum couldn’t protect me, so she put me in care, for me, because she loved me”.

This participant was only in his mother’s care until the age of five and cannot consciously remember the relationship they had. Instead, he reflects on the unconditional love that is deemed a prerequisite of being a parent. It is not to speculate the presence of this love or the linked attachment, instead one can see evidence the choice of being removed from the parent was to be “looked after properly” with the participant seeing this as an act of kindness and love “so she put me in care, for me, because she loved me”. The participant clearly shows positive reflections of his mother and there is no evidence to support feelings of rejection. On the contrary, there is evidence of acceptance that the mother made a correct decision to protect him, therefore showing she cares. Therefore, although perceived by the participant to be attached to his parent, the evidence shows an element of avoidant attachment (Ainsworth and Bell, 1970), as the mother was unable to respond to the child’s needs due to her lifestyle and drug taking. The ability for this participant to form a meaningful and secure attachment with his mother, after entering care, will be looked at in depth in the following section.
Participant: R5
Age Entered Care: 14
Attachment Status: Secure Attachment

“Before care, well it was lots of levels of good and bad. I mean, I didn’t go into care until I was fourteen. Up until my dad left, everything was ok. We were a very close family”.

“Influence wise, I think they were a good influence, I saw decent people showing me right and wrong. Well, like I said until my Mum went crazy. I saw my Dad every month and he noticed things were not good; I looked a mess you know and spoke of my Mum’s behaviour, those kinds of things. I also started to behave like a bit of a prick but just in a laddish way, fights here and there, but that was just part of growing up, I knew what was right and wrong. It didn’t stop my Dad worrying though”.

This participant provides a narrative which shows clear evidence of secure attachments with both his mother and father, “we were a close family” “they were a good influence”. The participant’s reflections show both closeness and positive influences in which he could model his behaviour on, a topic discussed in detail by Bandura (1977) amongst other behavioural theorists. Although there were severe changes in his family structure, with avoidant parenting due to his mother’s mental illness, there is no evidence to suggest it had an impact on the participant’s sense of belonging.

This follows predictions, with clear secure attachments influencing resilience and diversity in responding to changes in relationships (Ainsworth and Bell, 1970). This participant shows the problems with the later avoidant behaviour of his mother; however he does not present evidence of internalising this, instead, he displays the strength of his secure attachments and does not attribute his bad behaviour as being linked to this shift in parenting, instead he is able to link it to his mother’s illness and does not display any evidence of feeling rejected. In addition, he refers to his behavioural concerns as just
“laddish behaviour” “being part of growing up” and he “knew right from wrong”.
Therefore, whilst he displayed evidence of problematic behaviour, he does not present a
link between his family attachments and displays of violence.

Participant: R6
Age Entered Care: 5
Attachment Status: Disorganised Attachment

“I don’t really remember having much of a childhood. I can barely remember any good
things. My mum was useless and she left me with her boyfriend, he would do all sorts to
me. I can’t remember much, I do remember bits and pieces of violence and things of a
sexual nature which I don’t really want to go into. I missed my mum growing up but
looking back I don’t know what I missed really as she was a shit mum”.

In contrast, this participant shows no evidence of a secure attachment. Instead, the
parenting received, not only failed to provide attachments, but also caused direct harm of
both a violent and sexual nature. Interestingly, the participant also reflects how she missed
her mum before stating “looking back I don’t know what I missed really as she was a shit mum”. Similarly, to participant R4, she shows evidence of the unconditionally love that
links a parent to their child but also shows a realisation of normalised parenting. Through
this initial analysis, although this participant shows higher concerns due to the lack of
attachments experienced, she also shows awareness of knowing her home experiences
were abnormal.

Thus, instead of normalising or modelling the behaviour witnessed, the participants
understanding of right and wrong gives the care experience a base to build on. Therefore,
this participant has the potential to build new attachments, an analysis that will be
presented in the next chapter.
5.3 Kinship Participants

Participant: K1
Age Entered Care: 0
Attachment Status: Secure Attachment

“It was decided before I was born that I would not be able to be looked after by my mum, so all I have ever had is my grandparents and they are like my parents”.

This participant was moved into care at birth. Therefore, although absent from an attachment from their birth mother, there is clear evidence that a secure attachment has been made: “they are like my parents”. As research suggests, the first months of a child’s life are key to developing secure attachments, and this young person was given this through their grandparents (Bowlby, 1952). Therefore, this participant does not show any risk of the impacts of maternal deprivation, as the primary caregiver was allocated at the time of birth. Theoretically, this young person would have the secure base needed to reduce the risk of delinquency. The following section will examine this in detail, whilst analysing the impact of the participant growing up without their mother, and whether feelings of rejection will hinder the ability to develop into a prosocial adolescent. Furthermore, the forthcoming analysis will examine the extent to which the care system assists the overall development of resilience, by providing a nurturing environment with tools to assist individual resilience to risks associated with offending.

Participant: K2
Age Entered Care: 5
Attachment Status: Avoidant Attachment

“I went into care because I was neglected by my mum. We were skint as she spent all her money on alcohol and the social got wind of this and I was put into care. I loved her and still do, guess you do no matter”.
Theoretically, as she was with her primary care giver for the first five years, she should have been in receipt of a secure base and attachment. However, despite this participant stating her love for her mother, she was not in receipt of the responses a secure attachment should make. Instead, her mother “spent all her money on alcohol”, and not only does this raise the obvious concerns of parental ability, but also highlights the avoidant nature of the attachment through the mother’s inability to respond to the participant’s needs (Ainsworth and Bell, 1970). Therefore, although there is a clear instilled loving relationship, a secure base needs to be developed. Placements with family members are known to reduce the risk associated with removal from birth parents (Taylor, 2006). The following chapter will examine the extent to which the kinship placement will allow additional attachments to be made, and if behavioural concerns are apparent and attributed to attachment style.

**Participant: K3**

**Age Entered Care: 6**

**Attachment Status: Avoidant and Ambivalent Attachment**

“Thankfully I was taken into care at the age of six. I was subject to a full care order for abuse and neglect. I can’t really describe it, but basically everything parents shouldn’t do mine did. The school informed social services and the rest is history, my life then began”.

This participant had an extremely insecure attachment, in both ambivalent and avoidant forms. However, the participant is thankful to have been taken into care and states how his “life then began”. This is particularly interesting, as Bowlby (1952) stated the importance of receiving continuous care with the most important attachment figure for at least the first two years of an individual’s life. If this attachment is, disrupted, damaged or no existent during this period, the child is then seen to suffer from the irreversible long term consequences of maternal deprivation. However, this participant does challenges these deterministic predictions and shows that although his initial attachment was disrupted, this would not damage all of his future relationships. This participant’s journey presents a
hopeful picture for those entering care, both in terms of building a secure attachment and influences to prosocial behaviour.

**Participant: K4**

**Age Entered Care:** 7  
**Attachment Status:** Secure Attachment

“My early memories were very good, everything a child should remember. Then she got ill when I was about six and she went downhill very quickly, she had an aggressive form of breast cancer and there was very little they could do. She sadly passed away shortly before my eight birthday”.

This participant reflects that his early childhood was good, both in terms of memories and attachments. Sadly, he lost his mother when he was only seven, and was placed into kinship care. Although a sudden change of care giver and grief can influence behaviour due to the very impact of emotional turmoil on one’s sense of belonging, the overall risk of offending, as predicted by attachment concerns, is low. The full impact of kinship care on this participant will be analysed in detail alongside the other three participants, allowing a full exploration into the abilities of kinship placements to provide an environment of social resilience, allowing development and/or improvement of attachments. In addition, the extent to which kinship placements assist in offsetting the risks associated with offending behaviour will be considered.
5.4 Foster Participants

Participant: F1
Age Entered Care: 6
Attachment Status: Disorganised Attachment

“I went through quite a lot, too much that I do not really want to go into detail about. My mother was good to us before she ran away before I was five and then there were all sorts of abuse and neglect by my father. I was six when I went into care, so all I know really is what I have read and little bits I remember but it was very tough to read and very upsetting to see how I was treated. I do not think I will ever get over what he did to me, but I know it is not my fault and I must move on from it, which I have”

This participant recalls clear traumatic experiences within the first six years of her life. Not only did her mother leave before she was five, she was a victim of horrendous abuse. The excerpt gives some evidence of her mother being “good to [her]”, showing a form of attachment. Although we cannot speculate as to the reasons her mother left, the quality of this attachment is questionable. This separation, alongside the trauma of her pre-care experiences, can be noted to have impact on her abilities to form new attachments. However, there is clear evidence of the participant having gained an adult understanding that she was not to blame, and having moved on.

Therefore, although she states that she would not ever get over her experiences, she highlights her ability to move on. The next chapter will analyse the extent to which the care experience aided her emotional development, in terms of responses to her concerning attachment practices and the trauma associated with the abuse she received, and any links to behaviour.
Participant: F2
Age Entered Care: 15
Attachment Status: Secure Attachment

“We had a good life there. I was like enjoying, you know, life. But once my father was murdered by the Taliban and my mum died, then my life just changed”

This participant offers a completely contrasting experience to all other participants within this research group. He is an unaccompanied asylum seeker, who was trafficked into the UK when he was fifteen years old. Although this participant does not discuss his relationships with his primary caregivers, he clearly shows a good upbringing and reflects on happy times. When this young man was just fifteen years old, he witnessed his father being murdered and then subsequently lost his mother.

Although he experienced high levels of trauma, his life was filled with closeness and a secure base, which will allow him to create meaningful interpersonal relationships in the future (Farrington, 2007). Therefore it is of crucial importance to analysis the extent the care environment can build on these attachments and allowing the participant to rebuild his life, positively.
Participant: F3

Age Entered Care: 13

Attachment Status: Avoidant Attachment

“My old man killed himself when I was six month old. Then my mum met another bloke and they had a kid together, my little brother. He was a bit lairy towards us, umm I must have been about 5, he was only around for a year. Then my mum met another bloke and they got married and that was my stepdad, and then I was nine and he killed himself. Then a year or two later my mum met another bloke and they had a kid, that’s my little sister and we moved to another area. He was ok at first, but then he started getting a bit lairy again towards me and my older sister. After a few years he basically chucked me and my sister out and then they all moved away and that was it.

“Nah not at the time, umm no, not really close to anyone. My Nan has always been there in the background. But I mean at times they’ve stopped her from seeing us you know when we was younger and that. So it’s just basically my mum chose men over us basically, that’s the thing”.

Within his early development, this participant was subjected to extreme life events, with both upheaval and loss. Although it is evident that the participant’s mother was his primary care giver, he does not allude to the quality of attachment or impact of the loss of his father, and instead he highlights the instability he experienced. This instability, both in terms of relationships and being moved around, would result in confusion, and could impede the quality of the relationship between the child and primary caregiver. It is my opinion that this young person was in receipt of an insecure avoidant attachment throughout with his mother: “So it’s just basically my mum chose men over us basically, that’s the thing [...]”. 
The accumulation of the insecure attachments, suicides, violence and rejection within this young person’s childhood and adolescence leaves him vulnerable to impediments to his socialisation process, and as a consequence of this, puts him at an increased risk of offending.

The next chapter will present the complex integrations between this young man’s attachments, developments and offending behaviour, and will critically examine the extent to which his foster placements provided him with the tools to come to terms with these early experiences, and how this influenced his behaviour.

**Participant: F4**

**Age Entered Care: 13**

**Attachment Status: Avoidant and Disorganised**

“I went into care because of physical abuse and domestic violence and I cannot remember good things in the thirteen years I was at home, I never was loved like a normal child, in fact I was not even liked that much. I was really scared and damaged and witnessed many bad things and was victim to many bad things, I will never forget that and it has had a huge impact on my life”.

When looking at the pre-care exposures to a lack of attachments, the length of exposure is critical (Case and Haines, 2009). For this particular participant, the exposure was prolonged for thirteen years. Not only can the participant not remember anything positive throughout her childhood and early adolescence, she reflects on extremely negative experiences and no evidence of attachments at all: “I never was loved like a normal child, in fact I was not even liked that much”. It is evident that this caused many consequences, such as being “scared and damaged”. As literature suggests, individuals who are not in receipt of a secure attachment are more likely to be anti-social and less likely to be resilient to future stresses that occur within one’s life. The next chapter will examine the extent to
which the care system can counteract this predestined risk, aid the healing process of the participants and allow attachments to be formed.

**Participant: F5**

**Age Entered Care: 15**

**Attachment Status: Disorganised Attachment**

“Well up until my step dad came when I was about ten, I was close to my mum. Gradually he got worse and hit me and treated me like shit. My mum didn’t stand up to him and chose him over me, which is pretty hard to take, even at fifteen”.

“I had a troubled upbringing with lots of violence. No really gave a shit about me and I was so glad to go into care where they would care for me”.

This participant reflects on a childhood that can be separated into two parts, the first a childhood accompanied with a secure attachment and the second a childhood filled with violence and mistreatment. It is clear that there is a shift towards a disorganised attachment, but the extent to which a negative care giver can alter the already secure attachment is unclear. The participant states “my mum didn’t stand up to him and chose him over me, which is pretty hard to take, even at fifteen” showing how there was a shift from offering a secure base to an avoidant parenting style. However, this participant responds to this disengagement by welcoming entrance to the care system, in the hope of his needs being met. The extent, to which foster care was able to assist, will be presented in the next chapter.

**Participant: F6**

**Age Entered Care 4**

**Attachment Status: Disorganised**

“Well my mum was an alcoholic and tried to kill me, so there was no attachment there. My dad was a prick, so that was limited”.
This participant, although only offering a brief description of his relationships before care, directly observes no secure attachments alongside extreme violent behaviour.

Therefore, although based on little narrative, the participant entered care at the age of four with high risk due to lack of attachment, and its predetermined negative influences to behaviour. This participant, if placed in the correct environment, does have a chance to reciprocate attachments due to his age. The quality and stability of his care experience, therefore, is crucial to aid pro social behaviour.

**Participant: F7**

**Age Entered Care: 6**

**Attachment Status: Disorganised Attachment**

“Witnessing what I did, it is something that you can never get over it. And to think it happened, and then went back to it again when I was ten years old, for it to happen again now that is fucked right up and really fucked me up. I saw things and felt things that shape you. I didn’t know what normal family life was like until I went into care and then I was moved back home. I was so confused, as they took me out of a hellish experience, and then sent me back. I thought this must mean my parents were ok. I then saw a lot of violence again, and that made me go off the rails, kind of acting like my parents did. There was no change at all with my dad and I was put back into care again”

“My mum was a right dickhead and was very violent and my dad would do bad things. I don’t think I ever really liked any of them, either of them sorry. They were not into looking out for me and I can’t say I ever felt loved, not by anyone really”.

This case is extremely disturbing; both in terms of experiences and the impact this would have on attachments. Not only did this young woman have a difficult start witnessing violence and other bad things, which the participant did not want to go into, she also internalised this stating “I can’t say I ever felt loved, not by anyone really”.

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Such experiences show a clear absence of attachments, both in terms of avoidant and ambivalent experiences (Ainsworth and Bell, 1970). This participant was unaware of the normality of parental structures and this was heightened further from being moved back and forth into care. She clearly states “I didn’t know what normal family life was like until I went into care and then I was moved back home” and to then move back again clearly has negative implications and a disorganised attachment, leading to further rejection and confusion in what is expected of a parent.

The next section will present a full analysis on the ability of foster placements to address these concerns; providing an appropriate family environment, sense of belonging and promotions of pro social behaviour.

**Participant: F8**

**Age Entered Care: 14**

**Attachment Status: Secure Attachment**

“My mum died when I was two, so my Nan brought me up outside the system, so mum’s mum brought me up. I can’t remember my mum and how we were, but I know she would have loved me. So it was a normal life in my early years with lots of love and laughter, until I got into the wrong crowd. I tried to be good for my Nan, but she just couldn’t cope with me and put me into care. Things just went downhill from there, as I felt no one cared enough for me”.

This participant shows an unusual pre care entry. Sadly, her mother died when she was two and although she has little memories, she does reflect on knowing she would have been loved. This allows a clear presentation of a secure attachment with her primary caregiver. As clearly stated above, her maternal grandmother then gave her a childhood which was filled with love, again showing a secure attachment. This young person, although
experiencing the loss of her mother, presents no concerns with attachments before she was fourteen.

However, despite trying to behave for the sake of her grandmother, this participant's behaviour became too much and resulted in her grandmother putting her into care. This had further consequences, “things just went downhill from there, as I felt no one cared enough for me”. It is clear, that this participant felt rejected as she was put into care as a response to her behaviour. Although one cannot ultimately defend the intentions, it is evident, through parenting practice, that this removal would be to aid the participant’s lifestyle and not because she didn’t care. Furthermore, this participant attempted to improve her behaviour, whilst she was securely attached and was unsuccessful. Therefore, with her internal model of rejection, it raises further concern about her behaviour, as she no longer feels she has anyone to let down, an important protective factor within Social Control Theory (Hirschi, 1969).

Participant: F9

Age Entered Care: 16

Attachment Status: Disorganised Attachment

“We had a normal family life until my stepdad came along; I think I was about twelve or thirteen at that point. He thought he could step into my dad’s shoes and he took over the family. He tried to strangle me when I was sixteen and I was put into foster care. All my family turned against me as there was not enough evidence to get him done, they didn’t want me anymore and it was a very difficult time, they didn’t love me anymore. I just wanted to die and if I did, no one would have noticed, I felt really unwanted”.

“My sister stayed with my mum and that was tough”.

This excerpt, although lacking a detailed account of the relationship this participant had with her mother, highlights a normal family life. However, the introduction of an
additional care giver caused strain on the family environment and resulted in extreme violence, moving the participant away from a secure setting.

This participant was subjected to extreme violence, blamed and then put into care. Such trauma and rejection had a clear impact on this young woman, resulting in her feeling: her life was worthless; she was invisible and unloved. This rejection was further enforced with her sister remaining in the family home. Theoretically, the secure base experienced before this participants adolescence, will set up characteristics of resilience and high self-esteem. However, due to the appalling abuse she suffered within her adolescence, this shift towards disorganised attachment and therefore increasing the risks of physical emotional and social consequences, as a result of the low self-esteem and self-worth (Farrington and Welsh, 2005). The next chapter will critically analyse the extent to which the care system can help the participant come to terms with her feelings of rejection and low self-worth, and in turn, how this impacts on her behaviour.

**Participant: F10**

**Age Entered Care: 9**

**Attachment Status: Avoidant Attachment**

“My mum used to have fits and my dad was an alcoholic, he used to hit me with his belt. I used to really scared and felt so unhappy. My dad used to ask for money and go off with women, not looking after our needs. They loved me but we weren’t being looked after properly, so we had to go into care when I was nine”.

The attachment this young woman experienced was avoidant at times, with little protection of her needs. Although this participant felt loved, the main narrative highlights abuse and neglect and the need to enter care. However a vital protective component is present with the awareness of what a family should be, offering reassurance of the participant’s ability
to understand what is right and wrong. Therefore, if in receipt of proper care, this young woman does not pose a high risk towards anti-social behaviour.

**Participant: F11**

**Age Entered Care: 11**

**Attachment Status: Disorganised Attachment**

“The most upsetting thing is how they kept on putting me back with my mum, a drug addict. I had to put myself into care and refuse to go home, I did this at eleven. My mum loved drugs more than me, which was her love”

This participant offers poignant reflections on the relationship with her mother in her early years. This is a clear example of an avoidant attachment, insecure through the inability to respond to this child’s needs (Ainsworth and Bell, 1970). In addition, the violence and drug taking shows further damage and disorganisation to this already problematic parent–child relationship.

Not only does this participant highlight the damage caused in their early years, they highlight the further maltreatment and disruption caused by the re-entrance to the problematic home environment, prior to her putting herself into care at the age of 11. This continued shift in living environment is of central concern, with the need of consistency to develop an attachment. The extent to which the care system can address these issues will be addressed in the next chapter.

**5.5 Conclusion**

The sample is similar to the national observations of reasons for entry to care, with the majority of participants being subject to a care order due to abuse, neglect and family dysfunction (DfE, 2015a). Therefore, it is unsurprising that attachments are of central concern. However, just under a quarter of the participants (n=5) had secure attachments
before they entered care, offering positive messages of predicted resilience and prosocial behaviour (Farrington and Welsh, 2007).

In contrast, a third of the participants (n=7) suffered a disorganised attachment and a further third suffered attachments with either avoidant (n=6) or ambivalent (n=2) models, with evidence across the placement types. Finally, a small number of the participants (n=3) highlight no attachments at all. So, three quarters of the participants offer concerns linked with insecure attachment, with evidence of this across all placement types. As highlighted within Chapter Two, those with insecure attachments are more likely to experience concerning views of themselves and others, and lower levels of resilience. Therefore, the majority of this sample did not enter care equipped with the abilities to overcome adversities which are so strongly linked to offending, with this being less likely in foster and residential settings (Bowlby, 1952; Farrington and Welsh, 2005). However, despite these concerning pre-care experiences and the impact this may have upon the ability to be resilient, it is vital to acknowledge the responsibility of the care system to provide suitable placements to allow the development of attachments, in order to improve the likelihood of resilience. Without providing a suitable environment to build resilience the system is accountable for both the emotional and behavioural outcomes of their looked after children and care leavers. Therefore, this analysis has not been presented to add further ‘individual’ explanations of the link between care and criminality, but rather presents the need to look at the ‘system’ and its responsibility to address pre-care concerns.

The following chapter will present an in-depth critical analysis into the extent to which the different care environments can improve attachments and also offer new attachments, therefore increasing resilience and reducing the risk of offending. In addition, the narrative will focus on the extent to which attachments are of central focus within the participants’ understanding of their offending.
Chapter Six
Attachments During Care: Care Leavers’ Experiences

6.1 Introduction

The care system has a central importance in removing those in troubled home environments in order to keep them safe and give them the foundations for the best possible outcomes, free from harm. The previous chapter highlighted the concerns experienced before care, and within the participant’s narratives not only are there clear displays of negative and neglectful environments, there are obvious impacts upon the abilities of these young people to be in receipt of secure attachments. The key concern within this part of the chapter is to examine the extent to which the care system has the ability to not only overcome the adversities faced in terms of abuse and neglect, but also to aid the young person in receipt of care to be able to address concerns with attachments, and in turn provide an environment that can improve previous attachments and the ability to form new positive attachments.

This is not to say that attachments are the sole predictor of good behaviour, this chapter provides evidence of the importance of attachments in explaining the mechanisms behind the experienced ‘risk’. With this in mind, the analysis examines the extent to which the different types of care environments are criminogenic, with the criminogenic influence being mediated by negative or absent attachments.

6.2 Safeguarding: Feeling Safe

When looking at the care system, the aim of promoting safety from harm is at the forefront of the objectives of local authorities (Thorogood, 2015). Before presenting the experiences within this sample, it is important to acknowledge that not all experiences in care equate to
safety from harm, with both current and historical cases of child abuse within the care system being rife.

Although there have been efforts to increase child protection within local authority care, (see Chapter One), there are still many cases of child abuse being reported. In 2014, the National Police Chiefs Council [NPCC] announced their Operation Hydrant, a coordination hub that oversees the investigation of allegations of historical child sexual abuse within institutions or by people of public prominence (NPCC, 2015: 1). This operation, which covers all enquiries across England, Wales, Scotland and Northern Ireland, found that as of 20th May 2015, a total of 357 institutions were linked to investigations into child sex abuse, with 75 children’s homes being under investigation. These numbers are likely to be lower than the overall experiences of sexual abuse, with victims of abuse often feeling unsupported, ashamed and fearful of the traumatic experiences being revisited (Jay, 2014).

These concerns are not limited to historical reflections of the care system, with recent evidence showing concerning rates of allegations of abuse and neglect of children in both foster and residential care (Biehal et al., 2014). In a two-phase study carried out between 2009 and 2012, 211 local authorities in the UK were surveyed to show the scale of substantiated and unsubstantiated allegations of neglect and abuse within foster and residential care. The first phase, consisting of the survey of all 211 local authorities, received a 74% response rate (n=156 local authorities), with the second phase providing a follow up survey of 146 of the substantiated cases of abuse or neglect (118 cases within foster care and 28 within residential care) to present the types of abuse and/or neglect experienced.

When investigating the allocations made within foster placements, local authorities on average reported 10 to 11 allegations per area in each year of the study between 2009 and 2012, with a total of between 2,000 and 2,500 per year within the UK. These findings show
around 4 allegations per 100 children within this placement type per year. Of these allegations, between 22% and 23% were confirmed, with the remaining unsubstantiated. Therefore, there is less than 1 confirmed allegation per 100 children each year. However, when one looks at the UK overall, these findings give an estimation of between 450 and 550 confirmed cases of abuse or neglect each year within foster placements (Biehal et al., 2014:10). It is important to note that these findings are likely to be lower than the overall levels, with over half of the unconfirmed allegations not being proven either way.

The follow up survey, sampling 118 of the confirmed cases, showed 37% were linked to physical abuse, 30% emotional abuse, 11% sexual abuse and 17% neglect abuse – the remaining cases were in reference to insufficient standards of care (Biehal et al., 2014:12). When looking at allegations within residential settings, the survey was concerned with allegations made against staff, and therefore the following findings do not include other sources of abuse, such as that by peers and abuse away from the care setting. Local authorities on average reported five to seven allegations per area in each year of the study, with a total of between 1,110 and 2,500 allegations made per year within the UK. These findings show between 10 and 12 allegations per 100 children who live in residential care per year. Of these allegations made within a residential placement, between 21% and 23% were confirmed, with the remaining unsubstantiated (Biehal et al., 2014:15). Although the overall estimations are slightly smaller at between 250 and 300 confirmed cases of abuse or neglect in the UK per year, the volume of individuals placed within this placement is considerably smaller than in foster care. Therefore, there is a higher rate of confirmed allegations within residential care, with between 2 and 3 per 100 children in residential care each year falling victim to the care system’s failures.

The follow up survey, sampling 28 of the confirmed cases within residential care, showed seven allegations, across two institutions, which were to be closed down due to cultures of “physical coercion and compliance in which the physical abuse of children may have been
systemic” (Biehal et al., 2014: 15). Furthermore, over a half of these cases were related to excessive force when dealing with a young person within the institutions’ care.

Although the above evidence shows the majority of young people in care to be safeguarded, there is still a significant minority who experience further harm within the local authorities’ care. Although a lot of attention is given to historical abuse within institutions, as highlighted above, abuse and/or neglect can occur within any environment, in any form. It is therefore vital to understand the breadth of experiences within care, and to take note of safeguarding as a reality for all looked after children in care.

Not only are there cases of abuse experienced directly within the care setting, there is also increased risk of Child Sexual Exploitation [CSE] for looked after children outside of care settings. There are ongoing prolific cases within areas such as Rotherham, which show high levels of concerns within the looked after population and the likelihood of being a victim of CSE. In 2014, 16 of the 51 cases being investigated were linked to looked after children who were either at serious risk of CSE or had already been a victim of it (Jay, 2014). Thus, looked after children are often targeted, meaning their safeguarding is often compromised within and/or outside of the care setting.

Despite these ongoing concerns, the participants in this study did not report such experiences within their placements. Although this was not specified within the inclusion criteria given to the gatekeepers, they did not provide young people whom they deemed too vulnerable or a risk to myself as a researcher (see Chapter Three to revisit full recruitment procedures). Therefore, care must be taken to note that such findings are not representative of the care experience of all young people, with abuse and neglect still sadly apparent.

When looking at the extent to which different care environments provide ‘safety’, within this sample, the risk associated with the majority of placements is of little concern.
Therefore, from the perspective of the formal responsibilities of local authorities, the overarching aim of safeguarding - the prevention of harm - is of course paramount within their allocations of placements. However, ‘safe’ living conditions is not the only factor needed to determine positive outcomes for looked after children. Solely focusing on ‘prevention from harm’ fails to provide the full picture of the extent to which care environments are providing suitable placements to allow each young person to be happy, healthy and to achieve well (DfE, 2003).

The majority of participants, 19 out of 21 (90%) entered care with unsuitable living conditions as a contributing factor to their care orders, with only those who had entered care due to death of a parent not having previous risks associated with them. Therefore, the majority of this group of participants left their home environments for better conditions, and in turn, increase the likelihood of better outcomes. With the clear care foci being centred around risk removal, safeguarding/basic sustenance, educational commitment and life skills, it seems an important task to analyse the extent to which social services fulfil their ethos, and in turn aid the young person in their care, to be from offending.

The majority of the participants across all care placements highlighted how they were made to “feel safe”. It is important to note that is a subjective measurement, which is compared to the level of safety they felt before their entrance to care. This sample therefore does not present a sample with perfect experiences within care; instead, it shows a marked increase in protection from harm, as opposed to turbulent experiences before care. Therefore, although the participants describe their experiences as offering little concern in relation to ‘safety’, they experienced high levels of risk during care and therefore do not offer particularly convincing evidence of the remaining safeguarding principles. General ‘safety’ and removal of harm is not enough to ensure a young person is able to ‘enjoy’ their childhood, be physically and emotionally ‘healthy’, ‘achieve’, make ‘positive contributions’ and have ‘economic wellbeing’ after leaving care. The care system might
have provided this sample with the basic component of safety, but feeling both ‘safe’ and ‘a sense of belonging’ are crucial in determining positive outcomes for looked after children (DfES, 2003).

With this in mind, it is crucial to examine the extent to which the care system provides the participants with the foundations to feel like they belong, with the formation of attachments and emotional wellbeing crucial in achieving positive outcomes, which are free from offending.

The analysis presented in 6.4, examines the extent to which different types of care environments provide children and young people with the overall care they need, in addition to the basic safeguarding principle of ‘safety’. To what extent does this allow the children and young people to be equipped to make the right choices in terms of offending?

6.3 Maslow’s Hierarchy of Needs (1943)

![Maslow's Hierarchy of Needs](image)

**Figure 12**
As stated above, it is vital to move beyond the basic care foci of risk removal and safeguarding. Instead, we need to acknowledge the extent to which care builds on physiological and safety aspects, moving to the fundamental foundations of love, belonging and self-esteem, resulting in self-actualisation.

Therefore, the following analysis will challenge this central focus of safeguarding, adding the importance of attachment as a crucial component of safeguarding needs and potential influence to offending. Thus, the analytical discussions will focus on the extent to which attachments influence offending, despite what could be seen as a highly safe and protected environment.

**6.4 Attachments: Primary Influence on Offending**

This section will look at the longer term impact the care experience has on attachments, highlighting the further damage that is made to already weak family attachments, the ability to form new attachments, with family and peers, and the formation of ‘risky’ attachments. The focus will look at the extent to which different care experiences and placement types offer a successful influence on attachments and the concerns with ‘repairing’ poor pre care experiences and the influence on behaviour.

As highlighted, in Chapter Five, all insecure attachments arise from repeated experiences of failed emotional communication. It is crucial to see the extent to which the care system minimises the emotional impacts of previous exposure and provides a stable environment, and encourages formulations of new attachments.

This analysis focuses on direct influence of attachments, or lack thereof, to the outcomes of offending. The attachment position will be allocated descriptions in the form of how care has offered new attachments, improved family attachments, presented no change, and finally, impeded the process further.
6.4.1 A System of Assistance: Formulations of New Attachments and Rebuilding Relationships

6.4.1.1 Kinship Placements

The very term ‘kin’, part of the family, connotes a likelihood of positive acceptance and belonging. In addition, it is also likely that the child/young person will already have an existing bond and/or relationship with their kinship care giver.

Although, through this very concept and the known preference of kinship placements, for those out of their birth parents home, it is important to take time to understand how this placement links to offending outcomes. Thus, this analysis will look at the extent to which the placement offers secure attachments and if these are linked to offending.

**Participant: K1**

This young woman entered care at the birth and received two placements and is a non-offender. The following analysis will draw on both the important factor of being in care at time of birth and its increased likelihood of allowing full secure attachments.

“I had a wonderful life with my Nan and granddad and I do not remember anything other than a stable house filled with lots of love. I respected them and didn’t ever feel anything was missing, they were my parents and it was my normal”.

Despite being taken from her biological mother at birth, only positive reflections have been made. A childhood filled with stability, love and respect allowed this participant to reflect on a normal, even idyllic, early life.

When asked about what aided her assistance, in accepting her removal from her birth mother, this young woman stated the following:
“Incredible love and connection with my grandparents. I really couldn’t have wished for anymore, they are my world and I am so lucky to still have them both alive today. Their love guided me and made me feel the same as everyone else”.

Although this participant is a non-offender, the following excerpt highlights the importance of support and encouragement to challenge the negative perceptions of looked after children:

“People assume kids in care will be stupid or damaged or even both, they may also think they are trouble. This really isn’t true, with a good support network and encouragement looked after children are just the same as anyone else”.

This excerpt not only challenges the negative portrayals of looked after children, it provides evidence of the mechanisms needed to ensure looked after children achieve the same as non-looked after children. This finding is pertinent to the overall thesis, challenging the notion of predetermined labels which often stigmatise looked after children, thereby ensuring that the system is made accountable of its failings.

As highlighted in Chapter One, not only does the care system fail to address pre-care concerns, it often produces further adverse influences upon the children they look after, with the system failing to take responsibility, instead blaming the individual in care rather than providing suitable solutions (Staines, 2016). Not only does this divert the criminogenic influences away from the concerns embedded within the system, it does little to dispel such labelling, leaving a system fuelled with low expectations and allowing the ‘troublesome’ perceptions of looked after children to be prominent both within the system and within the wider public. The system has the responsibility to ensure that young people are given ‘good support networks’ and ‘encouragement’, so that they can expect to have positive outcomes. However, by failing to provide stable placements which allow foundations for encouragement and support, and therefore positive expectations and
aspirations of looked after children, they are directly responsible for the negative outcomes often apparent. As a corporate parent, the care system has a responsibility to all looked after children to ensure that they are placed within an environment which addresses their pre-care trauma and in turn provides them with a stable environment. As K1 highlighted, this can be done when one moves away from the notions of ‘damaged’ or ‘troubled’ and provides suitable provisions to support a young person in care. This provides a basis from which to challenge the perceived barriers within care in addressing behavioural and emotional concerns, and shows the importance of moving away from stigmatising looked after children as problematic, and towards accepting the responsibility of a corporate parent in influencing outcomes.

Through dispelling stigma, and providing suitable care which addresses areas of life linked to offending, the experiences of looked after children will be built upon positive aspirations and expectations, embedded within supportive and responsive parenting. It is only when this occurs that we can truly say that care has done all it can for an individual. Without such parenting, the labelling and stigmatising of young people in care will continue to impact upon the way young people see themselves, resulting in self-fulfilling prophecies with looked after children living up to low expectations (Merton, 1968). Increasing these expectations, through supportive placements, is key to reducing stigma and increasing the accountability of the care system.

**Participant: K2**

K2, entered care at the age of five, before being placed with her maternal grandmother, she experienced a foster placement for one year. In contrast to K1, she committed two offences whilst in care; her narrative highlights the importance of being placed with a family member:
“After I left my mums I was put into care with a foster family for a year, which I can remember quite well. It was supposed to be for a few months but it ended up being a year, it was not the best time to be honest. My Nan then took me and my sister in; it just took a while to be signed off for it. I was so happy to move with her as she was familiar, I built up a close relationship to her, she is like a mum to me”.

Although this young woman started her care experience as one that was not positive, on entrance to her Nan’s care, she offers a solid account of belonging and refers to a close relationship “she is like a mum to me”.

There is a clear relief when entering her grandmother’s care:

“I knew she wouldn’t hit me like my step dad did and I knew she wouldn’t leave me alone, like my mum did. She knew I was scared of the dark and I was so relaxed knowing I wouldn’t be hit for crying anymore. I guess it was so easy as she was my family, well our family. If it had of been with anyone else, you know a stranger, then it would have been scary as a child and I was with my big sister so I felt so happy”.

This account offers a transition of ease, with strong references to both safety and love. This particular participant’s reflections on both highlight the encouraging nature of kinship placements, to be present more than the basic safeguarding; as highlighted earlier, an important factor which many care experiences lack. Although safety is paramount, feelings of attachment are vital in determining ‘successful’ transitions; as highlighted within the accounts presented within this participant’s narrative.

This participants accounts, clearly show a loving and secure attachment, so with attachments being a clear protection towards offending, why did she commit crime?

“I know how lucky I was. I guess that sounds weird, being in care and all. But I was lucky to have my Nan to love and care for me, so I wasn’t going far wrong. You ask me why I committed crime and for that I cannot say it was down to not being cared for, but I know
that if she didn’t love me the way she did; I would have been in the worse place. Yeah I had a fight and a slight problem with shoplifting, but I always had a firm word from my Nan and it soon subsided”.

Although being in receipt of “love and care”, K2 still committed crime. However she reflects on the protective nature to have protected her from further criminality. Thus, the bond she has offers some level of restraint. Attachments to family cannot solely equate to a young person having pro social behaviour, instead it is important to acknowledge the impact of peers, as an influential force within adolescence (Farrington, 1990).

**Participant: K3**

This participant was placed into care at six years old, experiencing four foster placements before his kinship placement. However, this young man did not commit crime, despite a history of violent abuse and concerns on the impact this would have on him. K3 expresses his relief at entering care:

“My aunty and uncle took me in. Oh sorry, actually I was put in foster care until the court order was put through but from seven years old I was with them. They are wonderful and I couldn’t wish for better people to fulfil my parental roles”.

This young man’s experiences are in direct contrast to the others in the kinship group, through the very violent and abusive behaviour that he suffered. Questions were asked, regarding how his new attachments allowed him to overcome this and form pro social behaviour, instead of normalising the criminal behaviour he was subjected to:

“I could have quite easily gone into a dark hole from what I had lived through but they were there and encouraged and guided me through everything, undoing the wrongs. I never did anything criminal. I would have been in serious trouble if I had. Even when all my friends were playing up, with shoplifting, I just couldn’t I owed them too much”.
Undoubtedly, this young man shows a high level of resilience. However, it is crucial to acknowledge how care provided loving parental figures, who guided him, addressing the negative things he had seen. Furthermore, despite being seven, he still managed to be in receipt of a secure attachment with positive role models who were able to reinforce prosocial behaviour. Not only does this challenge attachment and behaviour literature, in terms of age restrictions, it highlights a great potential of the care system to aid older children entering care. The respect he has for his carers is powerful, and with such guidance, he is able to overcome the temptations of peers.

The relationship here is one that any parent would work for, behaving because he “owed them too much” shows his eternal gratitude and respect, which he asserts, kept him free from offending.

Finally, on asking this young man, whether he thought things would be different if he hadn’t been placed within his family, he stated the following:

“I definitely think the relationship with my aunty and uncle helped me through it. I had some pretty dark times but I could always turn to them and that helped me get the confidence to get the support I needed. If I was placed with someone that did not take the time to understand me, things could have been very different”.

The very nature of being placed into the care system often means that the individuals lived through particularly harrowing times. However, this excerpt shows strength ability to overcome adversity, with help from those who love you. In addition, having someone to understand and listen, will allow young people to be open and request help.

As widely discussed within the current policy debates, the signposting and multi-agency workings surrounding mental health, in particular preventive assistance, within care is deeply concerning (New Belongings, 2015).
Participant: K4

This young man, entered care at seven years old, experiencing a nine month foster placement, before being placed with his grandmother. He committed four offences whilst in care and the following excerpts highlight his attachments and consequences to his behaviour:

“It was a very tough time and unfortunately I remember it very well. I was taken into care for about nine months, before my Nan took over. That beginning part was tough, as my Nan was living abroad and she had things to sort before I could live with her. The beginning was tough, as I was grieving with people that were strangers to me. On a more positive note, when I finally moved into my nans house when I was eight and a half, things got better. We were very close and I guess in some way we got through it together and became closer. As a boy growing up I never really spoke much about things, but looking back as an adult she was like a mum to me and really did her best for me”

This participant makes clear comparisons between grieving with strangers and the closeness to his grandmother, allowing him to address the grief. This young man, openly shares his secure attachment with his Nan, therefore it is vital to analysis how this impacted on his offending.

“I just couldn’t help lashing out, I was very angry at life after it had taken her away. I should have spoken more about it, asked my Nan for help or the social workers”.

The grief cycle is one which impacts on everyone differently but often causes a change in perceptions and behaviour (Kübler-Ross and Kessler, 2014). This is difficult for everyone, let alone a young boy of seven who finds himself in care.

The vital point here is that he reflects on his need to have spoken more, to have “asked my nan for help or the social workers”. His reflections, on one hand, offer a positive portrayal of the care system, with his acknowledgement of available help. However, on the other
hand, it offers a concerning picture, the care system failing to proactively address the mental health needs of those in care. So, with these emotional concerns that remain undealt with, it is important to establish the relationship between his attachment and offending:

“I couldn’t help but be a dickhead, I was so angry at life, but I did feel really bad about it as it upset my Nan but I wasn’t grounded or anything. I never wanted her to find out and it did make me be more careful when I got took home by the police. I can remember seeing her face and she look so let down and I started to get a bit better”.

Although, this young man still committed these offences due his anger. The process of letting his grandmother down was a process which aided his behaviour and produced a gateway to change.

The final analysis comes from this young man’s descriptions of discipline. Through the research catalogue of respect and discipline, we understand that respect is needed for discipline (Farrington et al, 1986). However, discipline is not always produced and this narrative shows evidence of this. Unfortunately, this fits into social care research, with kinship care often fending worse in terms of discipline and behavioural outcomes (Farmer, 2009). The combination of mental health concerns and lack of discipline are key indicators of behavioural concerns. These concerns are echoed within research, showing kinship carers often being more lenient towards behavioural concerns, due to the circumstances in which they entered care (Farmer, 2009).

6.4.1.2 Foster Placements

The most striking divide, was the experiences within the foster cohort. Six out of the eleven (55%) participants highlighted a positive account of attachments within care. The remaining five were subjected to further impediments to their attachments and sense of belonging. Therefore, it is crucial to understand what makes the foster placement so different in terms of attachment, allowing us to present evidence to aid a model of
intervention to prevent further troubled narratives for those in care. Foster placements are the most commonly used type of care within the UK, with long term placements being the preferred option, after kinship (Monck et al., 2003; DfE, 2015a).

**Participant: F1**

This young woman, entered care at the age of three, and although she experienced a total of eight placements and therefore a high level of instability, she possessed only pro-social behaviour. With relationship instability being a key risk for weakened attachments and offending behaviour, her narrative offers interesting observations on this popular assumption.

“I went to many placements in the first part of my care experience, around eight I think. Then I was settled at six years old until I was fifteen. When I was fifteen my foster carers moved to France and their son then became my carer until I was eighteen. I was really lucky to have so much love and support and I only wish I’d been put there earlier. So in that sense, it was unstable at first but this had to happen to get the right placement and in the end everything worked out. As I said, it is just a shame I wasn’t in care from birth”.

After initial instability, F1 was issued a long term foster placement at the age of six, allowing her to develop a secure attachment with her carers with “love and support”. Although F1 experienced changes in stability within her care experience, it did not impact on her behaviour. She explains why:

“I think the single most important influence in my life was having someone to listen to me. Every time I got angry that I was in care and wanted to rebel, I always knew someone would listen. I may have had to move around a bit but that is part of it I guess, it’s no one’s fault. Although I wasn’t with my parents, I felt part of the family everywhere I went and that helped me so much. I wanted to behave and make them proud, which I did”.

Although this young woman moved around quite a lot, the quality of care she received made her feel “part of the family” and that people were there to listen to her. It is clear that she holds resilience in the face of adversity; however, the importance attributed to attachments in protecting her from rebelling is key to the discussion of the extent to which care environments can be successful.

The above evidence, suggests that there is not a direct correlation between instability, attachments and offending. Instead, it reflects the diverse link between them, and undoubtedly shows protective elements even when an individual experiences multiple placements. Thus, the volume of placements, although a good predictor of instability, cannot automatically be seen a predictor of criminality.

**Participant: F2**

This young man, at the age of fifteen entered the UK as an unaccompanied asylum seeker. He experienced four placements and although his experiences before care were devastating, he did not display criminal behaviour. Not only does his narrative display the resilience of a human, it highlights the importance of attachments outside of the direct family and how this can aid behaviour, even with the prospect of losing everything.

“I built new relationships, with college friends and other friends and my carers. I visit people’s families and feel welcome, so I do not feel alone and I am happy. They encourage me and help me at college and give me so many things to feel happy about. I respect them very much and they respect me and ask me to their dinners and parties. It is really nice of them. They all have done so many things for the home office and my appeal and support me and went with me. They do everything they can for the best for me, I wish I could pay them back they are lovely. The smallest thing I can give is being good and not doing bad things and that is exactly why I did not run away at eighteen, it is wrong and I must face my destiny”.
This young man’s story shows the true value, and strength of respect for others. Although he faced both his parents dying and having to seek refuge within the UK, away from his brother and all he knew, there is a clear strength and ability to adapt. The new relationships he made, ultimately made him face the ordeal of a Home Office appeal, not because he was forced to, but because he did not want to let anyone down.

He encapsulates the theories brought forward by Hirschi (1969), showing the importance of attachment, commitment, involvement and belief. This young man, despite the likelihood of being faced with deportation to a place which risks his life, values the system and all in it.

Ultimately, we cannot separate the impact that this young man’s previous secure attachments, cultural ethics and religious beliefs had on his ability to form new attachments and achieve pro social behaviour. However, it does show that despite the worse adversities that can be faced, relationships can aid individuals through troubled times and provide you with the strength and ability to overcome life’s challenges (Rutter et al, 1998). Thus, we cannot clearly separate the extent to which his care experience played a part in his decision making, compared to his pre care experiences. However, we can clearly acknowledge the working relationships between an individual and a system which offered positive experiences throughout the horrendous challenges he faced, allowing him to make the necessary judgements, to be law abiding.

**Participant F5**

F5, a young man who also entered care at the age of fifteen, experienced nine placements over three years, committing one offence during his time in care. Unlike F2, he was not in receipt of a secure attachment before care and directly links his problematic behaviour to this:
“In a way I was relieved to go into care, as I didn’t have good attachment before, that’s why I was misbehaving”.

Interestingly, although showing extreme instability through having nine placements in three years, his narrative clearly shows the ability to achieve a secure attachment later in life:

“I had loads of placements and some were not so good. I did get into a spot of bother for fighting before my final foster place. But then things were good and I really care about them and they care about me, this made me stand up and listen to them”.

This young man’s final placement produced a relationship, with respect, which allowed his behaviour to change. Again, this observation lends positive evidence of the importance of getting the placement right for an individual. Theoretically, with such high placements experienced, this young man was at a higher risk of offending. Therefore, care must be made to ensure placements are kept a minimum, in order for an increased likelihood of attachments to be made.

**Participant: F9**

This young woman, entered care at the age of sixteen and had one placement for the duration of a year. No offences occurred, before or during care. Although this participants narrative does not offer detailed discussions of behaviour, it offers solid insight into the importance of not only allowing new attachments which resemble family ties but also rebuilding old ones, an experience which has not yet been disclosed:

“I had a foster mum and sister, we were ok. I was treated like a member of the family and I respect that. It was better in care than at home, my foster mum would do everything together. I think everything happens for a reason, and going into foster care was the best thing that could have happened to me. I don’t think I would have got where I am, if it
wasn’t for being in care. I was shown how important I was and made to feel I could achieve anything, not like when I was at home”.

This excerpt offers a contrasting discourse to others presented within the foster cohort. Referring to her “foster mum and sister” and being “treated like a member of the family” offers a refreshing experience, especially in the times of professionalization within the care system. Not only did this young woman’s experience in care offer her all of the elements of a relationship, which every individual needs, it also provided support in order to rebuild previous attachments:

“I had to re bond with all my family after it all happened. It was a long task, but with the support of my social worker and foster mum, it all started to work out. As that is important too”.

It is clear, that rebuilding old relationships needs support. Fortunately, in this participants case, she was fully supported, an account which is isolated within the rest of the sample.

Although this young woman had never displayed problematic behaviour, her experiences of a successful placement lend insight into ‘what works’ in care:

“You need to have that, to keep you in line. You need the stability to see the carers as your mum or dad to stop you getting into trouble. Trust and respect is very important and you don’t get that unless you have a bond with someone”.

Participant: F10

This young woman, entered care at the age of nine and experienced one placement. Like F9, this narrative lends a detailed focus on the importance of attachment and being placed into care:

“Don’t get me wrong, I was scared. I mean, you are bound to be right? It was something I was unfamiliar with and at the time, I did think I would prefer to be with my alcoholic dad than go into care. But I was 9 years old and not able to see that, but now, you know, when you ask me how it affected my life, it was nothing less than an absolute god send and saviour, you know a kind of saving grace. I was safe and no one was going to hurt me or shout. I felt so relived, I was never going to go without and I was going to be looked after and loved, what more does a child need?”

The feelings of relief are forefront within this reaction to being placed in care. Being placed into care clearly changed her life; being a saviour and saving grace; freeing from abuse and an alcohol dependent parents, she was made to feel safe. When asked how this impacted on her behaviour, she offers further evidence of the quality of her relationship in care:

“I don’t think my life is any different to anyone who lived with their parents. I get told off if I mess up and do my best to behave. I try and copy what Anne does, she is a good role model like any parent should be”.

Evidently, placements that resemble positive family units, allow a solid basis in terms of love, belonging and guidance (Schofield, 2002). This participants experience fits directly into what is expected within the parenting process, from the initial bonding resulting in a solid attachment, the modelling and reinforcement of pro social behaviour and a stable structure.
Participant: F11

The final participant from the foster cohort experienced a positive attachment journey, after entering care at the age of eleven. Although committing one offence whilst in care, she shows the importance of developing a secure attachment:

“I was so lucky as I had my granddad, yes it wasn’t my mum but all you need is that one person to look up to. Yes I still did wrong but knowing I would let him down stopped me from doing more serious things. If I didn’t have him, I would have no doubt got worse as I didn’t care what my carers thought of me really. I think I was lucky to have him and I still have an amazing relationship with him, he really saved me”.

“I am glad that this relationship was a priority with my social workers, despite me not making their lives easy, they still pulled out all of the stops to make sure I saw him regularly”.

Although the care system itself, did not allow a positive relationship for this young woman, a solid relationship was achieved, with the support of the social workers. Again, this young woman, directly attributes her behaviour to have been better due to having someone to let down, again offering solid evidence of the importance of the family in relation to resisting offending. Such observations, through both the kinship and foster cohort, show evidence of the importance of multiple theoretical considerations to aid and understand desistance. Not only does the RPFP fail to acknowledge the importance of attachment, it does not allow a forum in which to allow the full lived experiences of those in care, which cannot be quantified nor easily predicted.

6.4.1.3 Conclusion: Outcomes in Kinship and Foster Placements

The above analysis concludes that attachments, when formed, are protective. However, only 55% of foster participants provide evidence of strong attachments, compared to all of the kinship placements. The foster placements which were able to provide attachments,
were highlighted to provide: love and support; being treated like a member of the family; normal family environment; contact with family; and mutual care, allowing them to be close to the care kinship provides. The remaining foster participants were absent of these provisions, and therefore were closer in outcomes to those in residential care.

6.4.2 Failure of the Care System: Further Impediments to Attachments and Little Change

In contrast, to a system of assistance in rebuilding relationships and offering new secure attachments, this analysis shows the failings of the care system and its impact on the individual’s sense of belonging, lack of attachments and the direct influence to behavioural concerns and/or offending. The findings will be presented by placement type.

6.4.2.1 Residential Responses: Concerns of Preference

This section will present the experiences of attachments and its links to offending within this ‘last resort’ placement. A key theme was apparent: acceptance of non-attachment, increasing offending, due to having no one to let down.

Participant: R1

R1, a young woman who entered care at the age of eleven, received thirteen placements and committed twelve offences during care:

“I unfortunately had to live in foster care. I constantly found myself being at logger heads with my foster carers and felt out of place. I remember this one family, they were so lovely with a child a year older than me, I so very much wanted to have a sister and be part of the family; that day never came. Instead, I was constantly reminded of being a spare part; not invited to family gatherings and not being treated the same as their daughter. I know I wasn’t their daughter, but at such a young age you would expect people to try and at least make you feel part of it. Instead I felt a burden and rejected all over again. My Mum has
chosen a man over me, now the people who were supposed to be my new family weren’t interested. I kicked off, anything to get some kind of attention. Not that it worked, I just got moved on to another home, where the same things would happen and I would again be moved on. That was until I moved to residential, at first it was horrible, and then I started to feel relieved. I looked at myself differently; I saw myself as a Tracey Beaker in the dumping ground and knew everyone had washed their hands of me. The minute I realised I was incapable of being loved, was the minute I was free. Letting go of a lifetime of let downs was a good thing for me, I knew where I stood and that was great”.

Responding to the influence this had on her offending, she highlights the detrimental impact to be of deep concern:

“It made me not give a flying fuck. Before residential care, I would spend so much time trying to feel something and trying to be someone. No one listened to me and that was the driving point for me changing. Yes, people may think I changed to a numb bitch but it was my way of dealing with things, you know, moving on. That made me happy and although in a fucked up way, I was never going to get let down again. On the bad side, I actually lost all respect for everyone around me; I had no feelings for me or anyone else and that showed in my behaviour. I did not think twice about kicking the shit out of people and stuff like that, I had nothing to lose”

The emotional neglect she faced allowed her to find comfort in her residential placement, a transition from her desire to be driven by the need for emotion and attachments, to accepting this void. She highlights her coping mechanism to aid her mental health, although in an unhealthy way when she states “The minute I realised I was incapable of being loved, was the minute I was free”.

This is particularly detrimental as not only does it damage her self-worth and self-esteem, it drives her further away from society; with “nothing to lose”. Such concerns are of direct
influence to offending, not only was she exposed to poor living arrangements, her neglected emotional needs changed her perception of herself and the system, losing hope.

This acceptance is of great concern, in relation to criminal influence, as not only does this affect the emotional stability of the young person it also allows their perceptions of success and happiness to be based on self-gain; with nothing or no one to stop them.

This young woman highlights it to be preferential “the best place for me”. The way in which this participant has judged her preference, is of concern, through the acceptance of remaining unattached, shows her to be further alienated from relationships, with higher risk of offending.

This participant went on to commit twelve police recorded offences in the four and half years she was in care. Although the analysis fully acknowledges the increased likelihood of offending to be linked with the age in which this young woman entered care (Moffitt, 1993). Her narrative highlights only one link to her offending, having no one that cared:

“You ask me why? It is very simply for me to answer. No one cared about me and I cared for no one, and especially not for myself. Why would I try and avoid doing the things teenagers do? Why would I not steal the things I wanted? Why would I not give a bullying bitch a good beating? There was no one to answer to, as you have to respect and love people for that. I did what I wanted, as I was worthless anyway”.

This young woman’s perception of herself was very low due to her experiences within care and how this left her feeling. What is interesting here is how she presents her questions. Her narrative takes the interviewer into a realistic questioning framework of ‘why’ and through the clear previous displays of ‘no one caring’ it leaves you having foresight into her response. Of course, this response is fuelled by what we know in social control theories and the importance of what makes us not commit crime, rather than what people commit crime, with the central focus of attachments. The very social bond of attachment is not
present in this participants narrative, and as displayed in the previous chapter, nor is commitment, involvement and belief. Thus, this lady asks a very fair question, how can you expect an individual to be resilient and law abiding, when they have no one to let down nor consequence of their actions.

This participant’s narrative offers a cruel reality of the impacts care can have, on an individual’s sense of belonging and self-worth, and how this lack of attachment can directly influence offending. It is evident that when attachments are poor or not encouraged, an instrumental view grows of self, system and the world more generally. One experiences oneself as a resource/commodity to be exploited, and therefore starts to relate to others in similar terms.

**Participant: R2**

This participant entered care, shortly after her thirteenth birthday, experiencing over twenty placements, and receiving five police cautions during her time in care. The following excerpt provides a similar acceptance of residential care, despite its negative influences to her behaviour:

“Yeah, I preferred residential because you weren’t going to get let down.. You were not going to get put into a family and then tossed away when you weren’t wanted or if that family wanted to go on holiday, you would be tossed away into another placement when they went on holiday, you know. It’s like you fucking what, you say I am part of this family and then you bugger off on holiday with all of your family, but because I am not your family you stick me in another home for a week or two. It was just like, how can I be family if you are sticking me in a home. In residential they are there to do a job and if they don’t do their job, you can complain about it and if there can be something done or should be done, then obviously it will be done. You know, you wake up and there is a carer there and then a couple of hours later there carer changes. Then in the afternoon the shift changes
again and you know whose coming, you know who is going to be there and who is not going to be there, all the time you know. It’s like you are not expecting anything from them, that’s their job just to be there and keep an eye on you and you have got the rules, the care home rules but you are not going against anyone or you are not actually hurting other children or rebel against them, you know you will be ok”.

When asked on the influence this had to her offending, she highlighted the following:

“Of course I was going to get into trouble. No one cared about me so why should I care about myself or what anyone thought of me. I just pulled the short straw and live a kind of fucked up life. I have no one to let down and no one to tell me off or be proud, I do what I want and don’t give a fuck what anyone thinks”.

The void this young woman feels, in terms of love and attachment is paramount and extremely influential on her behaviour. The very absence of having “no one to let down” and allowing her to “do what I want” reinforces the need to have a stable person in the home environment, not only to provide care, but also to allow moral boundaries by someone of value, an aspect of life that appears to be limited within the participants of this study.

**Participant: R3**

R3 entered care at eleven years old, experiencing thirty six placement and committed sixteen offences, during care. This young woman gives a similar account to that of her cohort, displaying concerns with her attachments and the consequences this had both in terms of her own internalisation of these feelings and also how this impacted on her behaviour:

“I had a proper time of it and so many placements, ranging from a night to a few months. That was until I got to the home and things quickly changed. Before, I was in like so many different houses with so many different families; none of which were my own and didn’t I
know about it. I was just a job to them and they soon shoved me on to someone else, when the going got tough, they got going. I guess it’s not funny; I was always trying to be part of it and trying to belong but Social Services would have none of that and royally screwed me over. I learnt that very quickly in the home; no one cared really. Well the staff would have a laugh and a joke and you would feel close to them, well I did at first and then I realised they were off to their families.

That made me really upset as you try and kid yourself that they care, but when they go home to their kids you realise it all over again; so I soon learnt not to get close to them, to protect myself. That’s where the fun began, having no respect for anyone was a great way to grow up; imagine a house with fifteen youngsters behaving like that and all on self-destruct. It’s kind of odd though as we would all reinforce its us against the system and rebel, I guess we encouraged each other to be twats”

Again, residential placements are referenced as preferred, despite it being at the expense of giving up on love and attachments and internalising a sense of worthlessness. The very measure of what is desirable, in terms of what a home and relationships should entail, does not fit well with what we have historically known, through research, theory, policy and legislative change. Therefore, one needs to be concerned with the abilities for individuals to make a sounds judgement on what is correct for them.

Critically, this analysis has a key focus on the increased life chances, free from offending. Therefore, seeing this ambivalent relationship which allowed violence to be modelled by this participant, or seeing individuals accepting a fate of being ‘unloved’ is not a measure which can be fed back into a model of intervention. Instead, the very nature of these internalisations, provides further evidence of the detrimental impacts care has on the self, with the consequence of a higher likelihood of offending.
Participant: R4

A key variable within this analysis was the age in which the participant entered care. Like the other’s within his cohort, R4 experienced over twenty placements and committed nineteen offences within his time in care. However, this young man entered care at the age of five. In line with the previous examples of the care system further impeding attachments, R4’s experiences are no different:

“I don’t do relationships as I have always been let down and I don’t expect anything from anyone but that means I don’t have anyone to let down either. So I was a little toe rag, a real little shit. I would run away and be nasty as hell; that way I felt I wouldn’t be rejected. By making them hate me, they were hating me for the bad me and not the good me; it was as if it hurt too much to be rejected for the good me; like my Mum had done. So in that way residential was easier, as no one cared about you either way, so I preferred it there.

The striking part of this narrative is that although this young man had every chance to gain a secure attachment, he does not display any evidence of attachments. Instead, he states how he never really belonged and preferred it that way, to avoid further rejection. This self-protection was made easier within residential, again accepting non-attachment within the care system.

With R1-R3, it is difficult to fully blame the care experience, due to their entrance to care being after the age of ten: increasing the exposures of pre care trauma and decreasing the window of opportunity for the care system. However, this isn’t the case for R4, with the correct system in place; this participant had all the foundations to build a secure attachment. Not only does this challenge the theoretically frameworks of attachments, it more crucially questions the ability of care to assist. This evidence, although requiring further research, shows a key concern with the care system. What hope is there, if a child of five years is unable to form secure attachments and a sense of belonging.
**Participant: R5**

In contrast to entering care at a young age, R5 was one of the eldest in the cohort to be placed into care at the age of fourteen. Having received three placement changes, this young man committed ten offences whilst in care, having only committed two before his entrance into the care system.

This participant’s narrative, although different in context, also shows the importance of attachments in reducing offending. His experience shows a secure attachment before care, despite a poor environment and neglect, and how crucial love and attachment was to aid his behaviour:

“It is so weird, as I was put into a safe place and moved away from neglect and being dirty and that. So odd though, as on paper people would think I was in better hands but I wasn’t. I may have been living in a nice place with nice things but that didn’t matter to me. I was living away from my parents and that was the killer. They could have given me all of the stuff in the world, but it wasn’t home. I just didn’t belong there, so I gave up”.

As discussed earlier in the chapter, safeguarding is a key concern within social services and their aims. This young man, again echoes how he was put into a safe place, and provided for. However, in line with the previous discussions, the foundations of the hierarchy of needs are not enough (Maslow, 1943). This participant highlights how he fared better before care, as material goods are not important, instead a need to belong is the crucial contender. When asked how this impacted on his behaviour, R5 highlight his reactions to being separated from his primary caregivers:

“I had no intention whatsoever to change when I was in care, I didn’t care who knew what I was up to. This was definitely because I was moved from my parents and I as soon as I knew I wasn’t going back, I just accepted I had no one to let down”.
His experiences present a good example of care attenuating existing attachments and the implications this has on his behaviour.

**Participant: R6**

R6, a young woman who entered care at five years old, experiencing sixteen placements and committing fifteen offences, adds a final dimension to the residential cohorts of further damage.

As highlighted above, there are clear shifts in the experiences within foster care and residential placements. This is also true for this young woman, reflecting extremely negative experiences within care.

“I can’t say I have ever had a solid or positive relationship. It has either been non-existent or crap. I remember one foster carer I had when I was about eight and she was nice and wanted me be part of the family but I didn’t get on well with her children, I wanted to be her real child and I had to leave because I was all over the place. That is when they decided to try me with residential placements, so I wouldn’t be jealous but that just made me feel even more shit as it was more rejection, so I would lash out more and cause stress for everyone, including the police. I had no regards for any consequences because I was never felt that I had anyone to answer to. You have to respect people for that. I guess without respect then you do not know which way to act towards people. I was a bitch and did everything I shouldn’t do. I didn’t give a shit and carried on doing whatever I wanted and no one cared. Well they did care that I was in shit, but they didn’t care about me, so I got used to this and came to accept it, then I was happier”.

Similarly, this young woman cannot recall any secure attachment whilst in care. However, her narrative is contrasting to others within this cohort. Instead of the clear failings within other care experiences, one of the foster carers who looked after this young woman presented her with the foundations of being part of the family. The problems stemmed
from the participants jealousy and need to be “her real child”, which ultimately ended in a breakdown of placement. The concerning factor here, is the shift into a residential placement, equating to further rejection and as a consequence made her behaviour change, after accepting “they didn’t care about me”.

Unsurprisingly, all of the residential participants experienced failures of the care system, with further impediments to their attachments.

As residential care is acknowledged to be a ‘last resort’ and used mainly after other placements have failed (Hayden, 2010), the participants were able to give clear narratives of the impact residential care had on them, after experiencing foster placements. The most interesting observation was the very contagion effects this type of care presented. The clear lack of opportunity for physical and emotional connections had severe impacts on the residential cohort. These impacts are clear, both in terms of emotional responses and direct influences to offending, with clear limits of discipline due the low levels of interpersonal respect. Evidently, the multiple foster placements experienced before residential care, will impact on the chances of success within this placement type. Thus, it is impossible to solely state residential is the only concern, in terms of attachment concerns and criminality. Instead, one has to turn to the inability of social services to tailor appropriate foster placements and additional mental health assistance for individuals like those in this study.

A striking and unexpected conclusion is apparent; all six residential participants preferred this placement. It was not due to its ability to provide the attachment, behavioural reinforcement, encouragement and expectations that the parenting process entails. Instead it had ended their journey of trying to being accepted. It had offered them relief and an end to their disappointment. No longer would these young people search for an attachment and feel rejected, instead a barrier of self-protection was apparent. This very barrier pushed them further away from a society and towards criminality.
6.4.2 Foster Placements

Like the excerpts above, those who only experience foster placements, face a challenging journey, in terms of attachments and achieving a sense of belonging. The following section will highlight, what hindered these individuals experiences and how this impacted on their behaviour, with attachments at the forefront of the analysis.

Participant: F3

This participant entered care at the age of thirteen and experienced four placements. Although not in receipt of a high volume of placements, he holds one of the highest offending profiles within the entire sample. The following narrative offers a detailed and striking account of life within care and the links to his prolific offending:

“I mean where I was they had two houses knocked into one and there was an older woman and man who were taking in kids. You know, it’s not very personal or individual, you’re just another person. They had like pictures of all the kids that they’ve had on the walls and that, you know like thousands of them. It’s just like you’re another person, you know and that makes you lash out and feel like crap”.

This participant highlights the impact of feeling invisible, in a house which is described as impersonal. Instead, of a home which puts belonging at the centre of its aims, this participants experience was very different. Not only was there little attempt to provide the foundations for new attachments, there were overall concerns with attachments with any significant other:

“There was no attempt to improve any relationships with anyone, obviously I know I need to do that myself but there was no help through social services to say do you want to explore building a relationship with your mum or anything like that you know?”. 
The crucial and saddening observation here is the second failing of social services. When asked if assistance from social services would have aided his behaviour, he disclosed the following:

“Yeah cause if you can build a relationship. Looking at other peoples, if people can fix a relationship when it has broken down, then they can get them out of care. Then they can get them back home, get them on the straight and narrow and that’s what it should be about”.

This young man’s experience is a concern, his recollections show no evidence of attempts to integrate him either within care or back into his family home. With such problematic behaviour and constant contact with the police, interventions were crucially needed. When asked what he perceived would aid his troubled adolescence, in addition to his already disclosed need to belong, he stated the following:

“Guidance I suppose and someone that gives a shit and cares really. Like a role model, say like a father figure sort of thing and being settled and getting to know people. If someone sat me down and just said look it will be alright and you ain’t got to keep running away. There was none of that, it was like I was gone again and that was it, you weren’t important to anyone. I never questioned my behaviour, as no one made me see it as a problem, no one cared enough”.

It is clear that this young man was let down by the system, he was not given a sense of belonging nor did he receive guidance to adopt pro social behaviour. With such little guidance and self-worth, the risk of offending was paramount.

**Participant: F4**

This participant, entered care at the age of thirteen, over a period of four years she experienced three foster placements. Her behaviour got slightly worse, resulting in three
police cautions. Sadly, this participants experience in care was not wholly positive, despite each placement lasting over a year.

When asked, what went wrong and made her placements break down. This young woman didn’t blame the carers; instead she presented an interesting observation in terms of the quality of relationships:

“All my friends would tell me what their parents were like and I never understood why my parents were like that. I mean the foster placements I was in, they would try and get me into their families as much as possible but it would never be the same. I didn’t have that connection; it is not a family and just someone doing a job. It’s never blood and it’s not love you get, you are cared for but not in the same way. I think if I could have been attached to my carer, like a parent. I would of behaved better, I mean they try and make you feel as much as part of the family as possible but at the back of your mind, you know you’re not. I mean every time you get settled and get happy then you realise that isn’t your parent. So then you get upset and angry again. So you are emotional, unstable and confused and make stupid choices”.

In contrast to many others within this cohort, this young woman observes the inability of the care system to replace the family bonds. Even, like in her case, with the best carers, it is not possible to replace or feel the void, of a broken attachment. The notable feature, is the participants age at entering care, it is not to say this may not be true for many others, but after thirteen years of exposure to poor attachments could lead to a near to impossible task for those foster carers trying to reach out.

This clearly impacted on her behaviour, making her emotional, unstable and confused, ultimately, she states, resulting in stupid choices. So, when faced with a case like F4’s what can be done to allow positive steps for this young woman?
“It’s always in the back of your mind that you have something missing. But one day, towards the end of my time in care, I saw that other relationships are important. When I connected with a carer, my behaviour got better. I had lived with her before I went off the rails, then after counselling and I went back to her, I accepted her as a mother and she did me as a daughter. So as soon as I belonged, I felt happier and behaved. I had no need to rebel for attention as I had it already. There have been no problems since fifteen, although she is not my mum and could never be my mum. I respected her then and put her feelings first and listened, I was stable and not confused and the different attachments made me have respect for me and for her. ”.

The striking observation of this narrative, even at the end of her care journey, the situation began to change. Although she does not see the care system as positive in terms of overall attachments, this lady shows hope after her acceptance of alternative attachments. The process of letting go of the need to mirror a parental attachment, aided this young woman immensely. This is a great contrast, to the participants from residential care, who were unable to form a new kind of attachment, preferring no attachment at all, causing huge detriment to their self-esteem and behaviour. The very acknowledgement, from this young woman, aided her journey of desistance. It is not to say that care did not help, however the interventions were clearly delayed, with the care system failing to deal with her behaviour. Once interventions were in place, there is evidence of a secure attachment. Despite the attachment, not being fuelled with love, it had the successful components of trust, respect and mutual care. Thus this relationship allowed this young woman to change her behaviour and not need to lash out, resulting in normalised behaviour reinforcement.

Participant F6

F6, a young man who entered care at the age of four, had eighteen placements and committed sixteen offences in care. His narrative highlights the complex nature between
the care system, multiple placements and being placed back into his family home. This following excerpt, highlight the extent his placements has his feelings of belonging:

“I did get close to a family I was with from six to ten, but they took me from that and I lost all hope really. I put up a barrier and it hasn’t slipped, I did not want to feel rejected again and if you don’t form that attachment you won’t so it is safer for you, you know for your mental health”.

Sadly, this young man was in receipt of a secure placement from the age of six to ten, but was then put back into his father’s care. The placement with his father lasted three years and then broke down. This participant’s narrative shows infrequent shifts with attachment figures, with his family relationships being fuelled with aggression and abuse. The impact the system had on him, resulting in him to refuse further relationships due to the fear of them breaking down, like they previously had. This narrative, echoes the concerns within the residential participants, with the care system impeding attachments to such a level, that an individual feels it is safer to put up a barrier. Although this barrier allows the individual to feel protected emotionally, the risks of offending increase (Jack, 2010).

“I didn’t trust anyone or anything, why should I. My family let me down, as did the care system so why would I bother. You cannot trust someone you don’t respect and respect doesn’t come until you trust someone, I know that neither could be achieved in my experiences and it made my behaviour worse. As I didn’t trust people that were trying to help as they didn’t really care. This was evident in my behaviour and my outlook on everything, from school to interests, you name it – I just didn’t give a fuck”.

The first main reason, linked to F6’s behaviour was his inability to trust and believe in a system he was in. In addition, there is no evidence of commitment nor involvement “my outlook on everything, room school to interests, you name it – I just didn’t give a fuck”. Again, similarly to the residential cohort, F6’s experience shows strong evidence
supportive of Hirschi’s Social Bond Theory, making it near to impossible to achieve prosocial behaviour (Hirschi, 1969). Furthermore, when asked to reflect on the concern with no one caring, being the main concern in care and on asking how this influenced his behaviour he gives a particularly harrowing depiction of his experiences:

“There were plenty of reasons, you know, reasons which made me do it. Not that it was a conscious decision, but I had no one in the world to let down. I had the worst upbringing and then, when I thought I would be happy and safe; I wasn’t. I was safe, but I certainly was not happy. I would have done anything to go back and take the beatings again, to know that someone cared enough to even hit me. That sounds crazy, but at least I was noticed there and they say bad attention is better than no attention, right? I guess the feeling of no one having that connection with you, you know love or whatever, makes you see yourself as a piece of shit and with that comes the crime and stuff”.

To long for abuse, rather than be presented with a lack of attachment, highlights the desperate need for attention to belong. Although particularly upsetting, the need of relationships being formed in care settings is paramount; any relationship is desired as a protection against offending.

**Participant F7**

This young woman, entered care at the age of six, experiencing three placements, including a move back to her family home from the age of ten to twelve. She also committed fourteen offences during care, offering a very similar experience to F6, both in terms of placement disruption and offending profile. When asked about the instability of her experience and the link to her behaviour, she disclosed the following:

“The homes were ok, in the sense of a clean roof over my head and food on the table and that obviously didn’t impact on my behaviour. But the feelings of loneliness impacted on my behaviour; I was all over the place and didn’t know my arse from my elbow. I was so
young and impressionable and I had no idea what was going to happen from day to day, I did not trust the system and was scared I would be sent home again. So yes I was a pain but it was because I was all over the place”.

Again, the most concerning element was the unknown and absence of trust with the system. The shocking observation, like that offered within F6’s narrative, is the fear of being placed back home and this very lack of trust, directly impacted on the ability to overcome adversity and gain positive attachments. The emotional implications of such an experience, is quite clearly horrific. One must question, regardless of a safe environment, how the care system can improve the integration back and forth to the family home. In addition, it is crucial to look at more than ‘safety’, paying more attention to the aspects within Maslow’s Hierarchy of Needs (1943). Although decades have passed since this development, there is a lot to be offered to current policy. It is crucial to address the entire area of need, with attachment at the forefront, equal to safety. As without such relationships, very little is likely to stem in terms of protection of offending and allowing a full actualisation of ones needs (Maslow, 1943).

**Participant: F8**

The final participant was aged fourteen when she entered care. Over the period of two and a half years, she received two placements and carried out four offences. Before entering care, this young woman had already received a change in her main caregiver, with her mother sadly passing away when the participant was two years old. However, as described in the before care analysis, this young woman was able to form a secure relationship with her maternal grandmother. Here, she explains what changed things.

“It is so difficult, as I was put into care to sort my behaviour out and the carers really did try. But it just got worse, as the one person I would try and behave for, gave me up. I know now it was with the best intentions, but then I felt rejected. It made it impossible for me to
This young woman carried the feelings of rejection she faced when her grandmother put her into care. This, coupled with the loss of her mother, made it very difficult to gain positive relationships and trust. Whilst looking at the extent to which the care environment can be deemed criminogenic, due to its inability to provide room for attachments, one must be fair in their observations. Not only did this young woman enter care having experienced two different primary caregivers, she felt rejected and fearful of losing people in the future. Despite only receiving two placements, the stability did not aid this young woman’s ability to overcome her previous loss of attachment. Thus, although the care system tried, the psychological welcoming of a new attachment was not there, being a barrier for undevolved attachments (Ainsworth and Bell, 1970).

6.5 Attachments and Offending

There is a clear link across the placement types, with the quality of attachment experienced and the influences to behaviour, with the exception of kinship, who do not perceive any negative correlations. Furthermore, although preferred, those in residential care can be concluded to have the most concerns with attachments and high links of offending, due to the ‘last resort’ status and non-familial setting. Those, whom have experienced foster care, show a split, with those who do not experience the familial settings they desire, being the most prolific offenders.

6.6 Conclusion

As highlighted throughout this chapter, the importance of attachment when assessing the criminogenic influences of care is paramount. Not only can attachment allow us to understand the levels of risk presented within Chapter Four, moving away from a
nomothetic assessment, it provides an idiographic analysis of the differing experiences of attachment and the correlations with both pro and anti-social behaviours. This analysis provided an examination into the extent to which the care system is, or can ever be, responsive to the concerns with attachment. The participants who did not have stable foster placements or resided in residential care did not provide evidence of attachments and directly linked this to their behavioural concerns and offending, with those who continue to have poor relationships. The next chapter will present the narratives of the carers and LCT, allowing an insight into the extent to which they perceive attachments to be a key indicator in determining behaviour and the ability of the care system to ensure this provision is in place.
TO WHAT EXTENT DO DIFFERENT TYPES OF CARE ENVIRONMENTS HAVE THE PROPENSITY TO BE CRIMINOGENIC?

A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy in the Faculty of Humanities.

2016

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Chapter Seven
Attachments During Care: Views of Professionals and Carers

7.1 Introduction

This chapter not only narrows the research gap by expanding the focus to multi participant
groups, but also allows for a better informed analysis. To what extent do the carers and
LCT agree with the experiences presented by the care leaver’s cohort? If the experiences
and perceptions are different, then what can we learn from them? Undoubtedly, we need to
acknowledge the conflicts that could arise from those in professional settings and their
perspectives on the system. However, the narratives below, after careful analysis and
attention to detail, highlight honesty about the concerns within the care system. We already
know what needs to be changed in order to better equip those at the hands of the system,
but to truly aid a model of intervention, we need to present the important voices of the
carers and professional teams, voices presented in detail throughout this chapter. Unlike
the previous analysis, the presentation of analysis will not be presented by placement type
or participant group. Instead, due to the smaller amount of participants, some areas will
focus solely on either the carers or the LCT experiences and perceptions.

The analysis will start by presenting the experiences of friendships within care. This very
interesting addition will be discussed in detail, aiding the reader to see the multi-
dimensional focus of attachments (Rubin et al., 2006). The central part of this chapter will
then examine the attachments present across the placement types, paying particular
attention to the concerns and barriers in gaining attachments. The issues of instability will
be discussed, before highlighting the psychological impacts of the concerns of young
people feeling different.
The impacts of having impeded or limited attachments are then presented, looking at the concerns of discipline and emotional barriers, which are in need of addressing. Finally the chapter will analyse the overall link of attachments to offending. Conclusions will then be drawn, comparing and contrasting the emotive analysis of those who have been in care, to those who have worked in the system. The aim of this chapter is to give a multi focus approach to the subject matter, with the hope of better understanding the impact of care on attachments and in turn as a risk factor for offending.

7.2 Friendships in Care

Whilst analysing the relationships within the care leavers group, little to no focus was given to attachments outside a care giver focus. However, attachment research offers insights into the importance of extra familial relationships (Rubin and Burgess 2002). Much of the recent research has focused on the link between relationship systems and the ways in which both familial or extra familial relationships may interact, both in the terms of quality of attachment and psychosocial functioning (Booth et al, 1998). Therefore, it is of crucial importance to see the impact of having impeded or non-existent familial attachment has on peer relationships.

7.2.1 Attachment Concerns

Evidently, those in care are faced with complex experiences in terms of attachments (Taylor, 2007). However, as stated above, there is a huge importance of friendships and the interaction they have with attachments within familial contexts. Due to the nature of the research, and the lack of attachment status with family highlighted in the care leavers group, the interaction here will be analysed with the main care givers as a familial relationship. The following section will highlight the extent to which those in care, as presented by carers from different types of placement, experience extra familial relationships.
The finding can be presented into two subgroups, the narratives which are fuelled with problematic experiences of friendships of those in their care and those who offer a more positive reflection. The purpose of this analysis is to show the extent to which the attachment status of the young person impacts on their ability to form other attachments.

Through the previous analysis of those who have been in local authority care, it is evident that secure attachments are of concern. The following participants present two similar experiences, in both foster and residential care, showing the concerning legacy of damaged attachments.

This foster carer, who has provided twenty six placements, ranging from one month to nine years, highlights the consequences of poor attachments and the expectations of friendships:

**Participant: CF1**

“*Relationships with others are often problematic too. I mean the kiddies I look after have not had good experiences with their families. They then grow up and latch on or become infatuated with people. Maybe it’s an attachment issue. This happens with friends a lot. In my experience, so much, even too much energy is put into trying to be so close to people, maybe to fill this void, this rejection. It is so hard to teach the kiddies their own value, and how not everyone will value you the same way you value them, but it isn’t a bad thing. It is like they want their friends there all the time and put so much pressure on them, they break – which is understandable, as they are kiddies that want to have fun and not feel bad if they want to play with someone else*.”

The ability for the young people to overcome the rejection experienced by their birth families is a particularly concerning consequence of broken attachments. This narrative show unhealthy expectations with too much pressure and infatuation on an informal relationship, often found with young people’s extra familial friendship patterns. A very poignant point is made putting “*so much pressure on them (friends), they break*”. The
breaking of such relationships is described as “understandable, as they are kiddies that want to have fun and not feel bad if they want to play with someone else”. Friendships occurring within younger years and adolescence can often be rather sporadic, with many changes over the years and little in terms of attachment expectations. It is clear, that the young people CF1 has encountered are unable to adjust to these realities.

The very reference to latching on and becoming “infatuated with people” adds further concern with the young people’s ability to form extra familial relationships. Although this is a distressing finding, is not surprising. The clear disinhibited symptoms of control, infatuation and unrealistic expectations are very specific to those who suffer from reactive attachment disorder (Richters and Volkmar, 1994). It is crucial that diagnosis of potential disorders are a priority within care, to ensure that looked after children are in receipt of specialist provisions to assist their emotional and mental health.

Although diagnosis of potential disorders experienced by those in care and after, is a priory. It is important to understand the extent to which the care system has the ability to overcome the adversities experienced before care and how these impeded attachments have consequential outcomes during care, and, specifically for this part of the analysis, the impact on forming new extra familial attachments.

The narrative above shows evidence of the carers experience with those whom have experienced anxious and/or ambivalent attachments, within familial contexts. Not only is there clear evidence of possessive and jealous behaviour, not understanding that “kiddies that want to have fun and not feel bad if they want to play with someone else”. There is a direct reference of using extra familial relationships to “fill this void, this rejection”. CF1 then highlights how “it is so hard to teach the kiddies their own value, and how not everyone will value you the same way. The notion of replacing or filling a void and the presence of low self-esteem and value is extremely concerning. Evidently, in this case and
others, a strong emphasis needs to be placed on feelings of self-worth, a concept discussed previously within Maslow’s Hierarchy of Needs (1943).

Sadly, this narrative was not an anomaly. This next excerpt draws on very similar experiences, but within the residential placement. CR2, a support worker who works with twelve to sixteen year olds, has seen over twenty people transition out of the residential home in two years. The following narrative highlights her experiences, concerns and insights for improvement:

**Participant CR2**

“In so many cases the young people do not carry the confidence that is needed to make good friendships. They tend to throw their all into them, often with people who may not be in the best place as well. This alongside not having the emotional ability to understand the expectations of friendships is very upsetting. If the friendship doesn’t go well, the young people often internalise this as there is something wrong with them, as if they are being rejected again. We all know this is not true but it is so hard to make them see this. I guess if I put myself in their position, I too would find it hard. Having little or no basis to judge a relationship, is of course the reason behind it. I think more needs to be done to combat a sense of worth and grasp the complexities of relationships, with family, friends and intimate partners. If, we as a system can do this, it would not only aid the young person but make our roles more positive in the young person’s life”.

Three key components highlighted, both with attachment literature and CF1’s narrative, are the crucial relationships between confidence, realistic expectations and the impact of rejection. Again, it is apparent that having “having little or no basis to judge a relationship” will inevitably lead to uninformed understandings of the expectations and the lack of confidence to realise it is far from rejection.
Understanding relationships and having self-worth is of central importance, something that the carers and care leavers have both stated not to be present within their experiences of care. Maslow’s Hierarchy of Needs (1943) is again of crucial guidance here, more needs to be put into place, in terms of allowing the young person to internalise the importance of attachments and self-esteem, rather than the key focus of safeguarding.

7.2.2 Criminal Peers

The impact on family and personal relationships is pertinent to understand the offending patterns of those in care (Farrington and Welsh, 2007). However, this section of analysis moves away from the notion of risk and adds a detailed focus into why and how these problematic extra familial relationships are in place. Furthermore, it will highlight what needs to be done to enhance the quality of friendships made within each care type, in turn reducing the impact of criminal peers.

CF2, a foster carer for new-born to sixteen-year-olds, has provided around ten placements, ranging from one week to two years. This narrative offers a documentation of the links between impeded levels of self-esteem and how this internalises for those who have been in her care:

Participant: CF2

“I would say that the low self-esteem and self-worth, often leads the children, especially in the teenage years, to latch on to someone who also is on self-destruct. I think the children I have looked after find it painful to be friends with children who are settled. I guess being friends with others similar to them is easier and lowers the feelings of difference, but it’s concerning. It may make them feel better, but it often encourages bad behaviour. I guess this is obvious though, you put groups of vulnerable friends together with little regard to others and of course they will be troubled. This is not the case for all, but when you ask about young offenders whom I’ve cared for, this is very much the case in my experience.
They soon follow their friend’s leads and it goes from there. It is so hard to stop them, especially if they do not respect you”.

The importance of self-esteem and self-worth is paramount within much academic debate about offending. One needs to feel important, respecting themselves and others. This narrative clearly highlights that those in the participant’s care find it easier on their emotional wellbeing to fit in with others who “self-destruct”. Taking part in extra familial relationships has been highlighted as a difficult task for those in care, except those in kinship care, yet this excerpt highlights that for individuals in care, being friends with those who are “similar to them is easier”. The reasons why are relatively clear: the legacy of poor, ambivalent, anxious or avoidant attachments will of course have consequences on a person’s ability to form positive friendships. It is clear from the above narrative that the combination of low self-worth and need for a sense of belonging escalate the likelihood of finding criminal peers; subsequently, these young people “follow their friends leads and it goes from there”. It is important to highlight that we cannot ignore the individual agency of the young person, but the combination of poor attachments, criminal influences and low confidence can be clearly linked to an increase in the likelihood of offending. Furthermore, to what extent can we state that the care system itself is linked to this outcome? We cannot say that the care system itself produces this behaviour, as we would not know what extra familial relationships would occur if the young people were still with their birth family. However, with clear absences of secure attachments, low confidence and feelings of difference, we can see the impact this can have on the ability to make informed choices within friendships.

Evidently, the problematic attachments developed before care has a continued legacy during care. Although we cannot conclude that the care system produces these problems, we can acknowledge the system’s failure in addressing the concerns embedded with negative relationships, in particular with criminal peers. The responses of the care system
are fuelled with concerns, either through their inability to build the necessary foundations within preventative measures or through their drastic interventions when met with problematic friendships and behaviours.

The above excerpt highlights the importance of working with the young person to prevent negative relationships. Acknowledging their concerns with self-esteem and feelings of difference is not enough, and fails to make the system accountable for its failings. Instead of having these fatalistic interpretations of a young person’s problematic or criminal peers, the system needs to reflect on its own practices and its ability to assist the young person in gaining the confidence and support to make prosocial choices, including friendships.

Although stability is a key focus in placements, many young people are not provided with the assistance they need to address their feelings of difference and concerns with self-worth. The system needs to go beyond providing stability, and ensure all people in its care are met with appropriate carers, so that “carers can act as parents” (Sinclair, 2005: 123). Such developments will allow responsive parenting, built on love and trust, to enable young people to have emotional stability, self-esteem and behavioral boundaries (Wilson et al., 2003). This kind of relationship will not only be important in assisting a young person’s thoughts and feelings about the themselves, it will make them accountable to others, providing foundations of respect, which are key to allowing successful discipline (Hirschi, 1969; Utting, 2003). Furthermore, having a stable relationship at home will nurture a young person’s ability to feel accepted, reducing feelings of difference and therefore providing a platform of confidence from which to gain extra familial relationships which are centered on enjoyment, rather than just a need to feel accepted.

However, as with non–looked after children, individuals in care will often make their own decisions regarding friendships, and therefore as a corporate parent, the system has the responsibility to intervene in an appropriate manner, again working with the young person. Evidently, as highlighted within CF2’s narrative, there could be limited respect between a
young person and their carer, which of course is a barrier to achieving successful parental
guidance. However, this cannot and should not be the responsibility of the young person in
care. It is vital that the parenting approach, to be used by all carers and staff, is centered on
the ability to understand the choices of a young person (and the related behaviours) as a
response to previous negative experiences, and assist the young person to make changes,
rather than blaming their pre-care experiences and unnecessarily criminalising their
behaviours (Schofield et al., 2014)

Although there are some positive interventions in place, such as peer mentors, there are
many extreme interventions used when looked after children get into ‘the wrong crowd’.
Many young people are moved out of placements, and in some cases to specialist TFCO-
UK placements, causing further internalised feelings of rejection, enhanced feelings of
instability and lower levels of trust for the care system. Thus, the current system not only
fails to prevent the negative behavioural outcomes for young people, which are often
enhanced by criminal peers, it fails to intervene appropriately, and by doing so creates
further adverse influences upon a young person in care, including unnecessary
criminalisation. This leads to further stigma, instability and feelings of difference, resulting
in a cycle of concern for a young person and their behaviour (Fitzpatrick and Williams,
2016; Staines, 2016).

The care system needs to focus their attention on the need for preventing negative
relationships and outcomes and nurturing the importance of self, relationships and
prosocial attitudes through tailored placements and responsive parenting. Without such
developments, the care system cannot deny responsibility; instead, it can be seen as failing
to address pre-care concerns, and be deemed directly responsible for further concerns due
to the inability to provide placements which react appropriately to a young person’s
lifestyle choices.
Before highlighting the concerns of extra familial relationships on the care giving process, the support workers within the residential setting, present a contrasting view. The following narrative, CR1, who has supported over twenty five young people aged twelve to sixteen, highlights the complex nature of friendships and their variance:

**Participant: CR1**

“It goes two ways in our place, the kids either form strong connections and become good friends or they hate each other and there is violence, theft and general problems. The problem is both; you would think that friendships are good and helpful in the kids overcoming their problems. It isn’t like that though; they are all fighting against a lifetime of abuse, instability and all sorts and all facing their demons. It is a recipe for disaster as they all encourage each other and all have issues, so drinking, drugs, sex, crime and so on doesn’t tend to be kept to an individual, instead it multiplies. It is hard to encourage other friendships, as they are either schooled in house or are quite far away from their school friends. Even in the best circumstances where they have other friends that bring other problems as they have such different lives. I think it is easier for them to be with similar people so they can feel accepted, share experiences”.

This narrative shows clear examples of the importance of friendships and how they can allow “strong connections. Making friendships is not of a particular concern, the quality is paramount. Evidently, the support worker echoes the quality of such friendships is crucial in influencing behaviour, however, with the young people “fighting against a lifetime of abuse, instability and all sorts and all facing their demons” they too will have attributes associated with anxious, ambivalent or avoidant attachments.

Although this narrative is similar, with descriptions of the impact on previous attachment concerns, it offers a detailed insight into the importance of these problematic friendships for the young people under his supervision.
Having acceptance is crucial to feel a sense of belonging and the extra familial relationships are evidenced to fit this purpose, despite the concerns of staff. This finding is not dissimilar to the previous chapters, highlighting the quality and preferences within residential care to be incompatible with professionals and those experiencing the care. The very components of a young person’s development, in this case - forming attachments, are incompatible between the emotional response of the young person and the practical implications echoed by a professional.

In addition, these young people are often placed in groups of six or more, heightening the risks of detrimental friendships being made. With many of the young people taking part in “drinking, drugs, sex, crime and so on” and the need for the young people to feel they belong, these consequences tend to heighten or “multiple”, findings similar to the projections of residential placements presenting criminal factories, a comparison to prisons (Hayden, 2010).

Interestingly, having a quality relationship will not always allow the young person to be happy “even in the best circumstances where they have other, decent, friends - that brings other problems as they have such different lives”. Evidently, the friendship either works for the young person being “easier for them to be with similar people so they feel accepted” but is concerning and problematic for those who care for them.

Both the carers and care leavers concerns can be concluded to be seen as either practical or emotional. Both of which are paramount in order for the young person to have improved life chances, a sense of belonging and a heightened likelihood to remain law abiding.

The above evidence, offers some insight into the concerns present within foster and residential care. The clear combination of the consequences of broken and/or damaged attachments before care, alongside the emotional quest for acceptance, increases the risk of
seeking this comfort with people like oneself. Such a process will decrease the overall psychosocial functioning and increase offending, in many cases.

Before concluding the analysis surrounding friendships, and offering ways of improvement, it is of fundamental importance to analysis the mechanisms carers have to combat such concerns.

7.2.3 Carers’ Concerns and Constraints

Conclusions are clear: pre-existing anxious, ambivalent or avoidant attachments impact on the young person’s ability to form new, positive and secure relationships. Thus, we cannot conclude the care system to be criminogenic in terms of the impact on extra familial relationships. However, it is vital we analyse the reality and restrictions faced by the carers in overcoming the detrimental impact of inappropriate attachments leading to criminality.

CF3, a foster carer who has given over forty placements to ages five to eighteen, highlights her concerns and the constraints she faces within her role:

**Participant: CF3**

“If we are too forceful in our opinions, regarding their friendships – well we run the risk of making them even more distant. It works best, if we do not interfere too much and monitor the situation”.

The limited or non-existent attachment made with the carer, has huge impacts on the ability of the carer to guide the young person. The lack of ability to exert assertiveness was also echoed within the residential placements.

CR3, a support worker who has worked with over one hundred young people, from the ages of ten to sixteen, offers very similar experiences:
Participant: CR3

“The more we push, the more they run. We either tell them who to hang around with and they will lash out or we quietly respect that it is something they need to do, to feel good and part of something”.

This honest excerpt shows the compromising constrictions apparent whilst trying to intervene. Evidently, those supporting the young person, want to assist them – but with their emotional needs of highest importance, and safety paramount, the risk of them running away is not worth it.

7.2.4 Conclusion

It is evident that the type of attachments experienced before care, impacts on extra familial attachments and relationships within care. This part of the chapter has clearly presented, in line with Dwyer et al. (2010) non-secure attachments with primary caregivers will not allow extra familial relationships to enhance the psychosocial functioning of a young person. Instead it increases their likelihood to have criminal peers. The legacy of the previous failed attachments have a clear impact on trust, self-esteem, self-worth, confidence and expectations of attachments. This coupled with the need to belong; further pushes looked after children into subcultures of vulnerable young people.

It is evident that the care system itself cannot be held accountable for the pre-existing experiences of attachments, which interact with the ability to form suitable extra familial relationships. However, it is evident when a young person is placed in an environment in which they can develop a positive attachment as this will be crucial in assisting their friendships. It is not to suggest all placements can replicate those attachments made within kinship placements, and instead it provides further importance of the need for love and affection.
7.3 Attachments with Carers

Evidently, the importance of attachments with primary care givers is of central importance and a crucial guide to understanding how young people in local authority care gain a sense of belonging, worth and trust. This section, will present a full analysis of the reality of the attachments, during care, as experienced by the LCT and carers.

It is hoped that these additional accounts, will not only offer more validity to the concerns of attachments, but will also present a critical overview of the expectations, realities and professional boundaries that indeed impact on both the attachments and quality of such relationships.

7.3.1 Expectations

The opinions of the young person will no doubt be very different to those who are situated within a professional position. This is particularly true, whilst looking at the levels of expectations associated with carers, across the placement types. The following excerpts will present comparative evidence, allowing a fuller understanding of the extent to which those in care are in receipt of secure attachments and the realities often impeding such processes.

The first important analytical consideration is presented through the widely acknowledged expectation of care placements being a replication of home environments. Despite the huge controversies and challenges faced within care, the idealistic expectations of a nurturing and loving care giver are paramount.

LCT 1, a leaving care worker specialising in education, shares her experiences of those in care:
“They will always want to be with their family. Most young people will hope to be with their parents, whether they realise it is a good or bad thing. Despite all that happens, they often still love them and find it hard to fill that void”.

The preference of being at home, despite circumstances, evidently highlights the importance and influences of your primary attachments. As a society, we are instilled with the importance of family, with the notions of ‘blood being thicker than water’ and with unconditional love being deemed a prerequisite between parent and child. In this sense, these findings are unsurprising (Beauregard et al., 2009).

A similar and striking narrative was presented by LCT 2, the manager of the leaving care services who has worked within the care and leaving care systems:

“Children will have this amazing loyalty and the whole ‘blood is thicker than water’, even a parent who is quite abusive, there will still be a tie and still be a bond, more than they may get within care. It may not be a positive bond but as a worker we need to acknowledge that. I mean you go in and think how can this child be loyal to this family, it’s the most ghastly place I have ever been to. But that’s that child’s experience and you have got to work with that child and understand that their reality. Some children will be completely traumatised of having to leave that family station and that will take a long time to address.

If you do not understand, they will run away and run back and they will damage themselves and get angry and damage other people, they will do everything they can to show their frustration and anger at what has happened to them and this can impact on further relationships being made”.
Echoing LCT 1, this narrative shows the consequences of prior attachments and the clear preference for secure relationships. The “children will have this amazing loyalty and the whole blood is thicker than water” and this will indeed be apparent “Even a parent who is quite abusive, there will still be a tie and still be a bond, more than they may get within care”.

However, this narrative lends more evidence to the importance of understanding this unconditional love and the reality of their experiences. To acknowledge the strength of their previous experiences, aids their transition into care; stopping them from running away and further damaging potential relationships. It is crucial this is built on, to allow those in care to have realistic expectations of what will occur, whilst still acknowledging the importance of their interpretations and lived experiences of love and attachments.

Finally, CF1 a foster carer who looks after children from birth until sixteen years, for duration of between one week and two years, gives her experiences of expectations:

**Participant: CF1**

“The young people often feel things will be the same as at home. This is far from true. Of course we do not mirror on the parenting practices they see, as if they were perfect they wouldn’t be put into care. But we also cannot replicate that bond, as despite what horrid things happen, they love their parents. I think that this is often the case in non-long term fostering, you cannot get close as they will inevitably leave and this would hurt them more”.

Again, the expectations of previous realities of attachments are often in place. Interestingly, this participant offers insights into the differing levels of concerns and the reasoning behind them. Evidently, when placements are not permanent, it would be detrimental to form secure attachments, due to the feared consequences of rejection often apparent within individuals whom do not have secure attachments (Ainsworth and Bell,
1970). Understanding the individuals lived experiences of normality, increasing the suitability and permanence of placements could provide experiences that complement the positive expectations and give the carers and social services adequate time to address pre-care concerns.

Perhaps, the most predominant finding, are the expectations of those entering care. Often, they have been victims of the most horrendous levels of abuse, yet still felt a sense of belonging, due to their attachment to their parents, even when the parents are the sole abuser. The system in place, will allow safety but to what extent can it allow a sense of belonging. Although the immediate concerns of abuse are addressed, what about the lifetime of rejection and mental health concerns that will follow? To see being loved as an idealistic expectation, as opposed to the reality presented by the LCT and the carers, is perhaps the most important area of improvement.

In conclusion, it is evident that expectations from those in care are dissimilar to those highlighted within the system, It is crucial that those in care can differentiate between positive, secure attachments and the alternative detrimental experiences of attachment, often experienced before care. In addition, it is essential to investigate the extent to which the preferred attachment type, can indeed by replicated within the care experience.

7.3.2 Importance of Family Environments and Feelings of Difference

This next section will provide an analysis into the extent to which the different care environments can offer the desired attachment outcomes, in turn allowing a sense of belonging and reducing the risk of offending.

CF1, a foster carer who has given twenty six placements, ranging from one month to nine years, expresses her concerns of the realities within foster care:
Participant: CF1

“What relationships? At most the kiddies had a controlling or violent relationship, so many were given up straight away or taken away due to the poor relationships. I think it’s something that would definitely have a knock on effect with their identity and stuff like that.

Imagine looking back at your life and wondering why people let you down, or why your mam had more kiddies and failed to get you back! What do you say to that? I mean you can’t lie, but you have to sugar coat it. I think the rejection stays with these darlings for life, often ending up with them blaming themselves and having low self-esteem.

Unfortunately, this impacts on their ability to fit into a home, even when I give them all the care in the world. I want them to see this as home and know how much they mean, but they cannot see it”.

The opening of this excerpt sets the tone of the experiences and harsh realities faced within the role of a foster carer. Clear acknowledgements are made, surrounding the quality and volume of attachments and the inability for the young person to be equipped for such rejection. The legacy of the concerning pre care attachments, and the impact on self-esteem and feelings of belonging directly impedes the ability of the young person to be able to open up to new attachments.

Analysing the voice of the carer presents a clear difference to the concerns expressed by those in this type of care. As highlighted within the previous chapter, those who have experienced foster care, feel lost and unloved, failing to see the restrictions of the carers. It is not to say that all foster carers hold this view, but many within this research shared such frustrations. Those in care may see foster carers to see it as a job, but the emotional responses presented here, give a differing view, showing how much care is given and how much they mean to the carer. This finding is replicated within other foster carer’s experiences:
Participant: CF2

“I think the feeling of being let down by their parents, makes them feel different and rejected right from the minute they enter care and this is often the start of a spiral of self-doubt and low self-worth, meaning little relationships can be formed. This is perhaps the most upsetting part of being a foster parent, you grow to really care for them and they cannot see it. Instead they push you away; I guess that it is a form of protection from being hurt again”.

The “spiral of self-doubt and low self-worth, meaning little relationships can be formed” presents a striking and concerning narrative. The detrimental impacts of pre care experiences are shown to directly impact on the young person’s ability to form new attachments. Again, this carer is longing to provide a secure base for those in receipt of her care, but she is pushed away, making any meaningful attachment unlikely.

This provides further evidence of the impediments to Maslow’s Hierarchy of Needs (1943), however, instead of focusing on the care system as solely to blame; this narrative directs the focus onto the pre care experiences. However, it is of critical concern for the care system to acknowledge their responsibility to facilitate positive changes, and put attachments at the forefront of academic debates and policy development. With the right direction and reinforcements, those in care could be convinced of their belonging and gain acceptance of their position, within the care system. It is not to say, that such concerns will be eradicated, however, with clear examples of the need for such attachments, from both the care leavers and those caring, shows a real element of hope.

Evidently, the above narratives show the desire to gain a relationship with those in care. It is of crucial importance to examine the extent to which this relationship can provide the young person with the sense of belonging they need.
The need for love, is constantly referred to within the care leavers narrative, thus it is central to examine how the carers reflect on such needs.

CF1 offers her experiences:

**Participant: CF1**

“I think the process of being in care has a massive influence on relationships. Like I said before, they have been let down by their loved ones and this will result in a lack of trust and lack of belonging. I guess no matter how hard I try, I can never fill the void of what they have been missing, maybe that comes from longer term or adoption. Saying that, with Joe was with me for a long time and even then, as soon as he left he developed a relationship he had always fantasised about with his mam. It felt right to him, but everyone could see it was wrong and affected his behaviour. He said to me, he never wanted to betray his mum and that is why he never got as close to me as he could”.

The clear bond between a mother and child is striking here. Despite others seeing the detrimental impact maternal and/or paternal relationships have on an individual, love and belonging is often instilled into a young person, despite the concerns it may produce. This clear desire, for love, and the concerns of the foster carer not being able to replicate it, causes many concerns. Joe always wanted his mum, and “no matter how hard I try” the carer was unable to replicate this. The constant comparison to the birth parents, and the inability to see multifaceted attachments, leaves little room for positive perceptions of progress. Such developments, will allow those looked after to have the best life chances and in turn enhance the likelihood of belonging and permanence.
CF2 echoes these restrictions:

**Participant: CF2**

“No matter how much attention and care I give the children, I can never step into their parent’s shoes. I guess for that to ever happen, the attachment needs to be one similar to once they have with their parents. I guess in many ways, it is one we cannot give. We cannot reach out and love them, or let them jump in our bed when they cry. I guess this doesn’t go unnoticed and although they can feel safe and secure, they often feel a sense of something being missing and that is love”.

The carer highlights the physical and emotional restrictions in place as a carer, and how without such closeness, they cannot replicate the parent-child bond. The importance given to love and physical contact is presented, however this carer states “cannot reach out and love them, or let them jump in our bed when they cry” and this is seen as a huge barrier. There needs to be a shift, moving away from what cannot be given and towards the multifaceted attachments described above. Concentrating on an inability to fill the void and not being able to “step into their parent’s shoes” cannot provide solutions in non-long term placements, instead there needs to be more guidance on how to achieve supplementary attachments.

The remaining part of this section, highlights the concerning realities, as presented by support workers within residential settings.

CR1 shares her experiences:

**Participant: CR1**

“The kids in our place have long and complex care experiences, sometimes spanning up to ten years. Their family environments may not be in their memories and many of the kids have little or no contact with their mum and dads. This is really sad and it makes me feel
really bad, I am twenty seven and still live and rely on my parents so much.. Yes, they have
us but we are staff and they know that although some try and form inappropriate
relationships with us. I don’t mean a bad inappropriate but they want a personal
relationship, like that of a brother or something and we cannot give that. I try my best to be
a mentor and friend, but it is as if they are kind of looking for someone to be part of their
lives, for the long term and our roles are not like that”.

This narrative highlights the increased concerns for those with prolonged distance between
their familiar attachments. Many of the kids might not have the memories needed or
foundations in place to internalise a perception of families. Although this shows less
concerns of negative experiences of attachments and limited experiences of rejection, it
does not necessary equate to a blank canvas in which an attachment can be freely made
(Ainsworth and Bell, 1970). Despite not having embedded expectations of family
relationships, there is a clear instinct for love and attachment. The inability to differentiate
between a friendship, mentor or family relationship is of great concern. The longevity of a
relationship is vital for successful attachments, with CR1, reflecting on her own
experiences living and relying on her parents in her adult years, something which looked
after children don’t have.

CR3 offers similar reflections:

**Participant: CR3**

“Attachments are hard to come by in residential. We cannot care for them in a way we
would our own. This makes the looked after child very sad and angry. Some are longing
for attachments, the younger ones mainly; the older ones have often given up. For those
older ones, they have been in care for many years and they understand what can and what
cannot be given but the younger ones are just babies and may be wanting to have a mother
or father or hoping to go home. It is such a shame; these children are not aware of the
reasons why the system is like that. They do not know it is to protect them from relationships which could also breakdown; they just think we don’t care”.

This narrative opens with a firm affirmation of residential care not being able to provide attachments. Although the caring role is apparent within the residential setting, it is evident that these familiar relationships cannot be encouraged. Although keeping a distance reduces the concerns of the young person feeling further rejection, it also presents an emotional barrier to their experiences growing up. As highlighted within CR1’s narrative, the care system is in desperate need of a shift away from such a resigned and fatalistic approach. There is no reason with a tailored approach, that this predestined failure should occur. A realistic approach is important, understanding not all placements will work out, but to base a system on a choice between predetermined rejection and avoidance of attachments, is concerning.

The very acceptances of these options are striking, a fact also presented clearly by the residential participants. The constant battle and/or discrepancies between what is longed for and what is available is concerning. More needs to be done, to allow those in care to have a clear understanding of what they will be in receipt of, but not at the detriment of what they need to be fulfilled human beings, attachments and love.

LCT 3 summarises these restrictions within foster and residential care:

**Participant: LCT 3 Offenders**

“Many young people are unaware that the care system is never going to give them the love a family would”.

Although care doesn’t provides all the love a family would, there needs to other avenues to fulfil attachments. They need not be based on a lifelong promise, instead, they should be incorporated into realistic relationships, with the young person able to been in receipt of positive attachments and awareness of their restrictions in terms of time.
It is vital that the gap in expectation and reality is eradicated. One of the most striking findings, through the experiences of those in care, was the distance they felt from their carer’s. However, through this very analysis, it is apparent that distance is not a preference but a predetermined expectation within the carer’s roles.

7.4 Impediments on Attachments

7.4.1 Stability

This first section focuses on placement stability, by members of the LCT and from carers from each placement type. The first excerpt highlights the procedural elements of placements, lending evidence of the barriers in gaining long term placements for all young people.

LCT 2, who has worked as a manager for the LCT for the last four years after a career within child care services, reflects on her time as a social worker, expressing the diverse nature of placement types and the likelihood of them being successful in term of allowing a platform for belonging and base for future attachments.

**Participant: LCT 2 Manager**

“It is a very mixed bag. When I was a child care social worker, the placements were predominantly foster placements because we were placing children from nought to the upper end. So most of the under sixteen’s were placed in foster placements, with some in residential but we do not have many here and try not to send them out of the county. This is not only due to expense but due to loss of networks and contact with family; all of those things which are disrupted from children who are moved away from home. But we also now are placing young people into supported lodgings sometimes and also into young people’s housing. There is a wide range of accommodation options for young people”.
Evidently, this LA echo national preferences of foster care and the importance of ensuring the young person is not isolated in terms of physical location and emotional terms. This narrative offers a positive stance on the experience of those within the care system within this LA, but is this always achievable?

What concerns are apparent when this is not achieved? LCT 2 offers her insights:

“I think that in common with most local authorities, because we are not alone, it’s difficult to have enough foster placements. We do our best but if it is an emergency placement then there is a limit in what you can do. We have an increase of children and young people who need to be looked after, like all other local authorities we are seeing an increase in the fourteen to sixteen age group. That is a very difficult age group of people to place, because they won’t necessarily fit well into a foster home, so you could do a really good matching but it just will not work for that person”.

“I think you need to look at a unique case by case basis. We do the best match possible, but sometimes we do not have the place to offer. So those placements will be short term, but we will be working hard to either get that young person back home or to be placed with extended family. It’s a hard job trying to make sure you have got that young person in the right place. I remember from some years ago, this one young person who was placed short term, used to laugh and say ‘I was placed for three weeks and was there thirteen years later’ which was the best possible outcome for him. I think that shows the flexibility in the system. The uniqueness and individuality of each young person that makes it very challenging, I think to get it absolutely right”.

This narrative offers a clear representation of the struggles faced by this LA and many other local authorities. As highlighted in Chapter One, there is an increase in the amount of children and young people who are in need of placements, making it more difficult to find suitable and stable placements.
The increase of young people entering care at fourteen to sixteen years old is of great concern. These young people will not only be less likely to “fit well into a foster home” but will be more likely to have had prolonged exposures to negative familiar relationships and/or experiences of emotional, physical or sexual abuse.

The prevalence of emergency placements causes great concern, limiting choices. Coupling this quick shift into what could possibly be a very short term or unsuitable placement, alongside the upheaval experienced through going into care, can cause further concerns with trust and believe in the system the young person has been placed into.

For those fortunate to be placed in a non-emergency placement, there will be more time to provide a “best possible match” but this is all based on having the available placements which unfortunately seen to be more problematic with the increase of those entering care.

The overall narrative shows a truthful and open account of the concerns faced whilst having the best intentions for the young person. The clear preference for foster care and the need to understand the “uniqueness and individuality” is crucial; therefore it is important to highlight what can change:

“We still have to work within the limit of the resources we’ve got and young people sort of have to fit. If you had an excess of foster carers, wouldn’t it be great. But choice would be great too, but it pretty much unachievable if I am honest”

Evidently, stability and appropriately matched placements are at the forefront for those working in the care system. However, we must pay attention to the limited resources before demonising the placement choices and blaming them for the less than desirable criminal outcomes.

The aims of social services were also reflected in great detail by LCT 1, highlighting stability to be a central focus when deciding placements. However, in addition to echoing the opinions above, LCT 1 shows, even with the best intentions, the placement may not be
suitable for the child or young person and that should be the main focus for the placement changes:

**Participant: LCT 1 Education**

“We aim to give stability but if a young person doesn’t like the placement or don’t feel settled or their behaviour is not deemed as acceptable then they will be moved on. It certainly aims to but I guess it down to how the young person adapts to that placement and if it right for them. Again, emotionally is everything ok for the young person. The care system doesn’t set out to not provide stability”.

Although, LCT 1 clearly highlights the same reflections of the care system aiming to provide stability, there is a clear shift of focus, with the young person’s wellbeing at the centre of the placement change and not the restricted resources.

LCT 1 concludes her thoughts as follows:

“The placement sets out to be stable. I don’t think they are placed thinking it will only last six months. I don’t know why but I am sure there are statistics on why placements breakdown often but I would say it is probably about the young person’s behaviour which is probably stemmed from their emotional well-being and if the right support isn’t there”.

LCT 1 highlights the potential influences of behaviour as a reason for placement breakdowns. Within her experience, the emotional wellbeing and behavioural concerns are reflected as a central focus. Such analysis raises questions: are the emotional and behavioural concerns responses to an unsuitable placement, either through system restrictions or poor placement choices; or a cause of such breakdown.

LCT 1 highlights the importance of understanding the difficulty in determining the cause of placement shifts and deciding the best possible outcome for the young person, she offers
a conclusive and insightful narrative of the challenges in gaining long term placements and the impacts of instability onto young people and why this is apparent:

“If the child has just been breaking down placements because of how unhappy they are, that again is pretty difficult. Some foster carers do get absolutely desperate with the young person’s behaviour or offending patterns and they say it just can’t work and I can’t manage this. The more the child continues to breakdown placements, the more difficulty it is to get stability for that child. But so is it damaging just keeping the child in one placement, which isn’t the right placement. Sometimes we get to points in our lives where we need something different and the placement that you are in, if you have outgrown it or it is not meeting your needs anymore then I think we have a responsibility to ensure the children are in the right place too. So, again we are back to looking at the individual and if you have a number of moves then you understand what those moves are about, in terms of the experience of the child, then you understand what they are about. Just looking at the number in itself isn’t necessarily indicative of what’s right or wrong.”

The above narrative highlights how the system is not always to blame. Instead, the child and/or young person can actively seek to break down the placement due to their unhappiness. In addition, foster carers do get desperate and will terminate placements due to the increasing concerns with the behaviour of the child and/or young person. The more the child wants to leave, the more their behaviour will become problematic and instability will increase, due to their placement moves. Although research focuses on the importance of stability, it is crucial to realise that keeping a child and/or young person in a placement which makes them unhappy, is incorrect. We must look at the individual circumstances and understand their experiences, rather than just looking at a number of placement shifts.

It is evident that the interrelation of such experiences are detrimental but more research is needed to examine the extent to which the system acts as a main influence and the extent to which this is of concern within each placement type. Such analysis will allow a deeper
understand of what is needed to assist the developments of attachments and therefore offer a potential reduction of offending behaviour.

Before moving onto the differing concerns within different types of placements and levels of instability, the remaining participant from the LCT, who specialises with working with looked after children who have offended, reflects on the placement type that is most problematic:

**Participant: LCT 3 Offenders**

“It tends to be foster placements which see a lot of shifts, but I am seeing more in care homes with my case load and they tend to be more likely to have bad behaviour and offending outcomes”

Although many researchers show residential placements to be the most concerning placement in terms of both instability and behavioural concerns (Everychild, 2011), LCT 3 highlights foster placements to show more instability, with those in residential care being more likely to have behavioural concerns.

Therefore in terms of criminogenic influences, it is difficult to determine the most detrimental placement type. One must be careful to highlight that instability itself, does not automatically lead to criminality. In addition, as highlighted by LCT 2, lower levels of residential placements are available within this LA as opposed to an urban area, therefore such conclusions cannot be generalised to show residential placements as more stable than foster care. The vast amount of literature surrounding allocations of placement types highlights residential care to be the last resort in terms of placement choice (DfE, 2015c).

One must take into consideration that social services only tend to use residential settings if all other avenues have been exhausted, thus after other placements. Such experiences would lend evidence to increased experiences of instability and alter the young person’s ability to adjust.

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LCT 3 offers her conclusions on stability to be similar to her colleagues:

“It can be stable, but it depends on the young person. I think the individuals don’t work in the setting; it could be the foster carer, residential staff or the individual’s behaviour. If they don’t have stability in their accommodation then their education suffers, their mental health suffers and they get in the wrong crowd with people”.

Again, there is a clear acknowledgement of the systems aims alongside the complex needs for the child or young person. One cannot clearly highlight the individual situations between the placement offered, stability experienced and reasons for placement breakdown. Therefore it is vital to open up the analysis to those who directly work with the young people, who experience the very successes and hindrances described by those in care.

7.4.1.1 Foster Placements

CF1, a full time carer who has offered twenty six placements, highlights the concerns to be linked to the resources and placement plans set out for those in care. Her own experiences are based on placements ranging from one month to nine years.

**Participant: CF1**

“I offer as much stability within the care plan as I can. As I stated before, I wish I could adopt them all but I can’t. Also they need to have certain help and assistance in instances, so they maybe suited to a residential placement or two foster parents rather than just me. It is different than having your own, when you just work through things and they sort themselves out. If they are behaving badly you seek mechanisms to deal with such problems, but as a carer you have limited time and sometimes the young person is moved as a result of something that could otherwise be sorted in a family home”.
A direct contrast is apparent, as compared to the young people’s narratives whom experienced foster placements, with this carer not only wanting to provide a stable environment but wishing she could offer them all a permanent home. There is clearly a great deal of love and affection offered by CF1; however she provides an honest response to her restrictions.

Unlike family environments, those giving care placements are under constant review of their ability to provide a home which caters for the young persons. All young people are at risk of developing behavioural concerns through their adolescence, evidence well supported by Moffit’s (1993) Age Crime Curve. However, within the care system, such concerns have to be addressed and often criminalise and label bad behaviour through the restrictions put in place.

CF1 expands on the impact such practice presents to young people:

“If your own kid is to lash out or break something, you wouldn’t have them removed unless you were failing as a parent. But as a carer any actions of concern are of course closely monitored and if they feel two carers or a team of staff would be better equipped, then the placement needs to change. I understand the logic but it is upsetting to see the consequences of such changes. They are often just lashing out for attention or as a response to their previous experiences. So moving them away will often escalate such problems”.

Safeguarding a young person is of paramount importance and no attempt is made to belittle such advances made within the UK social system. However, the above excerpt offers an insight into the differing practice apparent when caring for non-biological children. In addition to focusing on the child or young person’s safety and welfare, more attention needs to be given to the emotional consequences of placement changes. As highlighted above, by the LCT, restricted resources are of primary concern. Therefore when offering
guidance for a model of intervention, care needs to be made in determining what is realistic in terms of availability for procedures to keep young people with behavioural concerns with foster carers that are willing to work through such problems.

CF2, who specialises in caring for young people with behavioural concerns, offers her experiences of the importance and challenges of ensuring stability for young people with bad behaviour and offending patterns:

**Participant: CF2**

“When you put your time and effort, with the support of your partner and the system, then things will work well. It hasn’t been easy, but as full time foster carer I am trained to look after the most challenging young people. I make sure they know I care for them, no matter how badly behaved they are, like I would my own. Then when their behaviour is better or more manageable they may go home or be suitable for a long term placement. It is heart breaking letting them go, but my job is to provide intense fostering for those in need and unfortunately there is a process by which the children/young people will need to move on to allow room for others in need and they are aware of this. Having said that, it doesn’t make it easy on them, as they often settle and then have to be moved on”.

As highlighted above, CF2 offers placements for badly behaved young people and intense therapeutic fostering, for those with emotional and behavioural concerns. Although the children and young people CF2 provides care for are the most troubled, they are most in need of stability and attachment. This foster carer states how she makes sure “they know I care for them, no matter how badly behaved they are, like I would my own”. This narrative is contrasting to those above, highlighting the stability of her placement, despite the upheaval and problematic behaviour experienced, similar to what would be expected within a familiar unit.
Caring for a young person unconditionally, allows a strong foundation for the development of attachments, a vital component within corrective programs for young people such as the therapeutic foster care highlighted above. Such programs are becoming more widely used for children who have experienced great instability and exhibit challenging behaviour. These programs, namely MTFC allow the foster carer “to be supported around the clock by a team of professionals from health, education and social care” (Who Cares Trust, 2015: 1).

These programmes are individually created for each young person and highlight the importance of a tailor made approach, one of the most prominent requests by young people when asked for the area’s most in need of improvement. So much can be learnt from such schemes, with a clinical psychologist who develops the intervention programme for each child, skills coaches who assist the child in social activities, education worker who provides guidance to the child's school, teachers and mentors and family therapists who works with birth family to ensure contact supports the placement and who helps prepare the follow-on family (Who Cares Trust, 2015). With CF2 confirming “When you put your time and effort, with the support of your partner and the system, then things will work well”.

Such multidimensional support systems are vital in ensuring a stable environment for the young person, however as CF2 highlights “unfortunately there is a process by which the children/young people will need to move on to allow room for others in need”. The guidelines in fact set out the process as the following “Each set of foster parents looks after just one child for between six months and a year, concentrating on behaviour management to promote emotional stability and the skills needed to live in a family” (Who Cares Trust, 2015:1).
The promotion of emotional stability and behavioural management is the overall aim of MTFC and of central importance within the safeguarding principles across all placement types. Therefore, to what extent can these placement types be offered in long term placements and extended to all young people in care, across all age groups.

To conclude, with such programs in place, therapeutic foster placements cannot be seen to cause criminal behaviour, instead they offer great support and a degree of stability for the young person.

Future developments should work hard in ensuring such training and provisions are available for all foster carers, and those offering long term placements. Ultimately, such placement type should be more widely accessible with resources allowing them to be longer term. These enhanced programs should be considered earlier on in the care experience, ensuring multidimensional relations are made within initial foster placements. Allowing such placements, would ensure that the correct intense support is in place, without compromising on stability and therefore attachments.

The first excerpt from CF3, presents the concerns experienced within the least preferred placement type, as voiced by the young people within this research that emerge from sudden child protection orders.

Participant: CF3

“Sometimes you don’t even know too much about the young person, you can get them on emergency. Most of mine have been emergencies, with the most notice being a couple of days. I have never had a planned placement yet. They come and go very quickly, so I can only imagine how this would be for the young person”.

The evident unfamiliarity not only means the carer is unaware of the young person, it also will have a direct impact on the young person. Although it is impossible to erase these
placements, with flexibility of the carer and the correct resources, such placements are not always short term.

CF3 offers an insight into the potential of emergency placements to offer long term homes:

“She has been with me for nine years now and is my little shadow and I would be lost without her. Yes, I am her foster carer on paper but she is my daughter. When the time comes and she moves out, I will always support her in any way I can and she will always be welcome. You cannot just turn off the love and care you have for a child I treat her like I have treated my own”.

There is a clear integration of the young person into the family, with reference to the unconditional love and comparison to her own biological children. Such stability offers a safety net that is expected from parents, which is so desperately needed for secure attachments (Aldgate, 1994).

It is vital to acknowledge that no two placements are the same. However, the very nature of the types of foster placements, and even within such placements, present different concerns in terms of their ability to provide stable placements and in turn the foundations for attachments.

Time, commitment, belief and understanding provide the most suitable basis for the formations of attachments. The analysis showed the clear concern with the system restrictions apparent within emergency placements, short term and specialist placements. It is hoped that the findings will add to a clearer understanding of the need to have the quality multidimensional workings of therapeutic foster care, within all foster placements. The need for tailor made and planned placements are clear, however it is evident that the very restrictions highlighted above, make these developments difficult to achieve. Thus, when analysing the extent to which these sub groups are criminogenic, through the very instability they can provide, we can only conclude that there is a failure of the social
system to ensure all children and young people are in receipt of intense foster placements, should it be needed. The justifications for using care placements such as MTFC are for those who have been through traumatic experiences, leading to emotional instability and behavioural concerns; the evidence gathered within this thesis alone lends support that the majority of the young people entering care possess emotional instability, with many having behavioural problems. Therefore, more work needs to be in carried out surrounding intense fostering programmes and their availability. Thus, there needs to be a preventative method rather than a reactive procedure. It is not to say that all children and young people need multi-dimensional help, however all should be in receipt of a full assessment, throughout their care journey.

7.4.1.2 Residential Placements

Those placed in residential care are notably the most vulnerable, in terms of emotional stability and behavioural concerns. From the very status of ‘last resort’ and the least desired placement, as highlighted by policy makers, practitioners and academics, it was anticipated that the young people would echo such findings. However, as highlighted in Chapter Six, the young people who have experienced residential placements preferred it and stated that it gave them the emotional stability they were unable to achieve within foster placements, coming to their own realisation that they were better off without emotional expectations.

However, in terms of: emotional wellbeing; the importance of attachments; and need for support systems, residential care is still a concern for those working within social services, and those providing academic discussion. This final section will conclude the analysis on residential placements and their impact on stability and its influences on attachments and offending. It is not to undermine the narratives of young people and their preference for residential care; instead it hopes to highlight the importance of attachments as an outcome
and its impact on the level of emotional stability which is linked to the reduction of criminality.

CR1 reinforces the physical stability apparent within residential settings. Her narrative offers an insight into the complex dimensions of stability and the influence on a young person and their behaviour:

**Participant: CR1**

“The kids we look after are the kids who have had the roughest time of it. They are the kids who have been moved so many times, one girl has been moved over fifty times and she is only fourteen. Our home is where they end up if all else fails and a place to try and get them back on track. But it is very unusual that they will be moved on from us as there are little options after our place”.

“The lack of consistency in their previous placements makes them unsettled and when they are placed here and it is a planned longer term placement, they do not attempt to adjust and they just give up. It is almost like it is a coping mechanism, like a type of control. So yes, it is stable in terms of time and in a physical sense but in relation to how they adjust, or build relationships well that seems to remain unsettle and this doesn’t help their behaviour”.

Those placed in residential care are referenced to have had “the roughest time” with one example showing a young girl of fourteen having experienced being “moved over fifty times”, raising concerns of the trajectory young people in residential often face. These young people have not only faced instability and emotional trauma, as a result of being placed into care; they face rejection and upheaval during care. With such frequency of change, it is no surprise that this will become a norm and expectations of stability often cease to exist. CR1 states it is “unusual that they are moved from us”, as a product of this, stability is presented, but is it too late? CR1 highlights the emotional response to such a
change, with young people showing reactions to the “lack of consistency in their previous placements” causing them to be give up. Their unwillingness to adjust is a similar finding to the young people’s responses in Chapter Six, showing their way of coping to “like a type of control”.

Furthermore, whilst looking at the stability, experienced within residential care, this can only be seen within a physical capacity “it is stable in terms of time and in a physical sense but in relation to how they adjust, or build relationships well that seems to remain unsettle and this doesn’t help their behaviour”. There is a clear distinction between physical and emotional stability, with residential care providing a longer term placement but not providing the foundations to develop attachments or provide a basis for the young people to become emotionally settled.

These young people offer a prime example of the failings of the care system. Although, current interventions such as TFCO-UK are restricted to most in need, there is a need to extend such services or develop multidimensional assistance within these ‘last resort’ placements. The narrative above, alongside young people whom have experienced residential care, both show the deterministic tone and defeated perceptions young people have, when placed within this type of placement. No child or young person should settle for emotional instability, with little or no attachment to significant others, thus it is vital that these very voices are brought forward to current political debate surrounding the most vulnerable within the care system.

**Participant: CR2**

“The young people we look after have often experienced numerous placement shifts and are placed with us due to placement breakdown and problematic behavioural issues; although often they are one of the same thing. I think we can offer stability as the home itself is set up for longer stays if we cannot find them a suitable foster placement. In
reality, by the time they come here it is unlikely foster placements will happen as so many would have failed. I can say it is physically stable but emotionally probably not, they may be fixed in a place but are often unsettled after from being moved from place to place, numerous times”.

CR2 also highlights residential care to be filled with placement breakdowns and behavioural issues, stating “often they are one of the same thing”. This insight allows us to further analyse the link between instability and criminality and furthermore, acknowledge the need to address the starting point of their behavioural concerns. It is not to say that care creates the behavioural concerns, but to highlight the need for tailor made placements which accommodate behavioural issues instead of moving the young people on and heightening the risks of future problematic behaviour and/or offending.

Every young person needs reassurance and belonging, to feel that they will be cared for unconditionally. If that is not in place, it is of little surprise that some young people will rebel to gain attention, exert retaliation to the discipliner and show little leeway in terms of adjustment (Barkley and Benton, 2013).

The very legacy of rejection, described throughout this thesis, presents a strong need to stabilise placements and ensure carers are equipped to deal with such behavioural concerns, like expected within family homes. It is not to say that this can be done solely by the carer, but with trained staff and mental health specialists being to hand throughout the young person’s journey. Evidently, such developments will increase expenditure but such investments would lower the resources needed within later intervention. Such developments should be available from time of entrance to care and offered across all types of care placements.

Instability is shown to increase emotional and behavioural concerns and possesses heightened risk for those residential placements. The narratives offer evidence of the need
to distinguish between physical and emotional stability, going beyond the risk factors associated with living arrangements and neighbourhoods and towards a theoretical framework which incorporates the importance of emotional stability in achieving attachments and protective mechanisms against bad behaviour and offending. Furthermore, there is an urgent need for multidimensional assistance within all placements at entry to care. Every effort should be made, to assist the young person, in a way which best serves their interests, throughout their care experience and prevent the young person from giving up in residential care. Thus, in-depth and well planned placements need to be at the forefront of policy development, to remove the risk associated with physical and emotional instability.

7.4.2 Feelings of Difference in Familial Settings

7.4.2.1 Living with Carer’s Biological Children

Participant: CK3

“Yes, I do feel that they felt different from my children. No matter what I did or said to them, it would come out. They would say that they were treated differently, but they really weren’t. I can only imagine it was because they did not have a mum, they were not allowed to see her due to her addictions and this made them feel different I guess. The more I think about it, the clearer it becomes; of course you will feel different as I was not their mum and that would never change”.

Despite ensuring they were treated the same as her own children, CK3s nephews felt different. However, as CK3 highlights such feelings are in fact inevitable, if this is the case, care needs to be made in educating the young person of the importance of non-maternal and/or paternal secure attachments. Informing the child of their importance, value and place within a home can assist in the development of attachments but it is vital for the
young person to be aware of the multi-level and complex nature of attachments, reducing the feelings of difference and increasing the awareness and value of all relationships.

7.4.2.2 Procedural Parenting

Participant: CF2

“Although we care a great deal for them, the difference they must feel from their life before care must be staggering. The system is doing everything a good parent would to assist the young person’s emotional well-being and behaviour, but in a very procedural way. The normality and leniency within a family home is not apparent within my care, as there are very strict rules to follow. I do think this will put a barrier for them in making relationships and they certainly could not feel like this is normal”.

Intensive fostering has the same aims that a good parent would aspire to, but from a professional and often clinical viewpoint. This coupled with the lack of stability, due to the maximum placement term, means there is little chance of developing meaningful bonds which are vital for respect and discipline. The current system sees a procedure that presents the strict rules, without having the space for belonging, love and attachment. Therefore, despite all of the mechanisms and enforcements, the instability, feelings of difference and lack of belonging will have a direct impact on the ability to form attachments and therefore reduce the likelihood of developing secure attachments and pro social attitudes. These very barriers need to be addressed and, as highlighted within the discussions of Maslow’s Hierarchy of Need (1943), there needs to be equal attention to emotional stability and overall safeguarding. Without such developments, the young person is at risk of experiencing emotional instability and great feelings of isolation and difference, feelings which increase the likelihood of offending.
7.4.2.3 Comparisons to Family Life

Participant: CF3

“It is really hard, as they are always going to compare what they have with me, to what they had with their mother. Even if those experiences were not great, they shape their definitions of normality. I think they feel unsettled and no matter what I do to make them feel part of the family, they are never going to be blood relatives and I think they struggle with that. I think this links to how they behave and how willing they are to try and adjust”.

The constant comparison to their relationships before care, despite the quality of them, evidently impacts on the ability to settle in, whilst also increasing their feelings of difference. The foster carer can try their best to make them “feel part of the family” but the fact they are not biologically related, is of great concern. The consequences of this mental state will not only directly impact on the emotional wellbeing of the young person, but will also impact on their ability to settle.

This can then lend evidence, to the often increased behavioural concerns and the subsequent lack of respect for the rules. Thus, the young people could be seen to detach themselves from the family environment, as they perceive themselves to be different and this makes it easy to misbehave as they have no one to let down.

The final excerpt offers perceptions through the narrative of a residential worker:

Participant: CR1

“The whole experience is so different than being in an average family home or even any type of home experience. There are up to ten kids in at a time and staff clocking in and out three times a day, there is in house schooling, police in and out and kids running away and all stuff like that. All of this has to have an impact on how they feel; it is hardly a normal environment for them”.
Not only are these young people living outside of their own family environment, they are living in an environment which is not comparable to any family home. To think of a home with the care givers being on shift, and a home which has three different sets of staff each day: how can one expect the young person to adjust?

Although the physical stability is often in place, the setting to allow such relationships to develop is clearly not likely. In addition, to compare these experiences to those drawn from the residential care leaver’s cohort shows the acceptance of such concerns and actual preference for such feelings of difference. It is vital that developments are made, for no child or young person should ever perceive their emotional stability to be based on accepting difference and giving up on love and attachment.

Evidently, each placement type presents impediments, which often cannot be helped, to gaining successful secure relationships and subsequent attachments. Although, residential care presents a physical stability, it fairs worse both in terms of emotional stability and has the highest feeling of difference.

Unsurprisingly, kinship care shows the least amount of concern with attachments, showing little barriers in gaining attachments. Foster care presents similar challenges to those faced within residential care, however, these stem from the constant comparison to the familial attachments, a problem less prevalent within residential care due to the inability to even compare such an environment.

The above analysis highlights the potential criminogenic influences each placement could present, based on the varying abilities to develop attachments and therefore heightening the risk of emotional and behavioural concerns.
7.5 Consequences of Poor Attachments

7.5.1 Emotional Concerns

Two key narratives were apparent whilst analysing the perceptions and experiences presented by the LCT. Firstly, the extent of emotional concerns apparent within care and the current system’s assistance with such concerns, often as a consequence of trauma and broken attachments.

Participant: LCT 1 Education

“I don’t think it necessarily goes away, just because they have come into care. Often they can get worse, due to the separation of the young person with their primary care giver whom they often love, despite the horrific circumstances they may have put them in”.

This particular narrative lends a voice to the reality of emotional concerns within care, acknowledging that not only will they not go away, but instead often escalate due to removal of the young person from their primary caregiver.

Whilst highlighting the criminogenic nature of care as a whole, it is crucial to understand the level of intervention that social workers and leaving care teams can administer to those who have experienced problematic relationships that have arisen from abuse, trauma and grief. To what extent can they reduce the risk factors associated with emotional and mental health concerns in order to better serve the young person and divert them from the potential influences to adopt criminal behaviour?

“There are so many resources to try and overcome it. But the reality is you cannot help everyone. I don’t think it is the system fault but there are always ways to improve the services. I think Ofsted reports help, having more placements that provide more stability and more consistency. I think that is a problem all over the country and a funding issue.
Even if this is in place, it will not necessarily overcome the emotional difficulties and mend that”.

“Sometimes you can put everything in place for a young person but if the trauma is too significant, then you know people cannot facilitate these things to allow making the change for them”.

The current care system has in-depth interventions, such as TFCO-UK, but evidently they cannot help everyone. This further evidences the need to utilise these resources as prevention and not merely intervention. However, there is a fear that intense counselling and monitoring of emotional health could result in false negatives, or heightening damage by bringing discussions to the forefront. Overall, it is felt that enforcing mental health awareness and emotional assistance for all young people would allow better outcomes, and failing to this evidences the system’s failings regarding looked after children. It is important to note that the system, and those who work within the system, should not detract from their responsibilities, and blaming pre-care trauma and an individual’s inability to ‘facilitate’ changes diverts us away from the real concerns of the care system and their inability to provide the interventions needed, instead blaming the individual.

Stability is the crucial area in need of improvement to allow better emotional and mental health for those who have been in care. There have been huge developments within foster care, such as lengthening placements with ‘Staying Put’ programmes, delivered after the age of eighteen, and with current discussions of ‘Staying Close’ for those in residential settings (Action for Children, 2014). Legislation over the last decade has incorporated the need to keep placement moves to a minimum, with stability being central to developments, leading to vast improvements in terms of intervention.

However, such improvements still result in only half of looked after children having emotional and behavioural health that is deemed normal. Furthermore, 36.7% of looked
after children are stated to have emotional and behavioural health which is a cause for concern, with boys being at a higher risk (DfE, 2015b).

These statistics are repeated year after year, and amongst a variety of studies. Sempik, Ward and Darker (2008) presented the following table, comparing incidences of mental and behavioural problems in five to fifteen-year-olds for those in care and the general population:

Table 16: The Incidence of Mental and Behavioural Problems in Five to Fifteen-Year-Olds in the General Population, in Those Looked After and at Point of Entry into Care or Accommodation

<table>
<thead>
<tr>
<th>Mental and behavioural disorder or problem</th>
<th>General Children (a) %</th>
<th>Looked After Children (b) %</th>
<th>Looked After Children (c) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional disorder/problem</td>
<td>4</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td>Conduct disorder/problem</td>
<td>5</td>
<td>39</td>
<td>50</td>
</tr>
<tr>
<td>Any mental or behavioural disorder or problem</td>
<td>10</td>
<td>46</td>
<td>72</td>
</tr>
<tr>
<td>n</td>
<td>10310</td>
<td>828</td>
<td>249</td>
</tr>
</tbody>
</table>

(a) Meltzer et al (2000); (b) Meltzer et al (2003); (c) Sempik et al (2008); Sempik et al (2008:Table1)

Despite facing methodological concerns due to the low samples sizes, these findings reinforce the concerns highlighted within this thesis, policy development and legislative changes. The above statistics highlight the levels of concern exhibited on entrance to care and cannot provide firm evidence of the extent to which the care system is able to assist with such high levels, with 46% to 72% of looked after children having a mental disorder or behaviour problem at some point. Therefore, it is important to understand what goes wrong:
“Sometimes you can put everything in place for a young person but if the trauma is too significant, then you know the young people cannot facilitate these things to allow making the change for them. They are often scared and do not feel ready to address their past or it’s not the right time for them, say 9 o’clock in the morning”.

These feelings are echoed:

Participant: LCT 2 Manager

“The child really needs to work with you, you can put any amount of therapeutic interventions in place and layout all these clinical psychologists for them to see, CAMHS workers. But if they do not want to see them and don’t want to talk, then that is it”.

Participant: LCT 3 Offenders

“Within the care system there is the support, access to CAMHS and counselling but whether or not it is the right time for the young person to be doing that is another issue. I think there are quite a lot of support services but it is about time and needs to be tailored made. Some people are put into counselling straight away and that also can be a problem and make things worse, particularly their behaviour”.

Although there are successful interventions offered through psychologists, CAMHS workers and other therapeutic measures, the legacy of broken attachments and trauma clearly impacts upon the ability of professionals to assist with such concerns. If you are faced with a young person who has been exposed to a high level of abuse, the levels of mistrust they have experienced is likely to be great. The young person may not be open to interventions or assistance due to fear and lack of readiness. It is therefore vital that perseverance is present within any plans for the young person, and an understanding of the dynamic needs of the individual. With this perseverance and understanding of the need to work with a young person, the system’s link to emotional and behavioural concerns can be
reduced. It is crucial that this approach is adopted in order to move away from the accountability of the young person and towards an accountability of the system itself.

Furthermore, this static approach, which is system led due to the availability of staff and timetables of responsibility, needs to be addressed. One cannot expect a young person to divulge emotional matters in a scheduled setting, nor to a person whom they have not formed a relationship or rapport with. Without the ability of the care system to adapt to the needs of the young people they are responsible for, there are significant issues which undermine safeguarding principles, which ensure all looked after children are emotionally and physically healthy (DfES, 2003).

Timing is crucial to any assistance that professionals may deem appropriate. It is not enough to participate with psychological interventions when an individual is not ready or willing. Not only will this reduce the individual’s sense of control, an important aspect when dealing with your own life experiences, but it has the risk of causing further damage with consequences of behavioural concerns. Thus, there needs to be further research into the relationship between system requirements and approaches to young people’s emotional and mental health, as well as the individual’s preferences. This said, with the outcome of offending being a consequence of emotional concerns and their impact on attachments, it is vital that young people are actively encouraged throughout their care experience to address their pre-care experiences.

7.5.2 Overall Behavioural Concerns

**Participant: LCT 1 Education**

“I think their emotional and mental health has the most significant impact, with many young people having low self-esteem and unable to trust people. I think this certainly influences behaviour. If they do not have any self-esteem or respect for themselves then
consequences don’t really mean anything. They often have no self-worth so it doesn’t matter if they commit crime”.

As highlighted within Maslow’s Hierarchy of Need (1943) more is needed than basic physiological provisions and overall safety, in order to achieve prosocial behaviour. Love, belonging and esteem are crucial elements to allow self-actualization, which is responsible for the shaping of one’s morality. With this theoretical framework in mind, the lack of self-esteem and trust will inevitably result in a higher risk of offending. With the measured dimensions of esteem being centred on respect for others and respect by others, an absence of these will reduce any chances of feeling remorse or consequence for one’s actions upon others or oneself.

The following excerpt builds on the importance of gaining self-esteem in order to appreciate one’s own self-worth, in order to be able to make prosocial choices:

**Participant: LCT 2 Manager**

“If you have low self-esteem you often make associations that are not healthy or helpful. Just because you have come into care, doesn’t mean the problems go away. It takes a long time for self-identity and self-worth to allow you to feel a worthwhile person. It’s something which is built on from the time you are born and influenced so heavily from the relationships you receive. If you haven’t had it for the first thirteen years of your life, you’ve got a lot of catch up to do. So I think there is an issue and it influences behaviour”.

LCT 2 highlights the need to acknowledge the care system’s restrictions of its ability to provide a positive level of self-esteem, self-worth and self-identity. The later a young person comes into care, the longer their exposure to negative influences and relationships, which can often result in a young person who has extreme self-esteem issues and low self-worth. Therefore, one cannot say that the care system itself produces the concerns with esteem and its influences upon morality and prosocial behaviour; instead, one can conclude
that the system fails to address pre-care concerns, and by doing so holds some accountability for both the emotional and behavioural outcomes presented by a young person. It is vital that the care system acknowledges its failures so that it can focus on the need to provide appropriate interventions, allowing foundations to increase self-esteem and levels of prosocial behaviour, instead of diverting concerns to pre-care experiences.

In order to fully understand the extent to which different types of care impact on emotional and behavioural concerns, the following sections will be presented by placement type.

7.5.2.1 Foster Carers

**Participant: CF1**

“The problems show when the care system, being so damaged in many instances and it affects everything. Without their emotions and mental health being sorted, they lose the ability to develop in a positive way, this could be within education, relationships and certainly substance use as a means of escaping their realities. So what I am trying to say is with damaged mental health and emotional problems, all the things that come after and aid behaviour are also damaged and I think that is where the behavioural problems come into play”.

**Participant: CF2**

“To see yourself as worthless and not belonging, well that surely has to be a huge problem in understanding how to behave. I think the alcohol and drug abuse is a sort of way of forgetting everything and letting go of it, and for a while I guess that must work. The problem lies when this pushes them further and further away from their deep rooted mental health concerns, from their experiences before care, they then do not seek the correct help and find themselves with others in the same boat and the consequences can be committing crime”.
A young person’s pre-care experiences are shown to heavily impact upon their ability to develop emotionally and form subsequent positive relationships. The above excerpts highlight the consequences of pre-care experiences, showing low self-esteem and self-worth. In addition, the young person is referenced to often blame themselves for what has happened. This blame and self-loathing is deeply concerning, and undoubtedly influences their behaviour. The above narratives draw upon the high risk levels shown in Chapter Four, with issues surrounding anger and substance misuse, both key indicators of increased risk of criminal activity. Such behaviours will distance the young person from their own feelings, repressing issues which need to be addressed. Although this excerpt offers great insight into why young people in care suffer from both emotional and behavioural concerns, it does little to challenge the individual blaming approach. Stating that “they do not seek the correct help” again diverts the responsibility away from the carer and wider system. As a corporate parent, the local authority and the carers they employ have the legal and moral duty to ensure they uphold the safeguarding promises to all looked after children, and failing to ensure a young person is emotionally stable and prosocial can only be measured as a failure (DfES, 2003). This is not to say that all young people in care will not offend, however, it is crucial that the system does all it can to lower the prevalence of this, in order that it can confidently say ‘we did our best’.

In order to fully understand the criminogenic influences of foster care, one needs to identify the ways in which this placement type addresses these emotional and mental health concerns. Furthermore, it is vital to measure the extent to which the placement type has the ability to offer the support and stability to challenge feelings of difference and low self-worth.
Participant: CF1

“We do have the support for these people and try our very best. You can take a horse to water but you can’t make them drink. This is very much the case with those I have looked after. You have to respect that, as if that is their last bit of control and you take that away then things will escalate and their world will become even darker”.

CF1 highlights the need to acknowledge the restrictions in place when assisting with mental health concerns in the looked after population. Although we cannot state that foster care produces criminogenic influences, because of its inability to solve the high levels of emotional and mental health we must challenge the restrictions outlined by the above participant. Again, this participant references the individual’s responsibility for gaining the correct support “We do have the support for these people and try our best. You can take a horse to water but you can’t make them drink”. With pre-care concerns so prominent within literature (see Chapter One) it is widely recognised that young people in care have often faced highly traumatic experiences, sometimes prolonged, so diverting responsibility to the very person who has experienced such concerning life events is not something that should be apparent. Instead, research needs to focus on the system’s failings to a young person and the adverse effects this neglect can have on an individual, both in terms of emotional and behavioural outcomes.

However, CF2 also makes a crucial point to assist in the understanding of why carers do not push for intervention; this seems to be for the very sake of the young person. Seldom does a young person enter care through their own choice, resulting in a lower sense of control. Although as professionals we understand the need to tackle the emotional responses apparent due to removal from a parent(s), we must also acknowledge the need to ensure all decisions are driven by the young person. Interventions will only work when the individual makes the choice to embark on this journey. If professionals force them to
address their emotional responses to their pre-care experiences before they are ready, this intervention is less likely to succeed.

CF2 explains her experience within intensive fostering:

“They are told before they come. They don’t have a choice but they informed of what will happen in an age appropriate way. For some, they respond well and I guess they appreciate being told but they are very young so it is hard to judge. So, although they do not have a choice in the matter, they will get used to the idea and for many they open up”.

Again, choice and control are points of discussion when responding to the interventions in place to assist emotional and behavioural concerns. It is important to see the separation of a young person from their biological parent(s) as an external component of the individual’s life that they have no choice or control over. The internal components and responses allow the young person to feel a sense of control over how they respond to the situation. Evidently, being placed into CF2’s care is not a choice, and nor is the subjection to therapies, but informing the young person of such interventions increases their inner sense of control, allowing them to feel prepared as to how they respond to such experiences. It is therefore important to ensure that all young people are consulted and informed on all aspects of their life, empowering them and allowing a sense of control over how they respond. This willingness will allow the young person to form trust, and it is hoped this will reduce the risks of behavioural issues as a response to the young person’s emotional and mental health.

7.5.2.2 Kinship Carers

Those who are placed in kinship care already possess a familial bond with their care givers. Therefore, to what extent are emotional concerns linked to behavioural outcomes?
Participant: CK2

“They miss their mother so much and although I am so close to them, I can never compare to that bond. There will always be a sense of loss and it is this gap that makes them angry and play up at times. They are both in therapy and it is getting better, but I do think how someone feels is directly linked to their behaviour and this is something we are working on. Don’t get me wrong, the girls are not rebels or overly naughty, but they are very emotional, which understandably makes them angry and causes them to display behaviour changes which they did not display before my care”.

This lady’s narrative highlights the importance of the mother and child bond and its strength over any other attachment. The behavioural concerns apparent with the young people are linked to the grief of losing their mother, and not down to their care itself. The care system has a responsibility to ensure support is in place, in order to ensure that it is not to blame for emotional concerns. Whatever the reason for children entering care, attention needs to be directed towards understand the internal consequences and ensuring the carers are aware of such concerns.

The next participant, CK3, highlights a very different experience as a kinship carer to her nephews:

Participant: CK3

“Knowing their mum let them go has had a deep impact on how they see their selves and their behaviour. They have even asked me if I would ever leave them and of course I reassure them that I wouldn’t. Although this makes them feel secure in my care, they then ask why their mum didn’t see it that way and how can you respond to that. They really do know I love them and their mum had problems, but really struggle to see why they were not enough for her to change. I always tell them, it was not their fault and it should never
define them but I can’t change the way they feel just try and love them and make them

know I would never do that, no matter what”. 

In contrast to CK2’s narrative, these young people do not have emotional security and attachment to their biological mother. This coupled with the normality of family life within their placement further impacts upon their emotional trauma, causing them to question what their mother has done. The need for reassurance is clear, with the young people seeing themselves as not being enough for their biological mother to change, and seeing her substance misuse as being more important. The pre-care experiences and disorganised attachments has impacted upon their ability to feel settled, despite the love shown to them. This narrative offers evidence that despite the love and attachments present, kinship care still poses concerns in relation to emotional issues and their impact upon behaviour problems.

Neither participant attributes blame to the care system; instead, they acknowledge the concerns with the children in their care as inevitable products of the trauma they have been through. Despite kinship care being the more preferred placement type, the above evidence highlights that even within this environment, which often holds attachments, pre-care experiences cause emotional and mental health concerns. Therefore, all placement types include young people who have experienced traumas, but only some, like CK2 and CK3, contain the love and familial bonds which assist with recovery. The final section will provide a short analysis of the least preferred placement type, and that which is least likely to offer attachments.

7.5.2.3 Residential Carers

This final section highlights the emotional consequences of being in residential care and the impact upon behaviour.
Participant: CR2

“Rejection from their families and then foster placements takes its toll on the young people; by the time they get to us they have lots of it and the lack of trust to individuals is hard. This with their behaviour problems makes them depressed and this then makes them feel more rejected and more badly behaved. They do not value themselves and this projects on how they see others, it really is damaging”.

Not only will a young person feel rejection from their family, this can also be replicated if their foster placements are not successful. Such shifts directly impact upon their ability to trust, which can further impact upon their ability to connect with others and share their emotional concerns. This directly links to the behaviour of the young person, and as a consequence, they may have no value for themselves and others, highlighting concerns of esteem and self-actualisation, as discussed within the Maslow Hierarchy of Need (1943).

It is vital that all young people have a sense of importance and acknowledge their own self-worth. The final participant highlights the ability to encourage such processes and the restrictions upon doing so.

Participant: CR3

“We see them to be very special people, and a lot to aim for and become. They do not see this, they see the bad and find it hard to reach out and change. The journey of changing is harder than being what they have been and this is not nice to watch. The child sees low worth and feel that because they do not have their families that they have nothing, we should make them feel they have something as they do they have their futures, their whole life”.

Despite this staff member seeing the importance of each young person, the young person cannot see this. Their low self-confidence and perceptions result in a self-fulfilling prophecy, seeing themselves as of little worth, with limited life chances (Merton, 1968).
However, this participant highlights the importance of the system in assisting these concerns: “we should make them feel they have something”. By acknowledging this, the participant challenges the notion of individual blaming and accepts responsibility for young people and their emotional and behavioural outcomes. The care system has the responsibility to ensure they assist a young person in acknowledging a sense of self, to allow formations of relationships that will assist their behaviour and life chances.

7.6 Conclusion

This chapter presents similar concerns to those displayed by the care leavers. However, through an in-depth analysis with professionals clearer conclusions can be made for determining the extent to which each placement type can heighten the risk of criminality. Placements within a family setting, whether kinship or long-term fostering, have lower concerns of attachments and emotional instability than the institutional settings of residential care. However, the extent to which the care system is able to address pre-care risks is of central concern. One cannot state that the care system itself causes criminality, but for those who experience instability within foster placements and/or are placed in residential care, improvements need to be made.

The chapter has offered great insight into the experiences of carers, staff and professionals, greatly assisting in the understanding of experiences and the restrictions in place. However, there are key discussions of the individual responsibility of young people in care to gain the required intervention to assist both their emotional and behavioural concerns, clearly linked to their pre-care experiences. As corporate parents, the local authorities have the responsibility to ensure they address emotional and behavioural concerns. Failing to do this can in some cases mean that placements can produce criminality through their inability to provide a young person with the provisions needed. One cannot simply allude to individual pre-care experiences as a mechanism in linking care to criminality; this is fatalistic, as all
looked after children have a degree of pre-care trauma. Evidently, as highlighted above, there are many system restrictions which impede both carers and professionals in their ability to undo all the wrongs faced before entry into their care, but this should not be used to void the care system’s sense of responsibility. Rather, such neglect of responsibility should be seen as an adverse influence that presents further risks to criminality.

As Chapter 6 highlights, the system has the capacity to provide provisions for young people to be both emotionally stable and prosocial, with a strong focus on the system’s ability to provide secure and stable placements which allow foundations for attachments and a sense of accountability for an individual’s behaviour. Through understanding the importance of the system and its ability to reduce offending, the stigmatisation and unnecessary criminalisation of looked after children can be reduced. Currently, the system is failing some young people through its inability to deal with their pre-care experiences and provide them with services they so desperately need.

However, as highlighted in Chapter One and Chapter Two, there is a wide breath of research focusing on ‘individual’ explanations of criminality within care, which can divert us away from ‘system’ failings. It is vital to ensure that both pre-care concerns or ‘risks’ and adverse influences, or ‘further risks’ presented by care itself, are of equal importance when determining the link between care and criminality. Understanding the importance of the responsibility of the care system in addressing both is crucial for allowing better emotional and behavioural outcomes for looked after children.

The professionals within this sample are compassionate and informed, but clearly signpost the restrictions in place. It is vital to consult both the emotive lived experiences of those in care and the experiences of professionals to fully understand the barriers in place due to pre-care experiences.
Chapter Eight

After Care: Attachments, Transitions and Offending

8.1 Introduction: The Care Leavers Experience

The previous chapters present a journey, from the pre care experiences to the extent to which the care system can assist the young people, with a particular focus on the level of attachment a young person has throughout their care experience. This chapter will start by providing information in Tables 19-21, highlighting the exact position the participants are in, in terms of relationships and attachments, whilst also highlighting their offending patterns. This information will provide the foundations for the chapter’s analysis, looking into the young person’s ability to: form positive and meaningful attachments; the impact of care during the transition to adulthood; and their consequences on offending. The chapter then presents observations expressed by the LCT and carers, drawing on their experiences of attachment and offending and the concluding with the system constraints in addressing these concerns.

Table 17 Kinship Care: Categorisation of Attachment Type and Overview of Offending Profile - Before, During and After Care

<table>
<thead>
<tr>
<th>Participant</th>
<th>Before Care</th>
<th>During Care</th>
<th>After</th>
<th>Comments/Offending</th>
</tr>
</thead>
<tbody>
<tr>
<td>K1</td>
<td>N/A</td>
<td>1 (no) Secure attachment</td>
<td>1 (no) Secure Attachment</td>
<td>Non Offender</td>
</tr>
<tr>
<td>K2</td>
<td>1 (no) Attachments but problematic</td>
<td>1 (no) Secure Attachment</td>
<td>1 (no) Secure Attachment</td>
<td>Theft after care and one assault in care</td>
</tr>
<tr>
<td>K3</td>
<td>3 (no) Lack of Attachment/ Non Secure</td>
<td>1 (no) Secure Attachment</td>
<td>1 (no) Secure Attachment</td>
<td>Non Offender</td>
</tr>
<tr>
<td>K4</td>
<td>1 (no) Secure Attachment</td>
<td>1 (no) Secure Attachment</td>
<td>1 (no) Secure Attachment</td>
<td>Some offences in and after care</td>
</tr>
<tr>
<td>Participant</td>
<td>Before Care</td>
<td>During Care</td>
<td>After</td>
<td>Comments/Offending</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
<td>-------------</td>
<td>-------</td>
<td>--------------------</td>
</tr>
<tr>
<td>R1</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>2 (no)</td>
<td>One offence after care as opposed to lots in care</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/Non Secure</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td>New Attachments</td>
<td></td>
</tr>
<tr>
<td>R2</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>2 (no)</td>
<td>No crime after care</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/Non Secure</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td>New Attachments</td>
<td></td>
</tr>
<tr>
<td>R3</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>1 / 2 (no)</td>
<td>Care throughout</td>
</tr>
<tr>
<td></td>
<td>Attachment but problematic</td>
<td>No new attachment but Increase Attachment with Mum</td>
<td>New Attachments</td>
<td></td>
</tr>
<tr>
<td>R4</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>Crime throughout</td>
</tr>
<tr>
<td></td>
<td>Attachments but problematic</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td></td>
</tr>
<tr>
<td>R5</td>
<td>2 (yes)</td>
<td>1 (no)</td>
<td>1 (no)</td>
<td>Crime throughout</td>
</tr>
<tr>
<td></td>
<td>Good Attachments but problematic</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td>Rebuilt Attachments</td>
<td></td>
</tr>
<tr>
<td>R6</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>Crime throughout</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/Non Secure</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>Before Care</td>
<td>During Care</td>
<td>After</td>
<td>Comments/Offending</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
<td>-------------</td>
<td>-------</td>
<td>--------------------</td>
</tr>
<tr>
<td>F1</td>
<td>3 (no)</td>
<td>1 (no)</td>
<td>1 (no)</td>
<td>Non Offender</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/Non Secure</td>
<td>Secure Attachment</td>
<td>Secure Attachment</td>
<td></td>
</tr>
<tr>
<td>F2</td>
<td>1 (no)</td>
<td>1 (no)</td>
<td>1 (no)</td>
<td>Non Offender</td>
</tr>
<tr>
<td></td>
<td>Secure Attachment</td>
<td>Secure Attachments with Friends</td>
<td>Secure Attachments with Friends</td>
<td></td>
</tr>
<tr>
<td>F3</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>Open prison and lots of offences</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/Non Secure</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td>Rebuilt Attachments</td>
<td></td>
</tr>
<tr>
<td>F4</td>
<td>3 (yes)</td>
<td>2 (yes)</td>
<td>1 (no)</td>
<td>No offences after care</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/Non Secure</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td>New Attachments</td>
<td></td>
</tr>
<tr>
<td>F5</td>
<td>3 (yes)</td>
<td>2 (no)</td>
<td>1 (no)</td>
<td>No offences after care</td>
</tr>
<tr>
<td></td>
<td>Attachment/Non Secure</td>
<td>New Attachments</td>
<td>Secure Attachments</td>
<td></td>
</tr>
<tr>
<td>F6</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>Offences throughout</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/Non Secure</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td></td>
</tr>
<tr>
<td>F7</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>Offences throughout</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/Non Secure</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td>Further Damage</td>
<td></td>
</tr>
<tr>
<td>F8</td>
<td>1 (no)</td>
<td>2 (no)</td>
<td>1 (no)</td>
<td>Offences throughout</td>
</tr>
<tr>
<td></td>
<td>Attachment</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td>Further Damage</td>
<td></td>
</tr>
<tr>
<td>F9</td>
<td>2 (yes)</td>
<td>2 (no)</td>
<td>1 (no)</td>
<td>None except petty vandalism after care</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/Non Secure</td>
<td>New Attachments</td>
<td>Secure Attachments</td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>Before Care</td>
<td>During Care</td>
<td>After</td>
<td>Comments/Offending</td>
</tr>
<tr>
<td>-------------</td>
<td>------------</td>
<td>-------------</td>
<td>-------</td>
<td>--------------------</td>
</tr>
<tr>
<td>F10</td>
<td>2 (no)</td>
<td>1 (no)</td>
<td>1 (no) Secure Attachments</td>
<td>Non offender</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/ Non Secure</td>
<td>New Attachments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F11</td>
<td>3 (yes)</td>
<td>2 (no)</td>
<td>1 (no) Secure Attachments</td>
<td>No offences after care</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/ Non Secure</td>
<td>New Attachments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The numerical categorisations were recorded through the risk assessment, in response to “My family and personal relationships are/were minimal and problematic” 1=No, 2=Yes, Slightly and 3=Yes, Definitely. The participants were then asked to state if this influenced their behaviour and/or offending, stating ‘Yes’ or ‘No’. It is important to note that the influence was with regards to negative behaviour, thus a ‘no’ from a non-offender, does not mean the attachments did not influence their behaviour in a positive manner, offering a protective factor as opposed to a risk factor.

8.1.1 A Legacy of Positive Experiences

The first category of participants can be seen to show secure attachments throughout their lives, showing attachments and relationships not to be problematic nor linked to offending behaviour. Instead, they attribute the support they receive to offer their positive influences:

**Participant: K1 Secure Attachment**

<table>
<thead>
<tr>
<th>K1</th>
<th>N/A</th>
<th>1 (no) Secure attachment</th>
<th>1 (no) Secure Attachment</th>
<th>Non Offender</th>
</tr>
</thead>
</table>

“I have had them with me like I would have my parents there. I think that is where I am so lucky, as others in care are on their own at eighteen”.

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This participant was placed into care at birth, resulting in all of her developmental phases and attachment processes being based around her kinship care. This narrative is not easily distinguishable from a young person who lives with their biological parent(s), instead it highlights a strong familial bond and acknowledges the strength of having such relationships throughout their transition to adulthood. Therefore, this young person has been in receipt of a placement which can only be considered as positive, both in terms of attachments and behavioural outcomes. In addition, this participant experiences do not expose concerns within their transitional process, reducing risk of problematic behaviour to that of the general population.

The next participant moved to the UK at the age of fifteen, as an unaccompanied asylum seeker, after his parents were murdered in Afghanistan. Although this young person lost both his parents and was separated from his brother, his narrative below explains his resilience in face of such adversity:

**Participant: F2 Secure Attachments**

<table>
<thead>
<tr>
<th>F2</th>
<th>1 (no) Secure Attachment</th>
<th>1(no) Secure Attachments with Friends</th>
<th>1 (no) Secure Attachments with Friends</th>
<th>Non Offender</th>
</tr>
</thead>
</table>

“I was loved by my parents and I have always carried that with me. Remembering that gets you through the tough times. If I ever feel down, I think about what they would say to me and I know they would want me to reach out to people and be a good person. I would never want to let them down and I hope they are proud at how I am and how I have rebuilt a life”.

Evidently, this young man’s life choices are directly referenced to the memory of his parents and the secure attachments he was in receipt of throughout his adolescence. This narrative offers evidence of the importance of attachments in shaping your trust in others.
and ability to be resilient when you are removed from the primary care givers. This participant shows the positive consequences of initial attachments, providing the ability to shape your life overall.

Whilst highlighting the extent to which foster placements can be criminogenic, through their inability to provide attachments, this excerpt discusses the limits of care alongside the need to be realistic in terms of ones expectations:

“Although I have had to move many times, I have always known the system is here to help me. I think I have moved many times and I cannot blame anyone, they are trying their best for me and would not move me unless they had to and I will be eternally grateful for that”.

The care experience itself, is not shown to present a stable placement for this participant. However, despite stability being absent, this participant highlights his gratitude and belief in the system. Acknowledging the care system to be helpful is not a narrative prominent within this research, this alongside the self-actualisation produced from his primary attachments and care givers, allows F2 to deal with the negatives experiences associated with placement instability. However, the success of the participant cannot be solely attributed to the care system itself, due to the hurdles it presents within placement moves. Instead, one can highlight the individual’s gratitude and resilience, allowing acceptance of such instability, as opposed to anger and frustration which is common within this research. In addition, the care system did not produce any further damage and allowed this young man to develop new relationships, both in care and after.

Not only has this participant’s attachment before care, allowed him to be resilient to adversity within care, it has also allowed him to form new relationships, still present within his transition to adulthood:

“I have many friends and the lady I live with now, she is very nice and I care about her a lot. There are many people who I see as my second family and they make me very happy”.
This narrative provides evidence of the importance of gaining relationships outside the familial roles. In addition, to see these non-familial relationships to allow happiness, not only shows the strength of this young man’s developmental phases and earlier attachments, it also highlights the ability of the care system to provide foundations for new relationships to be formed; relationships that are secure and in place after leaving care.

Evidently, F2’s experiences can be attributed to positive attachments before entering care, allowing him to adapt to life in care. Therefore, it is important to acknowledge the experiences of those participants who were not in receipt of a secure attachment before care. To what extent was the care system able to provide: a sense of belonging; encouragement; and positive behaviour? The following three participants provide their accounts of life after care:

**Participant K3: Secure Attachment**

<table>
<thead>
<tr>
<th>K3</th>
<th>3 (no)</th>
<th>1 (no)</th>
<th>1 (no)</th>
<th>Non Offender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lack of Attachment/ Non Secure</td>
<td>Secure Attachment</td>
<td>Secure Attachment</td>
<td></td>
</tr>
</tbody>
</table>

K3 entered care with a lack of attachment, but after four placements she was placed in kinship care, providing foundations, stability and attachments. The following excerpt highlights her experiences:

“I am so lucky. I look at other people in care and see that they have to find their own feet at eighteen or so. I moved out when I was sixteen to study but with their help which was lovely. I have a family, support and love so I don’t really see myself as much different to anyone else. Well, except the things that happened to me before I lived with them and that is something I am working on”.
The reality for many leaving care is often a life with limited support, particular within emotional and practical terms, but this isn’t often true for those in kinship placements (Farmer, 2009). Although this young woman exited care at the age of sixteen, making her transition earlier than her peers and the majority of care leavers, she had a strong support network. She acknowledges assistance and a sense of normality, seeing herself as not dissimilar to her peers. This normalisation can be linked back to the care she received within her kinship placement, having “family, support and love” with a family as a safety net. In addition, these secure attachments have allowed the trauma faced before care to be addressed, lowering the risk of future emotional and mental health concerns and behavioural shifts. Evidently, kinship placements by definition provide a young person with a placement that has pre-existing familiar relationships, whether by extended family members or friends. Thus, when measuring the care systems ability to provide an environment which encourages and supports positive relationships, so vital for positive behaviour, this placement type is already acknowledged to need less intervention due its higher probability of being successful.

To fully understand the positive nature of care and its ability to provide foundations to rebuild and/or develop new attachments, placements without pre-existing relationships or familiarity need to be analysed. The following two participants, both from foster placements, highlight their experiences of entering into an unknown family environment, without previous experiences of secure attachments.

**Participant F1: Secure Attachment**

<table>
<thead>
<tr>
<th>F1</th>
<th>3 (no)</th>
<th>1 (no)</th>
<th>1(no)</th>
<th>Non Offender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lack of Attachment/ Non Secure</td>
<td>Secure Attachment</td>
<td>Secure Attachment</td>
<td></td>
</tr>
</tbody>
</table>
“I am now in my final year of Nursing at the local university and engaged. I see myself as the same as any other young person starting out their live and I am really thankful for all the encouragement and assistance I have received after care. I am still in touch with the family and we send regular letters and try to visit, so I see myself as no different to those who have not been in care”.

This young woman suffered extreme abuse before entering care, and as highlighted in the previous chapters, she was so relieved and glad to be put into a safe and secure environment. The relationships she built were long standing, having her carers as a safety net.

On asking on the influence this attachment had on her transition into adulthood, she stated the following:

“They are there every step of the way and although they cannot help me financially, like many parents would, they provide emotional support. I think the emotional support is invaluable and more focus should be on that, as you can provide young people with money but the world is a big scary place and you need to be mentally and emotionally prepared.

Everything I do is to make a better future and make them proud of me”.

This young woman places much of her stable transition to the influences and support of her foster family. Although financial assistance is not in place, this participant highlights the crucial components of emotional support and the guidance, allowing her to achieve and behave in a manner which allows them to be proud of her. Her experiences and outlook fit well within attachment literature and more specifically, within Social Control Theory (Hirschi, 1969) showing the importance of attachments to not only be important for self-esteem, self-belief and self-actualisation but fundamental to the wider social bonds of commitment, involvement and belief. This participant raises the need for emotional assistance within transitions to be of central importance, a concept widely acknowledged
within this research and complements the priorities set up within Maslow’s Hierarchy of Needs (1943).

The next participant, who also gained stability within care and was a non-offender throughout, highlights her experiences:

**Participant F10: Secure Attachment**

<table>
<thead>
<tr>
<th>F10</th>
<th>2 (no)</th>
<th>1 (no)</th>
<th>1 (no)</th>
<th>Non offender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lack of Attachment/ Non Secure</td>
<td>New Attachments</td>
<td>Secure Attachments</td>
<td></td>
</tr>
</tbody>
</table>

“I am going to stay with my foster mum until I am twenty one and I won’t have to leave until I am confident and ready. So I get looked after like a mum and dad would and I think this is important as it makes me relaxed and happy”.

F10 provides further evidence of the protection and stabilisation of a young person’s journey within care, which has the ability to provide the assistance within the vital transition to adulthood. Such comparisons show the ability for foster placements to offer relationships past the exit from care. These excerpts are from young people who left care before the introduction of *Staying Put*, thus with such provisions routed within social care practice, it is hope that more young people will be provided with an extended support network, mirroring the familiar set ups desperately needed.

**8.1.2 Attachments and Offending**

This section presents the experiences of those who gained attachments during and/or after care but still committed offences.


**Participant K4: Secure Attachment**

<table>
<thead>
<tr>
<th>K4</th>
<th>1 (no) Secure Attachment</th>
<th>1 (no) Secure Attachment</th>
<th>1 (no) Secure Attachment</th>
<th>Some offences in and after care</th>
</tr>
</thead>
</table>

“Well I left my Nan’s when I was eighteen and got myself a bedsit. We are still close and she is there for me whenever I need her, but she has no money, so financially I am alone. I did a six month stretch and my Nan was mortified, but that was nothing to do with care or anything. I know what is right and wrong, I made a choice”.

This participant highlights their experiences as being filled with love and attachments throughout their life. Whilst examining his offending patterns and attachments after care, he is clear that the latter had little impact on his behaviour. Although he highlights the presence of guidance, he puts emphasis on his own choices and actions related to his offending. There is a clear acknowledgement of the importance of accepting responsibility, with the notions of free will and agency as a driving force, and the reasoning behind offending behaviour. This reintroduces the importance of the young person having active agency and avoiding using care as an explanation or justification for offending behaviour. Thus, offending occurred despite the young person being in receipt of attachments and stability.

Therefore, it is crucial to note that not all behaviour is predetermined. Many aspects can play a part, including the importance of individual agency and the impact this has upon an individual’s choices. Although having a suitable environment is crucial in presenting opportunities to make positive choices, ultimately an individual, like K2, makes the decisions to commit crime.

As evidenced in Chapter Two, Attachment Theories present evidence of the correlation between poor attachments and offending, with attachments also being a key component of
resilience; however, this does not predict all cases of offending (Bowlby, 1952; Hirschi, 1969; Ainsworth and Bell, 1970; Main and Solomon, 1986, Rutter et al., 1998). This study has shown that problematic attachments are noted to be a key indicator of the experience of risks to offending (e.g. emotional and mental health, perceptions of self and others, substance misuse) and a key component of resilience. However, this does not mean that all risks to offending are linked to attachments (e.g. physical health, attitudes to offending). Therefore, this narrative offers evidence of the importance of using both Attachment Theory (to provide an explanation of heightened risk) and the RPFP (to present ALL risk experienced, including risks experienced as outcomes of poor attachments and those experienced due to alternative explanations).

The next participant also highlights their experiences of holding attachments, although problematic in parts before their entrance to care, whilst also exhibiting offending behaviour. The following excerpt highlights their experiences on exiting care, both in terms of attachment and offending patterns.

**Participant R3: New Attachments**

<table>
<thead>
<tr>
<th>R3</th>
<th>3 (yes) Attachment but problematic</th>
<th>3 (yes) No new attachment but Increase Attachment with mum</th>
<th>1 / 2 (no) New Attachments</th>
<th>Crime throughout</th>
</tr>
</thead>
</table>

“Emotionally I only get support from my partner; I don’t have anything like that from the leaving care worker. Practically they give you the basics. I need people to do be there for me; problems just don’t go away when you leave care. I am still depressed and have anxiety and this makes my anger worse but there is nothing. I can’t hold out for my monthly visit to get things sorted. I had like thirty eight different mums and dads and a fucked up life, I need to have someone there for me now. The initial rejection of being put
into care and then being moved around is happening all over again. I need someone to guide me now and I don’t get that and people wonder why I lash out.”

R3 speaks about a new attachment with her partner, but highlights this to be the only support she receives. In contrast to K4, her narrative (although inconsistent with the risk ratings) shows that she links her problematic behaviour to the inability of the care system to provide her with the support she needs, not only in assisting her into adulthood, but addressing the instability and negative trauma she had experienced before and during care. Thus, her experiences show that more needs to be done to ensure full emotional support is available, and such emotional support cannot be seen as a predetermined aspect of attachments made. The critical need for developments within both emotional and practical support will be discussed in section 8.2.5.

8.1.3 Lower Levels of Crime on Exit from Care

This section presents the narratives of young people who were in receipt of attachments after care, with their offending rates decreasing.

**Participant R1: New Attachments**

<table>
<thead>
<tr>
<th>R1</th>
<th>3 (yes) Lack of Attachment/ Non Secure</th>
<th>3 (yes) Lack of Attachment/ Non Secure – Further Damage</th>
<th>2 (no) New Attachments</th>
<th>One offence after care as opposed to lots in care</th>
</tr>
</thead>
</table>

Although this participant had concerns with attachments and behaviour before and during care, after care saw some welcomed improvements:

“It wasn’t until I was an adult that I decided to do things with my life, put my head down and keep on the straight and narrow. Once I wanted to be successful and I was. Just because I have been in care, it doesn’t define my adult life and what I have achieved”.

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Although her earlier experiences were turbulent, these experiences encouraged her to build a future and move away from being defined as a care leaver. This participant attributes the freedom from care as a turning point in her life, allowing her to take control and reduce her offending. However, as she was working at the age of twenty one, this exit happened before she was ready:

“It was because I was twenty one and not in education and that was against the rules, I know that, but sometimes they should see things differently. My care worker didn’t want to leave me, but because of the rules they had to. It shouldn’t just be about education but about personal circumstances. If it wasn’t for my partner I wouldn’t have anyone, I don’t have family or friends really as I am always working. I just think they shouldn’t have left me. I miss the advice I had. We should all be treated like individuals and nurtured like a parent would. You cannot help someone live a happy life through a rule book, no one is the same. A parent wouldn’t leave their kid on their twenty first birthday, so why should a local authority”.

This narrative offers a key point of discussion in reference to the termination of leaving care services at the age of twenty one. There is a need for tailor made approaches to making decisions with regards to services, instead of a measurement based on participation in education. This participant experience highlights the needs to challenge the current legislation, highlighting the current legislation to be unable to cater for all care leavers. The participant states how it is impossible to ensure all young people are able to have enriched lives, based on a rule book. The notion of no one being the same and a need to give a tailored approach to all young people is paramount, with the need to “see things differently” and acknowledge “personal circumstances” rather than decisions based on education.
“I understand you cannot have someone for eternity, but with my situation I am going for custody of my child and they have just left me in the middle of it. I could have gone off the rails, with no support. I don’t even want money, just emotional support and I need it as I am on my own in court and all that. I think there should be more to help people emotionally and I know that costs staff time but it is a drop in the ocean compared to the thousands spent when you are in care. Why spend all that money and then cut all ties that would only work if they got the system right, which they rarely do. I am not ready to have left care and I wasn’t even told officially, it is lucky I have kept my head in gear as things could have easily been different”.

This narrative highlights both her acknowledgement of the inability of the service to be a lifelong arrangement, whilst also stating how she was not prepared or correctly informed. Her detailed reflections on the need to address either the concerns within care, highlighting the readiness emotionally, or increase the assistance are striking. She challenges the priorities of the social care system and draws interesting observations on the investment to those in care. There is clear evidence of this participant’s perceived inability to leave care due to emotional concerns, and although she understands the system she is not convinced of its use of resources. Her acknowledgment of the staff resources that would be needed to extend emotional support, whilst comparing it to the financial investment made throughout her care journey, presents a striking comparison. The system provides safeguarding and support throughout a young person’s time in care, for this participant from the age of ten years old and through thirteen placements, resulting in a substantial financial commitment from local authorities. She argues, and explains well, the conflicting aims of resources used, with the “costs staff time but it is a drop in the ocean compared to the thousands spent when you are in care”. Furthermore, she argues “why spend all that money and then cut all ties that would only work if they got the system right, which they rarely do” highlighting a need to increase the importance of emotional wellbeing and attachments.
within care, making the overall need of emotional assistance lower after care or increase the assistance throughout – either way this observation raises questions on the inconsistencies faced within care and after care.

These concerns not only raise questions on the young person’s readiness to leave care, in terms of emotion support, it highlights the consequences on life choices. R1 highlights her position to have easily caused her to “go off the rails with no support” stating that “it is lucky I have kept my head in gear as things could have easily been different” with connotations showing the chance of poor life choices, due to the lack of support.

R1 presents a complex narrative showing many dimensions of her experiences during and after care and the consequences of these to be of concern, both in terms of her emotional wellbeing and increased likelihood of offending. It is not to say that she has not been supported after care, instead her experiences highlight the need to extend support for all care leavers. Therefore, such discussions open up the need to re-evaluate the current system of support, which currently stops assistance at the age of twenty one for those not at university, but can be reopened up until the age of twenty five, should the individual embark on a degree. It is vital that this is addressed, to allow recognition of the need of all care leavers and redefine the focus to incorporate both financial and emotional need. Furthermore, it is recognised that financial assistance for those not in further education is not expected at the same level, as these young people will be in receipt of benefits or have income from employment. However, the need for emotional assistance should not be differentiated based on achievements or employment outcomes, all young people should receive the same emotional support up until twenty five years. Currently, from developments made within the DfE funded project New Belongings (2016), local authorities around the country have extended their non-financial support, with one local authority making a promise to have contact with all care leavers for the duration of their
adult life (Stockport Council, 2016). It is hoped that such developments are recognised to assist all care leavers.

The following participants draw on their experiences of secure attachments, both during and after care, with their offending patterns dramatically decreasing in severity after care.

**Participant K2: Secure Attachments**

<table>
<thead>
<tr>
<th>K2</th>
<th>1 (no) Attachments but problematic</th>
<th>1 (no) Secure Attachment</th>
<th>1 (no) Secure Attachment</th>
<th>Theft after care and one assault in care</th>
</tr>
</thead>
</table>

“I do care what they think and that has helped. I am not saying I have totally become a good person, but my focus on behaviour has made me stop getting so mad. Yes, I still nick things and have been done for that twice but other than that I am trying”.

K2 still has contact with her family, in particular her maternal grandmother, with evidence of a secure attachment and guidance. Although she has carried out offences in care and after, the seriousness of the offending has decreased. When asked why she still offends, her response was as follows:

“ I don’t have much money and I guess it is so easy to steal, I should work on that but there are worse things I could be doing. It is not as if I go round mugging people, no one gets hurt. But when you need things or desperately want them, it is so hard to find the discipline to not take those things”.

K2 links her offending after care to be a consequence of a poorer income and what she perceives to be “so easy to steal”. Evidently, there are concerns for her ability to gain material or financial security for legitimate means and highlights dimensions of Anomie and Strain developed by Durkheim (1893 in 1964), Merton (1938) and Cohen (1957). K2 shows that if she needs or wants something, it is hard to avoid committing theft. This
narrative raises question on the ability of K2 in terms of circumstances, at the time of interview she had just been employed after a substantial amount of time on benefits, with such circumstances increasing the likelihood of offending (Marsh, 2008). Furthermore it raises concerns on the extent to which her local authority assists her to have conventional means available in order to adopt a non–offending lifestyle. The final excerpt from K2 describes her current situation and support network in terms of practical and financial assistance:

“I didn’t go to university so I did not have any support after I was twenty one. They just stuck my on benefits and hoped for the best. I have a job now and will be getting minimum wage and hopefully some form of top up, but I haven’t had what you can call support financially for many years. I can’t ask my family as they don’t have anything, so sometimes as I said before, I steal things to make things easier”.

Like R2, this participant was not eligible for support after the age of twenty one. However, K2 has the need of practical assistance, with emotional supports and attachments firmly in place. The extent, to which her support network can assist her behavioural concerns, is referenced to be limited, with her family unable to provide money to lower her shortfall. This narrative by no means suggests all people on minimum wage have Justifications for offences surrounding theft; instead it raises a need to revaluate support for all young people who are low earners. It is therefore important to look into ways which allow young people, with particular reference to care leavers, to have the support to assist them with budgeting and the attitude to pro social goals, regardless of their incomes. With such developments, and assistance for all care leavers up until twenty five, it is hoped that guidance will be in place to help eliminate such offences, as although lower in severity they will impact on the employability and therefore life chances of those individuals who engage in such activities.
The following participant, F9, highlights their experiences to hold better support in terms of practical assistance, with everyday support being in need of addressing:

**Participant F9: Secure Attachments**

<table>
<thead>
<tr>
<th>F9</th>
<th>2 (yes) Lack of Attachment/ Non Secure</th>
<th>2 (no) New Attachments</th>
<th>1 (no) Secure Attachments</th>
<th>None except petty vandalism after care</th>
</tr>
</thead>
</table>

“*My foster carers and the leaving care team have been outstanding. They help me financially and encourage all my work. The only thing is they don’t check on very often, I think you should be looked out for, you know as a person. It should be a needs based thing*”.

“I get easily led, even now. It would be nice to have someone there, you know someone to invest time into me. I do have people about, but more professional support would be good. I am used to having that alongside the people I care about; you know a sensible voice, stopping me from being getting myself in trouble. I am not saying it is anyone’s fault except my own, but it would be better to have someone there more often for me”.

F9 presents herself to need further supervision and guidance, with someone “to invest time”. Although she is practically supported, she refers to the need of having stable and regular interaction with a positive role model “a sensible voice” to stop her from getting herself in trouble. Thus, although she has reflected her attachments to be secure, one needs to be aware of the strength of such attachments and their abilities to promote pro social behaviour. Furthermore, as highlighted within R1’s narrative, it is vital to acknowledge the strength of one’s own agency, with F9 taking full responsibility of her actions (act of vandalism).
8.1.4 Non Offenders After Care

This section highlights the experiences of those who offended during care but transitioned to prosocial behaviour after leaving the care system.

**Participant F5: Secure Attachments**

<table>
<thead>
<tr>
<th>F5</th>
<th>3 (yes)</th>
<th>2 (no)</th>
<th>1 (no)</th>
<th>No offences after care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment/ Non Secure</td>
<td>New Attachments</td>
<td>Secure Attachments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

“They have been great and pretty much got me my first apprenticeship. They have been very proactive and supportive. Not only that, I will always think of them as an uncle and aunty, they have made me feel wanted and welcome. I am so glad there support has helped me keep my head down and now I am older I haven’t done anything against the law”.

F5’s narrative puts focus on his final foster carers as his main support through his transition of adulthood. Not only have they provided him with a sense of belonging, they provided him with practical assistance which has helped his employment opportunities. This continuity of the attachment gained in care has clearly assisted F5 throughout his transition into adulthood, whilst also providing him with a reason to keep his head down. However, there is also evidence of his offending patterns stopping due to his age, as presented within The Age Crime Curve (Moffitt, 1993) showing the likelihood of continual offending after the age of eighteen being unlikely. Despite such theoretical conclusions, the influence of F5’s foster carers can still be attributed to pro social behaviour, by lowering his risk factors and assisting him with his development. This narrative not only offers positive evidence of the importance of attachments to continue post care, it also highlights the ability for an individual to develop such attachments at the age of sixteen. Such evidence is welcomed and highlights the potential for foster placements to provide a young person with the relationships they need to have an enriched life with pro social behaviour.
“It is not about care or not being in care, I think it is to do with growing up and finding a purpose. My grandads love allowed me to leave care knowing who I was and not just someone from a broken home; he is someone to look up to. I stay clear of my old troubled friends and I keep my head down for my little girl. Maybe things would be different without her, but I like to think that they wouldn’t be”.

F11 does not relate her change in behaviour to be due the exit from care, instead she relates it to her change of lifestyle, becoming a mother and having a change of friendship group. Although attachments do play a part in her behavioural changes, with her grandfather’s love allowing her to leave care with self-esteem and a strong sense of identity, she puts an emphasis on her age and “growing up and finding a purpose” also echoing predictions offered by Hirschi and Gottfredson (1983) with a change in criminal patterns likely after an individual’s late teens.

This young ladies narrative not only highlights the importance of understanding the free will and agency a young person holds, moving away from care being criminogenic, it also highlights the importance of ensuring attachments are in place outside the care system which can allow the young person to be confident in their abilities to make pro social choices.
**Participant R2: New Attachments**

<table>
<thead>
<tr>
<th>R2</th>
<th>3 (yes)</th>
<th>3 (yes)</th>
<th>2 (no)</th>
<th>No crime after care</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Attachments</td>
<td>3 (yes)</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td>2 (no)</td>
<td>New Attachments</td>
</tr>
</tbody>
</table>

The narratives of many care leavers indicate frustration and concern when faced with leaving the care system, with no one as a safety net. With this in mind it is crucial to analyse the positive impact leaving care can have and the reasoning behind this welcomed change.

“I have got rid of the haters and all the people that drag me down. I have confidence now and I chose people I want in my life that actually stick around. It is so much different that in care, I am my own person now and so much happier”.

Leaving care allowed R2 to escape from negative relationships experienced in care. This allowed her to have confidence, choice, independence and control, attributes that had not been apparent whilst in care. Evidently, R2 defines their experiences of leaving care to be positive in terms of the development of their self-esteem and control. However, it is important to see the extent to which the overall experiences of leaving care provide a young person with the mechanisms to live a happy, healthy and crime free life:

“Things are tough and all that, but I would prefer it to be tough than have people who don’t care about me, ruling my life. Actually it is tough and rough but it’s my life and I do as I please. I keep my head down and just get on with it; I do that for me and the people who are important and care about me”.

For this young woman to prefer a lived experience after care, which is referenced to be “tough and rough” but preferred to having “people who don’t care about me, ruling my life” is deeply concerning.
The key mechanism for change is demonstrated through the presence of attachments and new found ability to exert control, experiences also expressed by F4:

**Participant F4: New Attachments**

<table>
<thead>
<tr>
<th>F4</th>
<th>3 (yes)</th>
<th>2 (yes)</th>
<th>1 (no)</th>
<th>No offences after care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lack of Attachment/Non Secure</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td>New Attachments</td>
<td></td>
</tr>
</tbody>
</table>

“That part of my life has gone now. As soon as I left care, I found out what it was like to feel happy. I now have a lovely boyfriend who treats me right and it has helped me keep my head down and I haven’t stepped out of line. I have too much to lose now”.

This excerpt highlights similar reflections of feeling happy on exit from the care system, and directly attributes the feelings of control and belonging to her change in behaviour:

“I just chose to make it, without their interference and messing around. Finally I found me and grabbed it with both hands. I am so happy right now, happier than I have ever felt. A lot of that is to do with my boyfriend who loves me unconditionally and shows me what I have always wanted. I feel free and know how important it is to stay on track, so that is what I am doing and as I said before, I couldn’t be happier”

The element of control is paramount within this narrative, with the care experience not offering the freedom and love that is found on exit. Not only has this participant felt a sense of control, her attachments have improved after care and have a positive impact on her to “stay on track”. F4 has not committed offences after care and this coupled with her happiness, sense of belonging and sense of control, offers a positive direction after she has left care. It is not to say that care is criminogenic, but this particular participant highlights
her success after care to be a product of belonging and love, bringing her happiness and allowing her to make positive decisions, feelings she did not possess in care. Such excerpts highlight the need for care to put a focus on such attachments, alongside safeguarding. Young people across all placement types need to focus on instilling such attributes during care, in order to lower the risk of offending.

This section has highlighted the positive experiences often faced by care leavers, after they have left care. Therefore, after an often troubled time in care, and before their care entrance, these young people’s emotional experiences and behaviour improve after care. However this is not always the case, many care leavers face the same emotional and behavioural concerns, experienced before and during care, despite leaving care. The next section presents the narratives of those who have experienced both emotional and behavioural concerns, up until the time of interview.

8.1.5 The Legacy of Attachment Concerns

The remaining participants do not hold those same experiences instead their narratives show concerns with both their attachments and offending behaviour, throughout their care journey. The first two participants who experienced residential care as their main placements, both share concerning stories, with before, during and after care all seen to be absent of secure attachments and fuelled with behavioural concerns.

Participant R4: Lack of Attachment/ Non Secure – Further Damage

<table>
<thead>
<tr>
<th>R4</th>
<th>3 (yes) Attachments but problematic</th>
<th>3 (yes) Lack of Attachment/ Non Secure – Further Damage</th>
<th>3 (yes) Lack of Attachment/ Non Secure – Further Damage</th>
<th>Crime throughout</th>
</tr>
</thead>
</table>
R4 shows negative experiences throughout their journey into care to their exit from the care system. It is crucial to identify the failings of the system, and the extent to which one can attribute responsibility to the care system in terms of restrictions to attachments and the direct influences to behaviour, during and after care. The following excerpt highlights R4’s experience after care:

“I am never close to anyone, I struggle so much to trust and this doesn’t help me at all. I wish I had someone to answer to and give a shit about but I am too scared to, I would prefer to be just about me and do what I want, no matter the consequence. I just think it is easier now, you give up on having a family in the end and you can f**k up as much as you want and no one cares”.

The above excerpt provides evidence of his fears of getting close to anyone. When asked about the restrictions he faces within building relationships and addressing his behavioural concerns, R4 states the following:

“I still cannot believe I am stable as an adult, so I move around a lot now even. It has really made me weary of trusting people and that is a big problem when you are forming relationships and trying to keep on the straight and narrow. I guess we all need someone to be accountable to but due to my experiences I struggle to let away close to me and then I do not have anyone to let down, so I do what I want. So I am haunted by what happened with my mum and all the moving here and there, it is like I do not know how to deal with living in one place and how to get close to people in a good way”.

The particularly striking part of this narrative is the participants clear understandings of the importance of attachments towards his behaviour, highlighting the need of accountability. As R4 highlights, without relationships, he has no-one to “let down” and therefore continues to make decisions he deems appropriate, despite recognising that they do not allow him to move forward “on the straight and narrow”. There is clear evidence of the
importance of attachment as a social bond and as a mechanism for emotional stability, both of which are absent due to the legacy of earlier trauma and instability.

It is vital to understand that R4 could have had the ability to experience stability and form relationships, after being in care since the age of five, if his needs would have been met. The very system which is there to improve life chances, as well as safeguard young people, needs to look beyond the basic components of existence and take full responsibility in addressing the emotional and behavioural concerns. Understandably those in care for a short period are exposed to longer durations of pre care risk and a reduced window for interventions, but this must not the case for R4. The level and duration of intervention surrounding attachments may vary, but every effort needs to be put into place to ensure all young people are given the best input possible, in order to progress from their pre care concerns.

These experiences are not isolated; R6 highlights similar experiences throughout her care journey, with her time after care being subjected to further concerns.

**Participant R6: Lack of Attachment/ Non Secure – Further Damage**

<table>
<thead>
<tr>
<th>R6</th>
<th>3 (yes) Lack of Attachment/ Non Secure</th>
<th>3 (yes) Lack of Attachment/ Non Secure – Further Damage</th>
<th>3 (yes) Lack of Attachment/ Non Secure – Further Damage</th>
<th>Crime throughout</th>
</tr>
</thead>
</table>

“The care I had or didn’t have left its mark for sure. In fact, things are even worse now. At least I was provided for in care. But I now don’t have anything or anyone and it is so hard to stay on the straight and narrow. When you have no one to look up to and encourage you, it is hard to make that jump”.
Not only has the care experience limited her abilities to ensure that she can gain a positive and supportive network and is ‘cared about’ she also is not in possession of the skills needed to be able to be ‘cared for’ practically and able to ‘care for herself’. R6s reflects on the struggle to “make that jump” to make her stay on the straight and narrow, with little support and encouragement.

**Participant F6: Lack of Attachment/ Non Secure – Further Damage**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Lack of Attachment/ Non Secure</th>
<th>Lack of Attachment/ Non Secure – Further Damage</th>
<th>Offences throughout</th>
</tr>
</thead>
<tbody>
<tr>
<td>F6</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td></td>
</tr>
</tbody>
</table>

“*Nothing has really changed, except I am away from that dreaded place with people pretending to give a shit. I now do my thing and no one at all gets in the way of it now, I can do as I please because I don’t give a fuck about anything really*”.

F6 provides evidence of a consistent lack of attachment and offending (sixteen offences during and fifteen offence after care), with further damage being apparent both during and after care. This participant’s placement moves, equated to an average of one per year, a finding which shows a failing of the system, with key indicators to his behavioural outcomes.

**Participant F7: Further Damage**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Lack of Attachment/ Non Secure</th>
<th>Lack of Attachment/ Non Secure – Further Damage</th>
<th>Offences throughout</th>
</tr>
</thead>
<tbody>
<tr>
<td>F7</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td></td>
</tr>
</tbody>
</table>
“I long for stability and for everything to be ok, with my baby to love and care for but life isn’t that easy. I am trying to get on track but it is tough when you don’t have anyone who is willing to give you a chance and belief in you”.

Despite entering care at the age of six, F4 is unable to care for herself, her child and form relationships, again providing evidence that the care system failed this participant.

The remaining participant, whom carried out offending throughout her care journey, provides further evidence of the importance of a positive attachment.

**Participant F8: Further Damage**

<table>
<thead>
<tr>
<th>F8</th>
<th>1 (no) Attachment</th>
<th>2 (no) Lack of Attachment/ Non Secure – Further Damage</th>
<th>1 (no) Further Damage</th>
<th>Offences throughout</th>
</tr>
</thead>
</table>

“At sixteen I told the leaving care team I was moving in with my boyfriend, they didn’t try and stop me and would give me so much money. A couple of months down the line, he started being violent towards me and a little while after that I found out he was a heroin addict. I was stuck then. I had nowhere to go, I couldn’t go back to foster care. I did speak to my leaving care worker at this point and nothing happened. She just shrugged it off. I then got into drugs as well and told my leaving care worker about that. She just told me to get clean and I knew that. It just spiralled out of control from there. At seventeen, I was addicted to heroin. It then got worse and I started robbing and the violence got worse, I even went from smoking it to injecting it. Once they put me in the flat, I hadn’t heard from my leaving care worker for six months and when I did hear from her it was only a quick call. It was too late by then as I was heavily drug dependant. They did put money in my
bank for my rent but no help or emotional support. I cried out for help and there wasn’t any”.

Although this participant developed an attachment at the age of sixteen, it was far from a positive relationship. She references having “nowhere to go” with limited contact, despite her drug dependency. This narrative shows an example of a failure in service, as offered by the local authority. Whatever efforts were put in place by the leaving care worker, it is vital to listen to such experiences, with this participant feeling alone, despite her crying out for help. There is no reference to emotional support, except from her drug dependant partner. Although the aim of this analysis is not to put individual blame on the worker involved or the local authority as a whole, it illustrates the importance of ensuring emotional and mental health, is at the forefront of their focus. Although one can highlight the direct cause of criminality was due to F8’s drug dependency, the failures to appropriately intervene raises concerns of the approaches offered by the care leaver’s service.

The following excerpt highlights how she overcame such adversities:

“At eighteen I had enough of the violence, so the drug dealer across the road kicked him out for me. At this point, up until the January I was still drug dependant, I had enough and went to support groups to get clean and I did get clean, I managed a month and a half. I then ended up getting raped and then I relapsed. I moved away to get away from the man who did it to me, and ended up in a hostel in another town. I was still on the drugs at this point and then I realised I needed my family to help me. So my Nan agreed to have me there until I got myself sorted and as soon as I got back I had the strength and got clean and quit the stealing. It was hard, but I did it myself”.

F8’s narrative highlights her free will and strength to address the abuse she was facing and her drug addictions. Despite facing further abuse and a relapse, she continued to have perseverance and strength to change her life. Evidently, the choices were driven by her
own desire to take control of her addiction and behaviour, with no mention of assistance from the local authority. However, the importance of familial attachments is clear when F8 was unable to complete her rehabilitation alone and reached out to her maternal grandmother. With this support in place, F8 was able to get clean and stop offending.

8.1.6 Rebuilt Attachments and Reoffending

**Participant R5: Rebuilt Attachments**

<table>
<thead>
<tr>
<th>R5</th>
<th>2 (yes)</th>
<th>1 (no)</th>
<th>1 (no)</th>
<th>Crime throughout</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good Attachments but problematic</td>
<td>Lack of Attachment/ Non Secure – Further Damage</td>
<td>Rebuilt Attachments</td>
<td></td>
</tr>
</tbody>
</table>

“*It sounds silly but I rebuilt my relationships with people, I mean my Mum and Dad and then I felt good about myself. I guess all my problems seemed smaller because I had someone to share them with, someone who actually gave a shit. Nothing has all of a sudden changed to make us into a perfect family, but we are a family and that is what counts. I still screw up sometimes, but it is different now as I care what happens to me, something I have not felt in a long time.*”

R5 highlights his behaviour to have changed, due to receiving a custodial sentence and increased self-esteem, gained through rebuilding attachments. However, it is important to understand successes in terms of: the reduction of severity and frequency of offending, rather than expectations to cease offending altogether. R5 acknowledges “*I will screw up sometimes, but it is different now as I care what happens to me, something I have not felt in a long time*” highlighting the absence of feeling ‘cared about’ during care. Although R5 does not state that his attachments influenced his offending during and after care, his in verbal accounts allow links to be formed. Despite the inconsistencies of these findings, in relation to causation or heightening risks of offending, there is clear evidence of the failings to provide and/or encourage attachments during care. Such findings, again present
concerns of the ability for residential care to go beyond the safe guarding of young people and ensure they are not only ‘cared for’ in a practical way, but ‘cared about’ to ensure they are able to ‘care for themselves’ during their transition to adulthood.

**Participant F3: Rebuilt Attachments**

<table>
<thead>
<tr>
<th>F3</th>
<th>3 (yes)</th>
<th>3 (yes)</th>
<th>3 (yes)</th>
<th>Open prison and lots of offences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lack of Attachment/Non Secure</td>
<td>Lack of Attachment/Non Secure – Further Damage</td>
<td>Rebuilt Attachments</td>
<td></td>
</tr>
</tbody>
</table>

F3 went to a YOI and upon his release, at the age of sixteen, he moved into his maternal grandmother’s residence. Although he had a good relationship with her, his behaviour did not change:

“I went to prison and come out when I was sixteen and went to stay at my nans. She really tried but I was still wild, you know and did not want to change so it was not enough. She had armed police kicking the door in and all sorts, I was too much so she couldn’t handle me which was fair enough, so she had to chuck me out and then I was homeless again for a bit and then I went to the hostel and that’s where I stayed until I got sentenced for this”.

The above excerpt highlights the difficulties in predicting lower levels of criminality based on presence of attachments. F3 provides an honest account of the challenges his maternal grandmother faced and highlights the reasoning of subsequent behavioural concerns, to be a consequence of his own behaviour and unwillingness to change. Although the concept of freewill is not frequent within the analysis, it raises important challenges in attributing criminogenic influences to the care system. This example does not associate his behaviour after care to be a product of his past experiences or lack of positive attachments, instead he takes responsibility for his actions, despite the presence of love from his maternal grandmother. When cross analysing F3’s narrative with the risk assessments, family
relationships were high risk throughout his life and he stated that they did influence his behaviour. His narrative does not suggest that the attachment was present; instead he highlights the familial relationship to not hold a capacity of discipline, which he needed. F3 goes on to describe other attempts to address his behaviour from the leaving care team:

“I have also had people take time to try and help me change, being hard on me to sort myself out but that never worked as I was not in that headspace to change. I guess at the time I didn’t want any help, I felt really low about myself and being able to change”

F3 shows awareness of people caring about his outcomes, acknowledging consistent help and investment into his life. However, despite both professional attempts, alongside his grandmothers, he did not have the confidence and motivation to change. Thus, one cannot state that the care system itself failed this participant nor can we conclude that a lack of attachment caused this outcome, instead it can be concluded that the respect and discipline from both the caregiver and professionals were unsuccessful due to F3’s lack of confidence and his perceived inability, and therefore unwillingness, to change.

At the time of interview, this participant was serving time for his part in the death of a member of the public, he reflects on his current position:

“I guess since I have come in here, I have started to rebuild things with my mum and got a lot of support, which has helped. Support is a massive thing, you know. I finally realised I needed help so I’ve got a leaving care worker and she’s been a good help. They have obviously funded me my courses. Again, she tried helping me when I was out there but I didn’t want to know. So I think having this practical support and the emotional connection with my mum that is what is keeping me focused and made me want to find a purpose and be a better man”.

Since receiving his sentence this participant became aware of the need to change and the importance of receiving support in doing so. The support described above is provided in
practical terms from his leaving care worker, with the emotional support from his birth mother keeping him focussed.

He then moves on to explain how this has helped him build the foundations to move forward and increase his life chances:

“The thing is out there I had no confidence, I had no self-esteem, so that’s a major thing if you haven’t got them two things, you can’t really function properly I don’t think, in anything you do in life and can easily go down the wrong path because you are scared of failure or whatever. But through my support and doing fitness and that, it’s built it up and that’s basically it. I hope I can take these skills to the outside and start a career, things are different now and people believe in me”.

F3 reflects on a time where he was scared to try anything, for the fear of failure and this closed many opportunities. Key developments can be noted in terms of transition from: a lack of confidence and attachment; to a developing attachment; self-esteem; and self-actualisation, a process that should be at the forefront of the care system throughout.

8.1.7 Moving On, Survivors and Victims

Not being able to overcome the difficulties faced in care leads to an increased likelihood of offending (Wade and Dixon, 2006). There are different pathways for care leavers; directly related to the quality of care they experience (Stein, 2006). It is important to examine the extent young people who offend fall into the ‘victims’ of the care system; possessing adverse life chances offering no resilience to crime.

The above analysis presents differing experiences after care, across those who experienced kinship, foster and residential placements. This final section looks back at Stein (2006) and his research on care leavers. His work, presented in a resilience framework, shows care leavers fall into three groups and can be used to categorise the above experiences. The three groups are as follows:
Firstly, a ‘Moving On’ group that possessed stability, attachments, educational and transitional successes and whose existence can be interpreted as reflecting resilience enhanced by being in care. This group can be evidenced within those who were in possession of attachments during and after care and/or did not offend throughout their care experience.

The second group ‘Survivors’ possessed instability, movements and disruptions leading to fewer qualifications and early transitions affecting their life chances. This group can be evidenced within those who did not experience secure attachments during care but regained them after and/or did not offend after care.

The third group ‘Victims’ experienced high levels of instability, no qualifications and had profoundly compromised transitions into adulthood resulting in poor life chances. This group can be evidenced with those who did not experience attachments and/or offended after care.

Tables 20-22 provides the transitional outcomes for all care leavers, measured in terms of experiences of attachments and offending behaviour. Although Stein (2006) measures the overall outcomes of those leaving care, separating such outcomes allows the analysis to confirm both the link between attachments and offending, whilst also providing a summary of the likelihood of future offences to be carried out.
### 8.1.7.1. Residential Participants

#### Table 20: Residential Participants: Transitional Outcomes for Attachments and Offending

<table>
<thead>
<tr>
<th>Participant</th>
<th>Before Care</th>
<th>During Care</th>
<th>After</th>
<th>Transitional Outcome: Attachment</th>
<th>Transitional Outcome: Offending</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1</td>
<td>3 (yes) Lack of Attachment/Non Secure</td>
<td>3 (yes) Lack of Attachment/Non Secure – Further Damage</td>
<td>2 (no) New Attachments</td>
<td>Survivor</td>
<td>Victim</td>
</tr>
<tr>
<td>R2</td>
<td>3 (yes) Lack of Attachment/Non Secure</td>
<td>3 (yes) Lack of Attachment/Non Secure – Further Damage</td>
<td>2 (no) New Attachments</td>
<td>Survivor</td>
<td>Survivor</td>
</tr>
<tr>
<td>R3</td>
<td>3 (yes) Attachment but problematic</td>
<td>3 (yes) No new attachment but Increase Attachment with Mum</td>
<td>1 / 2 (no) New Attachments</td>
<td>Survivor</td>
<td>Victim</td>
</tr>
<tr>
<td>R4</td>
<td>3 (yes) Attachments but problematic</td>
<td>3 (yes) Lack of Attachment/Non Secure – Further Damage</td>
<td>3 (yes) Lack of Attachment/Non Secure – Further Damage</td>
<td>Victim</td>
<td>Victim</td>
</tr>
<tr>
<td>R5</td>
<td>2 (yes) Good Attachments but problematic</td>
<td>1 (no) Lack of Attachment/Non Secure – Further Damage</td>
<td>1 (no) Rebuilt Attachments</td>
<td>Survivor</td>
<td>Victim</td>
</tr>
<tr>
<td>R6</td>
<td>3 (yes) Lack of Attachment/Non Secure</td>
<td>3 (yes) Lack of Attachment/Non Secure – Further Damage</td>
<td>3 (yes) Lack of Attachment/Non Secure – Further Damage</td>
<td>Victim</td>
<td>Survivor</td>
</tr>
</tbody>
</table>
Four out of the six residential participants were categorised as ‘Victims’ of the care system within their offending categorisation, three of which were categorised as ‘Survivors’ within the attachment category and were in receipt of at least one attachment after care. The remaining participant, who offended after care, had an attachment category of a ‘Victim’ of the care system with no evidence of attachments during or after care.

The remaining two participants had an offending category of ‘Survivors’ of the care system, showing their offending to stop after leaving care. Of these participants, one also had an attachment category of ‘Survivor’, with new attachments made after care. The final participant’s attachment category was as a ‘Victim’ of the care experience, with no attachments made throughout their care experience.

Despite four of the six participants gaining attachments after care, they still offended. This raises questions on the ability of attachments alone to protect the residential participants from offending. Furthermore, only one of the participants offending patterns reduced after care, providing further illustrations on the impact of attachments in reducing offending behaviour. However, whilst looking at the extent to which the care experience can heighten the risk of criminality, none of the residential participants experienced attachments during care. This observation lends evidence to the criminogenic influences of care, with a lack of focus on the emotional needs of the young person which evidently influences on behaviour. However, one can observe the positive transitions out of care, with four out of six participants, highlighting a lower overall risk of offending due to their accountability to others and sense of belonging.

The remaining participants did not commit offences after care. One built new attachments after care and linked this to their behavioural change and the other was not able to build attachments and still did not offend. These participants provide a stronger link to the care experience, attachments and offending, with their behaviour changing after care despite a lack of attachment for one of the participants. Therefore, one can conclude that there is
evidence of a link between attachment and offending but this cannot be determined as the sole predictor.

Looking at the residential participants as a whole shows five of the six participants experiencing a positive change after care. Although only one can be noted to have positive outcomes with both attachments and offending, the remaining four show positive outcomes in one of the categories. This provides conclusive evidence of the improvement of life’s after individuals leave residential care.

8.1.7.2 Kinship Participants

Table 21: Kinship Participants: Transitional Outcomes for Attachments and Offending

<table>
<thead>
<tr>
<th>Participant</th>
<th>Before Care</th>
<th>During Care</th>
<th>After Transitional Outcome: Attachment</th>
<th>After Transitional Outcome: Offending</th>
</tr>
</thead>
<tbody>
<tr>
<td>K1</td>
<td>N/A</td>
<td>1 (no) Secure attachment</td>
<td>1 (no) Secure Attachment</td>
<td>Moving On</td>
</tr>
<tr>
<td>K2</td>
<td>1 (no) Attachments but problematic</td>
<td>1 (no) Secure Attachment</td>
<td>1 (no) Secure Attachment</td>
<td>Moving On</td>
</tr>
<tr>
<td>K3</td>
<td>3 (no) Lack of Attachment/ Non Secure</td>
<td>1 (no) Secure Attachment</td>
<td>1 (no) Secure Attachment</td>
<td>‘</td>
</tr>
<tr>
<td>K4</td>
<td>1 (no) Secure Attachment</td>
<td>1 (no) Secure Attachment</td>
<td>1 (no) Secure Attachment</td>
<td>Moving On</td>
</tr>
</tbody>
</table>

Half of the participants offended throughout their care experience, highlighting their offending outcome to be categorised as ‘Victims’ of the care system. Both of these participants, had attachments throughout their care experience, highlighting their category to ‘Moving On’ as they experienced progress within care.
The remaining participants were categorised as ‘Moving On’ with reference to both attachments throughout care and non-offending.

All of the participants within this placement type had attachments during and after care, with half of the participants committing crime throughout their care experience. When addressing the extent to which kinship placements are criminogenic, using the ability to rebuild or develop attachments, this placement type cannot be considered to heighten the risk. In addition, whilst looking at the self-assessment of whether family and personal relationships influenced their behaviour, all of the kinship participants stated this was not of a concern. Therefore, looking at attachments alone cannot predict their offending.
## 8.1.7.3 Foster Participants

Table 22: Foster Participants: Transitional Outcomes for Attachments and Offending

<table>
<thead>
<tr>
<th>Participant</th>
<th>Before Care</th>
<th>During Care</th>
<th>After</th>
<th>Transitional Outcome: Attachment</th>
<th>Transitional Outcome: Offending</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>3 (no)</td>
<td>1 (no)</td>
<td>1 (no)</td>
<td>Secure Attachment</td>
<td>Moving On</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/ Non Secure</td>
<td>Secure Attachment</td>
<td>Secure Attachment</td>
<td>Moving On</td>
<td></td>
</tr>
<tr>
<td>F2</td>
<td>1 (no)</td>
<td>1 (no)</td>
<td>1 (no)</td>
<td>Secure Attachments with Friends</td>
<td>Moving On</td>
</tr>
<tr>
<td></td>
<td>Secure Attachment</td>
<td>Secure Attachments with Friends</td>
<td>Secure Attachment</td>
<td>Moving On</td>
<td></td>
</tr>
<tr>
<td>F3</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>Lack of Attachment/ Non Secure – Further Damage</td>
<td>Survivor</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/ Non Secure</td>
<td>Lack of Attachment/ Non Secure – Further Damage</td>
<td>Rebuilt Attachments</td>
<td>Victim</td>
<td></td>
</tr>
<tr>
<td>F4</td>
<td>3 (yes)</td>
<td>2 (yes)</td>
<td>1 (no)</td>
<td>New Attachments</td>
<td>Survivor</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/ Non Secure</td>
<td>Lack of Attachment/ Non Secure – Further Damage</td>
<td>New Attachments</td>
<td>Survivor</td>
<td></td>
</tr>
<tr>
<td>F5</td>
<td>3 (yes)</td>
<td>2 (no)</td>
<td>1 (no)</td>
<td>Secure Attachments</td>
<td>Moving On</td>
</tr>
<tr>
<td></td>
<td>Attachment/ Non Secure</td>
<td>New Attachments</td>
<td>Secure Attachment</td>
<td>Survivor</td>
<td></td>
</tr>
<tr>
<td>F6</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>Lack of Attachment/ Non Secure – Further Damage</td>
<td>Victim</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/ Non Secure</td>
<td>Lack of Attachment/ Non Secure – Further Damage</td>
<td>Lack of Attachment/ Non Secure – Further Damage</td>
<td>Victim</td>
<td></td>
</tr>
<tr>
<td>F7</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>3 (yes)</td>
<td>Lack of Attachment/ Non Secure – Further Damage</td>
<td>Victim</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/ Non Secure</td>
<td>Lack of Attachment/ Non Secure – Further Damage</td>
<td>Further Damage</td>
<td>Victim</td>
<td></td>
</tr>
<tr>
<td>F8</td>
<td>1 (no)</td>
<td>2 (no)</td>
<td>1 (no)</td>
<td>Further Damage</td>
<td>Victim</td>
</tr>
<tr>
<td></td>
<td>Attachment</td>
<td>Lack of Attachment/ Non Secure</td>
<td>Further Damage</td>
<td>Victim</td>
<td></td>
</tr>
<tr>
<td>F9</td>
<td>2 (yes)</td>
<td>2 (no)</td>
<td>1 (no)</td>
<td>Secure Attachments</td>
<td>Moving On</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/ Non Secure</td>
<td>New Attachments</td>
<td>Secure Attachments</td>
<td>Victim</td>
<td></td>
</tr>
<tr>
<td>F10</td>
<td>2 (no)</td>
<td>1 (no)</td>
<td>1 (no)</td>
<td>Secure Attachments</td>
<td>Moving On</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/ Non Secure</td>
<td>New Attachments</td>
<td>Secure Attachments</td>
<td>Moving On</td>
<td></td>
</tr>
<tr>
<td>F11</td>
<td>3 (yes)</td>
<td>2 (no)</td>
<td>1 (no)</td>
<td>Secure Attachments</td>
<td>Moving On</td>
</tr>
<tr>
<td></td>
<td>Lack of Attachment/ Non Secure</td>
<td>New Attachments</td>
<td>Secure Attachments</td>
<td>Survivor</td>
<td></td>
</tr>
</tbody>
</table>
This placement presents the most complex analysis, with 6 variations experienced. The first three variations consist of six of the eleven participants to be in possession of positive outcomes in terms of attachment and non-offending, at the time of interview. Three of the eleven participants show the entire care experience to be positive, with attachments and non-offending throughout and were therefore categorised as ‘Moving On’ for both transitional observations. Such findings lend evidence to the value of the care experience in allowing the young person to move forward and increase their life chances, therefore not providing links to criminogenic influences. Further positive experiences can be shown, with two participants being shown to have gained attachments throughout their care experience, again being shown to have a ‘Moving On’ status. Although both of these participants offended whilst in care, their behaviour changed after exiting the care system, allowing them to be noted as ‘Survivors’. The remaining participant who had positive outcomes after care, experienced no attachments and offending during care but both changed after exiting the care system, allowing this participant to be a ‘Survivor’ of the care system.

The remaining five participants offended throughout their care experience, during and after care, therefore were categorised as a ‘Victim’ of the care system. Three of these participants, also had concerns with attachments throughout their care experience and were therefore noted to be a ‘Victim’ with relation to the care system’s assistance with their family and personal relationships. One participant experienced attachments throughout their care experience and therefore was recorded as ‘Moving On’ with their placements allowing new attachments to be built. However, this participant offended throughout and therefore in terms of behavioural outcomes, they were categorised as a ‘Victim’ of their care experience.

The final participant experienced attachments after care, and therefore was categorised as a ‘Survivor’. The framework of analysis does not fit this participant’s trajectory, as his
narrative highlights two stages of after care: before and during prison. Therefore, his self-assessment stated he offended after care allowing a ‘Victim’ status, but this was before his attachment and his prison sentence. This participant was in prison at the time of interview, and therefore was not offending.

The foster participants can be separated into two categories, with six participants being in receipt of attachments and non-offenders after leaving care. Three of these participants highlight the positive influences foster care produced, with attachments being apparent throughout their care experience and no evidence of offending recorded during and after care. Such findings present foster placements in a positive light and highlight their ability to provide the foundations to improve the life chances of the young persons who enter such placements. However, the remaining three participants do not provide evidence of foster placements being positive in terms of attachments and non-offending, although two of these participants gained attachments in care their offending only stopped after care. Therefore, these observations show differing conclusions; the foster placements have allowed positive changes within these young people’s family and personal relationships, however this was not enough to positively influence their behaviour. Thus, one can highlight the need to consult more than attachments and also question why their behaviour suddenly changed after care. The final participant had negative experiences during care, in terms of lack of attachments and offending behaviour. However, both of these experiences changed after they exited care. This finding raises severe concerns on the quality of the care they received, with a life after care to be directly in contrast to the experiences they received during care.

The remaining five participants offended throughout their care experience, during and after care, therefore one can conclude that their care experiences were concerning. Three of these did not have attachments during or after care, with these participants raising more
prominent concerns relating to their foster placements, with the legacy of their experience in care carrying on during their transition to adulthood.

The final two participants present difficulties in concluding the extent to which their care experiences enhanced the likelihood of offending. The first experienced attachments throughout, with this measurement their care experience can be noted as positive, but they offended throughout, which raises questions on the extent to which their attachments influenced their offending. The final participant presented a different outcome in terms of attachment, with possession of attachments only being apparent after care. Due to this participant only developing his attachments whilst in prison, one cannot state how this has influenced his behaviour in the community. However, one can conclude these attachments have motivated this participant to change, something which was not noted until he was receiving support from his leaving care workers and a relationship with his birth mother.

8.1.7.5 Conclusion

Through analysing the attachments and offending after care, one can conclude that those who only gained attachments after care and ceased to offend can directly provide evidence of the failings of the care system, in providing the love and belonging so desperately needed. In contrast, those who experienced attachments throughout care and did not offend, promote the quality of care offered within the UK, although only evident though foster and kinship placements. The remaining trajectories offer differing interpretations of the care experience, with those showing one or both outcomes to improve after care, offering evidence of limitations of the care experience. The trajectories with no positive change after care, in one or both outcomes, provide a less clear link of care to criminality, although it can be argued that the legacy of in care experiences is to blame.

It must be noted, that despite the often poorer conditions faced after care, no participants experiences declined after care, shown through loss of attachments or an increase of
offending. Therefore, except the participants who had positive experiences throughout their care experience, the remaining participants do not reflect the care experience as a protective factor, as without care their offending did not get worse.

The above analysis was carried out whilst taking the age crime curve into account. All of these participants left care between the ages of 16 – 18 years old and can therefore still be categorised under a higher risk of offending (Hirschi and Gottfredson, 1983).

8.2 Transitioning into Adulthood and Attachments: Observations by the LCT and Carers

This final section allows the experiences of the LCT and carers, to be discussed both in response to the same themes highlighted above and offering any additional themes present within their narratives, as a consequence of poor attachments. This analysis does not include all nine carers, due to non-contact with those whom they cared for, within the exception of kinship carers. The absence of contact after leaving their care is important to note, as this highlights the processes apparent within the care system. In addition, only one kinship narrative is available, with the CK2 and CK3 still providing placements for their nieces and nephews, respectively.

The aim of this final section is not to question the care leavers experiences, instead it aims to provide a clear overall analysis, identifying the challenges faced amongst carers and the ability of those in caring and professional roles to assist.

8.2.1 Positive Experiences

Participant CK1

“My girls have blossomed and have done really well for themselves. They have even said that they are so pleased they were put into my care, as they have seen how their mothers other children have turned out. It is so rewarding to know the correct choice was made for them and how they have never gone without love. They were both troublesome teens and
rebelled in the usual way, but always responded when they knew they had let me down. So I think this has played an important role in shaping who they are, they value me and our relationship and I will always be here for them”.

The above excerpt reflects on a very successful placement, showing the true value of being placed within the family (Winokur et al., 2009). There are two clear messages presented, reflecting on the importance of a secure attachment in overcoming earlier experiences and the impact these attachments have on behaviour. This narrative starts with a reflection of CK1 referencing her granddaughters as “my girls “showing a strong connection and reinforcing the strength of their attachment and overall relationship, with the two granddaughters having “never gone without love”. Furthermore, CK1’s ability to provide an unconditional bond and a safety net, allows her emotional support to extend after the placement and in turn providing security and belonging for her granddaughters.

The success of this placement is not only evident within CK1’s reflections of the strength of the placement, but also her direct reference to her granddaughters acceptance of the placement “they are so pleased they were put into my care, as they have seen how their mothers other children have turned out”. Evidently the relationships presented have allowed the granddaughters to move forward from their troubled past and have been able to respect the direction and guidance offered by CK1, assisting their behaviour.

The above narrative offers a positive portrayal of care and the importance attributed to attachments: to overcome adversity and allow discipline and direction, throughout a young person’s life. The next section offers a contrasting experience, with CF1’s narrative discussing the challenges between attachments made within her care and the disorganised and ambivalent attachment with the young person’s birth mother.
8.2.2 Attachments and Offending

Participant: CF1

“I often do not see this outcome, but when I did with Joe he got worse. He had moved into his mams house, a place he wasn’t allowed to go since he was taken away. I found this hard, but this is where he wanted to go, despite me telling him of my worry. I just wish I could have had him to stay with me, but he wanted it to work out so badly and to have a normal family. I had my misgivings because I know the damage his mum did to him, all those years ago. I was at my wits end and in the end, rightly so. He had been stealing cars and committing lots of petty crime. In the end we lost touch; I am so sad as he was the one kiddie who had such a stable place with me, for eleven years. He meant a lot to me but I guess no matter what I did, he wanted his mam and all she was. I hope one day he will get back into touch, just to see how he is getting on”.

CF1 looked after Joe for eleven years and in doing so, gave him a stable upbringing. The extension of care offered provides evidence of the attachment present, with CF1 stating how much he meant to her, but the desire for a relationship with his mother was overpowering. Unfortunately CF1’s doubts were confirmed and Joe, after experiencing eleven years of stability and guidance, moved towards criminal activity. One cannot state that his behaviour was a direct result of his new relationship with his mother, but conclusions can be drawn on the importance of a biological attachment and the negative consequences of a problematic attachment. This insight allows an acknowledgement of the limitations of non-familial attachments and the inability for the care system to extend restrictions beyond the young person’s time in care. Such findings present a complex relationship between what the care leavers needs emotionally and the living arrangements needed to reduce the likelihood of criminality.
The remaining carers share their experiences to include prolonged concerns within the availability and quality of attachments during a young person’s transition to adulthood, and the increased concerns of behaviour:

8.2.3 Attachment Concerns: Impact of Previous Experiences

Although CF2 now specialises in intensive fostering, she starts by offering insights into her experiences as a foster carer:

**Participant: CF2**

“*The children have problems with their self-worth and a lack of consequences for the actions to others and this often is the case when they leave care. I totally understand this, they feel alone and do not care for others; not all of the children I have looked after are like that when they leave but many are. It is so sad, as people do care for them, me being one of them. But even with the best intentions their experiences before care influence how they respond in care and this can shape how they are after care. They just want to belong and no one can wave a wand or turn back time, we can only try and deal with the consequences of their past and often we do not have long”.*

There is a strong emphasis made to both the emotional concerns apparent and the lack of consequences as a result of troubled relationships. CF2 highlights that despite providing a caring environment, the negative experiences before care have a legacy, often into their adult life. Furthermore, CF2 acknowledges the restrictions of standard foster carers to be able to have the time and resources to address both emotional and behavioural concerns, which will inevitably cause further problems. When asked to reflect on her experiences as within intensive fostering, she highlights the following:

“*Yes the support is there and many children do really well. But there is limited time in the placement. I think this need to change and/or every foster carer should be trained. If they were, then they wouldn’t need to give up on a child, instead they would have the*
mechanisms to go through the behavioural journey with them and hopefully make changes. I am yet to be able to reflect on the impact of intense fostering and its implications on adult life and behaviour but it has to be better than a placement that is not intense. So this should be extended to all young people who show early signs emotionally or behaviourally”

Whilst reflecting on her current work as an intensive foster carer, CF2 urges for an extension of such placements. Although she is unable to evidence the success of this placement type against her previous foster placements, she voices the need to incorporate the streamlined training within all foster carers and/or extend the fixed durations within intense fostering, to allow carers to go on a full journey with the young person, allowing the time and attachments needed to fully address pre care experiences.

“I think the damage is done, you know way before the children are put into care. I think the system is given an impossible task to undo all the wrongs they have experienced or seen. At best, we can give them the mechanisms to try and come to terms with these wrongs. But for many who do not experience intense programmes, either because of their age or behaviour or expressions of emotions are not bad enough at the time, well these children are so very damaged and this tends to live on through their time in care and often after they leave”.

This narrative focuses on both CF2’s experiences as standard foster carer and her current roles specialising in emotional and behavioural concerns. Regardless of the interventions in place, a carer cannot undo previous experiences but can aim to give a young person the mechanisms to address the trauma, during their time in care.

CF2 concludes:

“I guess the legacy of being put in care carries on. It carries into their experiences within care and how they struggle to adapt right through to when they are adults. If this is an
issue within care, it is even more likely to be an issue after they leave care. There is less support after they leave care, well emotionally anyway. So if they did not want help or failed to receive it, then I fear their self-worth and esteem could be damaged a lot. I guess, even though the children I have looked after to date rarely like me, they still got attention from me and knew I had an interest in them – that goes, and all they have is a leaving care worker”.

This concluding narrative offers evidence for the need to acknowledge the impact on pre care experiences in line with the reduction of support after care. Analysing the two concerns together, allows firm conclusions of the increased likelihood of emotional and behavioural concerns, with support often being limited in practical terms during the young person’s transition to adulthood. CF2 also highlights the importance of having an constant authority figure in a young person’s life, even without attachments, as a care giver’s attention and commitment to the young person is shown through their everyday contact, something which cannot be provided by a leaving care worker. This finding is not to advocate leaving care workers to mirror the frequency of carers, instead it raises the need to ensure the care system equips the young person with the resilience to cope with the inevitable transitional to adulthood.

The final excerpt from CR2 seeks to explain why pre care experiences hinder developments of attachments within care and the subsequent impacts on the trajectories of behaviour.

**Participant: CR2**

“I think a lot of the problems after care come from the concerns faced within care, with decisions often being challenged as they have little to no respect for others. If they do not understand and trust we are doing the right thing and do not respect our boundaries then they go against them and get into trouble. But then again, it must be hard to trust after being let down by your biological parents and then not finding what fills that relationship.
So yes, I think we do try and help them in care and people try after, but sometimes the things that happen before the system are what haunt them”.

Despite the efforts of residential staff, young people often do not understand the importance in focusing on dealing with past trauma, often questioning and challenging such advice. This mistrust in the system can be linked to challenge the system further, pushing the boundaries which can result in additional behavioural concerns. This narrative does not seek to blame the young people; instead it goes on to express an understanding of the reasons behind young people’s mistrust both during and after care. The central message within this narrative is the need for both understanding and persistency whilst dealing with young people, particularly those who not only face attachment difficulties before care, but also have experienced numerous failed foster placements. This focus will firstly allow the foundations of trust to be made, to then build a stable connection which will increase the likelihood of a young person to express the reasoning’s behind their emotional and behavioural concerns, which present consequences into their adult lives.

In line with the analysis of the carers concerns with emotional and behavioural outcomes after care, participants from the LCT provide similar reflections. However, their responses provide responses to the concerns, allowing an analysis of the extent to which the leaving care service can reduce the impacts of previous experiences, before and during care.

**Participant: LCT 1 Education**

“I think the problems with relationships are very much still there and possibly getting worse as they are dealing with adulthood, so yes I think having such problems does not help their behaviour. They have no one to let down I suppose and will often challenge us when we try and intervene or assist. In addition you have to see the time period we work with these young people, if they are not dealt with during prolonged periods in care, for instance, then we are already against the odds in trying to resolve them”.
LCT 1 echoes the concerns with relationships after care and the impact on behavioural outcomes. Furthermore, the narrative highlights the position of the leaving care team in addressing such concerns, with reflections of care leavers often challenging their directions whilst trying to intervene or assist. Whilst taking into consideration the experience from all participants: care leavers, carers and the LCT, the common theme of pre care influences is paramount. However, whilst analysing the position of each participant type, you can divide them with emotional responses, from care leaver and carers, and practical responses from the leaving care workers, whom provide the continual support into adulthood. It is not to say that either response is more valuable than the contrary position, instead it allows a full analysis to be made. With this in mind, one can conclude that leaving care workers do strive to address concerns surrounding attachments and behaviour, yet raise the question on the expectations in doing so, in particular when a care leaver has yet to receive or is willing to address such concerns during care.

LCT 2 provides further illustrations of these expectations:

**Participant: LCT 2 Manager**

“When you are talking about coming to terms with traumatic events that can take years or even a lifetime. Some people can never trust again. It’s always there and I think it would be hard to suggest that just because a young person has been in care, that we would be able to address all the emotional and mental health issues. So much damage is done and that continues and I do think that has an impact on offending behaviour throughout”.

Taking the above excerpt, whilst looking at the extent to which the care experience influence offending, provides a practical response to the expectations we push onto the care system. LCT 2 highlights the difficulty in upholding such expectations, with traumatic events sometimes never fully dealt with. It is vital to take such practicalities into consideration, as had a young person with trauma not have been placed into care, the
outcomes could be the same or more severe. Again, such reflections allow challenges of the blame attributed to care causing behavioural concerns and instead provide further evidence of the influences being a direct consequence of their traumatic experiences before care. However, this does not mean that the care experience is not in possession of flaws, with the window of change more apparent during care, with a decrease in success attributed to age.

LCT 2 concludes:

“All of the values, beliefs and the rights and the wrongs and the responsibilities need to be in place. The seeds have got to be sewn and you have got to make your own decisions and just because you’re eighteen doesn’t mean you will be able to do that, the risk to fall back into a pattern is quite high”.

The extent to which the care experience can ensure values are in place is of vital importance. However, as LCT 2 highlights these “seeds have got to be sewn” once a young person faces their transition to adulthood, with many not in possession of such values and this will increase risks of offending. As presented throughout this chapter, the inability for those in care to be provided with and/or be open to attachments, result in a limited ability of carers and staff to have the respect needed to inform such values. The legacy of such limitations is reflected to increase the risk after care, raising questions on the experiences during care. This provides further evidence, of the inability of many placements to address the pre care concerns, causing problems within the transition into adulthood.
8.2.4 Transitional Concerns

This section moves away from the legacy of pre care experiences and the implications to life during and after care, instead focusing on the transition to adulthood as sole focus. Two excerpts have been chosen, to allow illustrations from both foster and residential carers.

**Participant: CF1**

“Leaving a system, whether they liked it or not, a system which protected them from hurt to a certain extent, you know more protection than they will have outside of it, well that must tough. They tend not to have a family, so whatever family substitute they have had is gone after they leave care. I don’t think that helps them keep on the straight and narrow and make the right choices”

The central focus within CF1’s narrative is that of safeguarding concerns. Although this concept of safeguarding has been argued throughout this thesis, the central component of removal from harm is an element which has been upheld throughout the narratives of all participants. The removal of this component is concerning, offering comparisons to life after care with no family substitute and therefore no protection from harmful influences. Although this can be delayed by ‘Staying Put’, there will be an inevitable shift. Therefore, although the narratives expressed by foster carers do not highlight secure attachments with those whom they looked after, the basics concepts of being cared for are present and provide a level of protection against offending.

**Participant: CR1**

“When they leave our place and go to the supported accommodation or independent living, they do have support from the PA’s. PA’s are very different in their approach and support as compared to social workers and us, the staff at the home. I think this is a big problem as they have an even smaller network and are free to do as they please. There
needs to be more in place, a longer transition and bigger support network as they do not have family and if they do, they are not positive relationships. I know you cannot replicate a nurturing family, but they often have nobody and this causes so many problems for them when they have to totally fend for themselves at such an early age. People my age still need their parents; it isn’t something that disappears at eighteen”.

There is a clear need to extent the transitional stages for those who have experienced residential care. However there are many barriers, including the logistics of having over eighteens within a residential unit and the delay in an inevitable shift. However the following options have been discussed by Action for Children (2014: 2): care leavers remaining in the same home until they are twenty one; care leavers living in a separate building but in the same grounds as the children’s home they were in when they were in care, up until they are twenty one; to provide supported lodgings, this option is already used and involves removing the care leaver from the original care home at the age of sixteen up until the age of twenty one; and finally care leavers ‘staying close’, involving them living independently but close to the residential home they lived in, they will have a support worker who they know really well and are able to visit the home. These suggestions offer positive and equal opportunities for those who receive their final placement within a residential setting. The last option provides the best link for the analysis presented throughout this thesis, allowing a young person to have a significant other up until the twenty one. Furthermore, having the emotional support through their transitional period, moving into their own accommodation from sixteen to eighteen years old, will provide a period of three to five years of adjustment. Although, like the other alternatives, this option also is limited in time, instead of putting off the inevitable life after care, this placement type allows acknowledgments of life alone, with support gradually being reduced. Not only would this provide residential care leavers with equality within legislation, such developments could stand as examples to ‘Staying Put’ set ups within
foster placements. It is hoped, with such extensions of support, young people leaving both residential and foster placements, will have the support network to enable and encourage them to make positive choices.

8.2.5 Emotional and Practical Support

Participant: CF1

“I guess they face a lot of barriers, especially emotional neglect and not to mention the material goods they will have to go without. It is crazy as they are given so much within care, in the sense of belongings – maybe to feel the void of not being with parents. But the fact of the matter is that they then have to adjust to not having the latest trainers or stuff like that and this too can be problematic and increase crime for material goods. It is almost like belongings are a comfort or some kind of substitution”.

Although there is acknowledgement of a level of support, it is not noted to be sufficient. Instead, the narrative focuses on the change in support, with a reduction in emotional support and practical assistance, which was often used to fill the void whilst in care. Thus, not only do we see a direct decrease in emotional support, which increases the likelihood of behavioural concerns, the limit in practical assistance will also add to such concerns. Furthermore, the emotional concerns during care are stated to be concealed and/or addressed with material goods. Therefore, with both elements of support reducing, the previous heightened emotional concerns can no longer be addressed with practical gain. Instead, a young person is more likely to commit crime for financial gain, to further deal with their emotional concerns, with belongings seen as “comfort or some kind of substitution”. The idea of those in care seeing the system as instrumental rather than expressive has been discussed within Chapter Six, with this excerpt providing the link to increased risk of criminality after care.
The remaining participants discuss the restrictions in ensuring that both emotional and practical assistance is met:

**Participant: LCT 1 Education**

“Looked after children become independent at a very young age, so it is about trying to empower them. In terms of material assistance we do all a parent would do. Emotionally we are there to support them as well and try and make sure they are well and are accessing services. And you know, be there as a shoulder for them to lean on really and sometimes to cry on, quite often. We try and help them overcome barriers, but in terms of offending, it doesn’t necessarily work as I think it goes back to their emotional wellbeing and if they are ready to accept the things you have put into place”.

Unlike previous narratives, LCT 1 shares the importance of attempting to empower young people during their transitional periods, and in doing so offering support which would be expected from a familial relationship. This support is not limited to material assistance, and LCT 1 expresses the importance of being there “for [the young people] to lean on really and sometimes to cry on”. Despite such interventions and support, LCT 1 states that this is not always a solution; instead, one must acknowledge the emotional wellbeing and ability of a young person, as if they are not willing to work alongside the system then the interventions are likely to fail. As discussed in Chapter Seven, it is vital that the care system does not attempt to detract from the system’s responsibility to assist a care leaver.

The above narrative alludes to a system which puts suitable support in place: “it doesn’t necessarily work as I think it goes back to their emotional wellbeing and if they are ready to accept the things you have put into place”. However, the system needs to take responsibility for failure to assist the emotional wellbeing of a young person before their transition to adulthood. Therefore, although LCT 1 states that both emotional and practical support is apparent, it is key to note that the outcomes of care leavers need to be seen as a consequence of the support they received during their time in care.
The agency of a young person is a predominant factor, whilst highlighting the extent to which the care system increases criminogenic influences. LCT 1 shares her experiences of cooperation between the aims of the leaving care worker and the responses seen by care leavers:

“I think if the young person doesn’t want to take help they won’t. It is very individual and it is about how you work with them and build that relationship to encourage them to make them changes and take up the options that are available to them. You need to keep trying and keep offering. They may know they can commit a crime successfully and be good at that, they may well choose that. So I think the barriers if they are ready or not and their self-esteem and confidence. It takes quite a while for them to believe in themselves but when they do, they often will be ready to take on the harder path of changing”.

Although this narrative highlights the barriers in gaining trust from care leavers, it also shows the need for understanding and persistency. LCT 1 reflects on her experiences of doing both, never giving up and acknowledging the alternatives will often be more desirable than one’s current direction. However, through building their self-esteem and confidence, young people will often have the courage and motivation to change.

LCT 2 shares her experiences:

Participant: LCT 2 Manager

“Support is available to desist from offending. Everything is in their hands and nobody elses. However hard we work, we can’t make somebody else make positive choices. We can only lay the foundations, and they have got to do the building. There are foundations and we provide the blocks, so it is up to them if they knock them over or build them up”.

This narrative shows two clear areas in need of discussion, the support available within the ‘system’ for young people leaving care and the importance of the ‘individual’ in utilising these provisions.
LCT 2 highlights how the system has a responsibility to provide the foundations to assist a young person, through offering support and ‘building blocks’. However, little more is stated of the support in place. Therefore, the following section will provide a brief overview, as provided by the National Audit Office [NAO], to highlight the levels of support offered nationally.

Despite the continual efforts since 2000 (see Chapter One) there are still concerning outcomes for care leavers, with huge variations of support available within care leaving services, and many failing to provide the support care leavers desperately need (NAO, 2015). Although there has been improved monitoring of support offered, through separate Ofsted inspections (the first carried out in 2013), the results so far have been poor, with two thirds of inspected local authorities being either inadequate or requiring improvement. As of June 2015, only one out of the fifty-nine inspected local authorities were judged as outstanding, which is unacceptable and reinforces the ‘postcode lottery’ when determining the quality of support. There is clear evidence that states the support for care leavers varies widely between local authorities, with a range of support being estimated at between £300 and £20,000 (average of £6,250) per care leaver. However, there is no evidence of the relationship between how much is spent and the quality of the support (NAO, 2015). Not only is the financial support noted to be a concern, but so is emotional and practical support. In 2014, only 12% (n=8) of the local authorities (n=151) stated that they knew where all their care leavers were living and their EET status. This provides evidence of the inadequacy of the support, particularly for those who are likely to be more vulnerable.

The quality of support or ‘building blocks’ are not always positive, with many young people lacking adequate emotional and practical support from their leaving care services (NAO, 2015). Therefore, when looking at the quality of care, one must move away from taking the legislative developments and inspections as indicators of success, and
acknowledge that the system, in some local authorities, is failing to provide the necessary support to allow positive outcomes for their care leavers.

More needs to be known about the quality and components of these blocks, rather than them being taken at face value. One needs to measure the availability and quality of building blocks to allow a young person, during or after care, to build a positive future. Only if the support is acceptable can the care system be void of responsibility of the link between care and criminality.

Before moving on to the barriers presented by the LCT and carers, it is important to analyse the above quote and the individual responsibility attributed to care leavers to utilise this support.

“We can only lay the foundations, and they have got to do the building. There are foundations and we provide the blocks, so it is up to them if they knock them over or build them up”

How realistic is it to expect looked after children/care leavers to take sole responsibility for utilising the support provided by the leaving care team, given the potential failures of the system in addressing pre-care concerns and often providing further adverse influences?

Ultimately, the care leaver has to make the decision as to whether or not they choose to engage with the support offered. However, many care leavers will be a product of system failures throughout their time in care, and should not be made solely accountable for their inability to successfully engage with the support given. Instead, the young person should be met with an understanding of the reasons why they are unable to utilise the ‘blocks’ provided, with specific attention paid to the impact of both pre-care experiences and their life within care.
8.3 Barriers

8.3.1 Professionalism

Participant: LCT 1 Education

“It’s about knowing yourself as a professional. As you could hug someone and they could form an inappropriate attachment, it could make things worse. So as a professional you need to know really what’s right and what’s not right for a young person. I think everyone will say you offer that normal side to young people, not just the worker side. But if I have worked with a young person for a significant period of time and really offered a lot support and made a difference to them and they have trusted me through that period of time and it is time to say goodbye, if it is appropriate then I might give them a hug and say it has been lovely working for you and good luck and best wishes for everything. It is if I feel it is appropriate and that will be my judgement. A lot of people say it is best to be safe than sorry and probably wouldn’t, but if someone is crying in front of you is it really difficult, as a human being. I think you do have to be careful”.

LCT 1 shares her experiences to be based on judgement and in doing so highlights the flexibilities and realistic interpretations of appropriate relationships with care leavers. Her narrative offers examples of when emotional assistance was deemed appropriate, after forming a professional relationship with a young adult. Furthermore, offering her “normal side to young people, not just the worker side” reiterates normality for a young person and in doing so allows potential for mutual respect and trust. However, as LCT 1 points out, if a young person suffers from attachment disorders, then offering a more relaxed personable approach could be misconstrued and result in further damage, with a young person adjusting to this relationship and becoming reliant upon it. Therefore, the ability for leaving care workers to provide normality alongside their primary role of support, within their professional capacity, offers a great insight into the potential for trusting, stable
working relationships. However, such approaches may not always be appropriate and therefore many professionals are more comfortable in providing a role which is purely grounded within their professional capacity. Whilst it is evident, that care leavers are in need of secure and stable relationships, there are clear challenges to this, the risk of reliance of a leaving care worker as a sole source of support may provide a short term solution to emotional needs but in doing so, could result in further feelings of confusion when this relationship ceases to exist. Although many care leavers have the right to keep in contact with the local authority, after they leave care, their leaving care worker and the support they provide, is no longer funded and therefore any request in contact can be rejected. It is not to say that this is always the case, with care leavers often getting back into touch and meeting informally, but this can only be the case when the care leaver is of a level of maturity where it is deemed appropriate. Current developments are in place within The New Belongings Project (2016) with a local authority in the North West of England, offering a lifetime commitment to care leavers. This commitment is limited in its practical support but offers a base for care leavers of all ages to have a community of belonging. Such developments are welcomed and could assist many isolated care leavers, whom may have relied on leaving care workers throughout their transition to adulthood. Furthermore, having contact and updating the local authority on a young person’s progress, is a way of reconfirming a young person’s importance and therefore could assist in their life choices.

8.3.2 Window of Opportunity

Participant: LCT 1 Education

“Sometimes you cannot make a difference. We often only have a small window to try and help someone, in comparison to the time they spent at home and in care placements. They often, as an adult can still be carrying around with them at forty or fifty the trauma. So the
window you have to try and help them stand on their own two feet, form positive relationships and make positive life choices, is quite a tall ask”

LCT 1 provides an honest and realistic narrative of the inability of the care system, as a whole, to make a difference to the emotional and behavioural outcomes to all looked after children and care leavers. The impacts pre care experiences have been discussed in detail and its legacy is often carried out into adulthood, as reiterated here. However, when comparing the time spent before, during and after care, the transitional phase after care is limited and can vary between the following: 3 years (if the young person leaves care at eighteen and support stops at twenty one, due to non-continuation of education); 5 years (if the young person leaves care at sixteen and support stop at twenty one, due to non-continuation of education); 7 years (if the young person leaves care at eighteen and remains in education up until 25, although many local authorities support the young person until the course has finished) and 9 years (if the young person leaves care at sixteen and remains in education up until 25, with local authorities extending the services until the course has finished). Furthermore, The Children and Young Persons Act 2008 set out the responsibility for all local authorities to allow a young person to return to the leaving care services, up until the age of 25 should they want to continue their education (DfE, 2010b). The durations, based on the scenarios above, vary on average between three to nine years, with the longer periods allocated for those engaging in further and higher education. However throughout this thesis, it is evident that those who leave care earlier, often through an end to their support but sometimes through their own choice, are those who have higher concerns within attachments, emotional needs and behavioural concerns. It is not to say that those who are continuing education are not in possession of these concerns, but some level of stability and positive life choices are apparent. All care leavers need support, regardless of their educational achievements, with those who are NEET often being more likely to have poor relationships and higher levels of offending. Throughout
this chapter, the need for emotional and practical support is striking and the link to offending has been attributed in some cases. Therefore, the discrepancies between the levels of support offered can provide damaging consequences. Of course one has to acknowledge the economic implications, with leaving care services not being able to fund those who are NEET, due to the need for those over eighteen to claim mainstream government support, but this is not the sole need of a young person within their transition to adulthood. The need for emotional support, continual support networks and practical advice are striking, it is these elements which need to be offered to all young people up until the age of twenty five should they be needed, allowing a potential nine year transitional period for all care leavers. Through such developments, criminogenic influences could not be attributed to the leaving care services, but without such transparency and fairness, one can conclude that the limitations of support based on educational achievement favours those who are less likely to be the most in need of help.

8.3.3 Familial Influences

**Participant: LCT 1 Education**

“I know a young lady who we are working with now and doing everything we can for her, as soon as she has contact with her family, everything goes wrong and spirals for some time before we are able to stabilise things”.

The above participant provides evidence of the ability of familial contact to impede on the progress made with a young person. The power of the familial bond can be result in strong influences, which can often be negative and/or a continuation of harmful behaviour which can be attributed to the reasons why a young person was placed into care. Although family contact can be monitored in care, when a young person reaches adulthood there is no restrictions in place.
Participant: LCT 2 Manager

“I think however hard you work with a young person in the care system, there are still potential for family and personal relationships to have a massive impact on the young person. Some families do seek to sabotage, I know situation where contact with family is very significant for their behaviour and can have quite detrimental effect on the young person”.

Such evidence lends evidence of the powerful influences of, often problematic, relationships, as opposed to diverting influences of the leaving care service/care system. This narrative raises awareness of the limitations faced within the leaving care services, with little to no control on contact with biological family, a direct contrast to the legal conditions often placed whilst in care. It is unsurprising that those leaving care chose to regain relationships with their family members, and this is unlikely to change. All young people should leave care, with the ability to recognise positive and secure attachments, having the mechanisms to make positive choices and recognise the importance of the support workers within their transition to adulthood. There needs to be a balance between the need for love and belonging, alongside the practical advice from a trained professional. Although this thesis is advocating attachments to be crucial to the success of the care system and the outcomes for young people, these should not be at the expense of the professional’s direction. Instead, they must exist together, with problematic attachments being carefully monitored during a young person’s transition to adulthood.

8.3.4 Prolonged Exposures and Emotional Trauma

Participant: LCT 1 Education

“Sometimes the damage is too great, so it is about helping them manage their life. Young people are often not ready because they still have many emotional issues which are massive barriers. Many come into care too late, what do you when you have a fifteen year
old who has no boundaries and feels no one cares about them? How you do then change their behaviour as a social worker, carer or leaving care worker?”.

As previously highlighted, the pre care experiences are reflected to be the most criminogenic influences to a young person’s behaviour and the most detrimental to their attachments. This finding provides further evidence of this, highlighting this to be a prolific concern amongst those who entered care later. Not only does this mean they have increased emotional and behavioural concerns during care, it makes the tasks throughout their care journey, into adulthood more difficult. Therefore, with such prolonged exposures to traumatic experiences, the expectations for the ‘in care’ and ‘after care’ services need to be reviewed. Whilst looking at the extent to which the care system heightens the concerns faced emotionally and behaviourally, one must take into consideration the length of time they have been in care. Thus, for those who have been in care for a longer duration, one can present stronger influences or failures to address such influences, by the care system itself. These conclusions are not to exempt the care system from any links to such outcomes; instead it allows realistic expectations whilst concluding on the criminogenic influences of the care experience.

**Participant: LCT 2 Manager**

“I don’t see that the care experience in itself encourages criminal activity. I think if you have a child who is incredibly damaged, who has been damaged by their previous experiences then I don’t think it is reasonable to expect the care system on its own to put it right. And it is an unreasonable assertion that it can indeed put things right, what it can do it provide the opportunity should that child decide to accept them, to change the path for that child but if you have got too much damage then there might just not be enough time to really be able to put it right and this becomes more difficult whilst under the leaving care team”.

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LCT 2 provides a narrative which directly responds to the questions of criminogenic influences of the care system. Instead of highlighting the care system to be criminogenic due to the inability of “the care system on its own to put it right” LCT 2 explains that the realistic expectation of the care system is to provide the opportunities for a young person, should they chose to accept them. This insight is particularly poignant to the central research question, allowing the measurement of criminogenic impact to shift from direct influences to failures to provide opportunities, during and after care. With this in mind, the evidence of criminogenic influences being apparent due to lack of opportunities is not as clear overall. For example, opportunities are present to lower risk of criminality, as shown within the risk and protective factors paradigm. However, if we look at the opportunities to form attachments, to allow successful experiences of these domains in life, the criminogenic influences are clearer and are shown to be of concern during and after care. Furthermore, acknowledgements must be made of the choice of a young person, to work with the system, with their unwillingness or inability to, providing further concerns. These findings will be discussed in detail within the concluding observations in the final chapter.
Chapter Nine
Discussion, Conclusions and Recommendations

9.1 Introduction
This chapter concludes the thesis. The research aims, objectives and questions will be discussed and the findings will be presented with key messages to inform policy and practice. Furthermore, the chapter will provide firm implications for future research needed, to assist with life chances of those who have been looked after and reduce offending for young people in care and after.

9.2 Care Environments and Criminality: The Reality
The previous chapters have presented key messages regarding the overall experiences throughout the care journey and their potential link to increasing the risk of criminality amongst the in care and after care population. The following sections will draw together the key points of analysis, whilst also providing key conclusions regarding preventions and interventions needed for young people before, during and after care. The conclusive evidence will provide ways forward in terms of attachment concerns and overall consequences, with a central focus on reducing offending.

9.2.1 The RPFP: Measuring Trajectories of Risk and Offending
When investigating the overall experience of risk and its impact on offending, residential placements were shown to be the most criminogenic, with the highest increase of risk ‘during care’ and reduction after care. Foster placement risk remains constant, showing concerns with the ability of foster care to reduce risk, while kinship placements show an increase ‘during care’ but are seen to be the least criminogenic, with 5/12 risk factors (half show 1/12 and half 9/12).
Residential participants were shown to have both the highest rates of offending and the biggest changes throughout each transition, showing an increase of mean from one to twelve, and then a sharp decrease to six on exit from the care system. The remaining figures were lower, and did not reflect such dramatic changes in offending profiles, and therefore as concerning images of the care system and criminality.

All participant groups showed Living Arrangements, Emotional/Mental Health and Family /Personal Relationships to be the biggest influence upon offending.

Although these findings highlighted the levels of concerns apparent by placement type, they did little to assist the understanding of ‘how’ the care system influenced these outcomes, either through their inability to address pre-care risks or by the further ‘adverse influences’ within the care system. Thus, although the RPFP and related risk assessments show the inability of care to minimise areas of risk within care, and highlight the areas of risk most prevalent, it is not clear as to ‘why’ this is apparent. The remaining findings provide explanations as to ‘why’ looked after children are experiencing such risks, with the central mechanism being measured through the presence and quality of attachments.

9.2.2 Attachments and Offending

9.2.2.1 Headline Findings

- Attachment underpins the experience of risk, with the exception of physical health.
- There were clear differences within institutional versus family settings, with long term foster care offering the same outcomes as kinship.
- All residential participants preferred this placement type, due to previous instability and internalised feelings of ‘not being capable of being loved’ directly impacting upon their behaviour.
- Having ‘no one to let down’ was the most cited reason for offending.
Attachments were also seen to be the biggest influence upon risk factors and overall offending.

The LCT acknowledges the impact of pre-care experiences, alongside the window of opportunity within care, and challenges the extent to which care can be deemed criminogenic.

9.2.2.2 Overview of Attachment and Offending

9.2.2.2.1 Importance of Attachments to Behavioural Outcomes

The first part of this section will look at the care leavers’ lived experiences.

Of those who lived with family members, half of the participants offended and the remaining did not. For those who did offend, they still acknowledged secure attachments to their grandmothers, and highlighted influences upon offending to be linked to anger and dealing with pre-care experiences. The importance of familial attachments was also prominent within two of the foster participants, with one participant attributing her happiness to her attachment to her maternal grandfather and the other expressing the importance of pre-care attachments to his family, allowing him to demonstrate resilience in the face of adversity. For those placed in foster care, the ability to replicate family environments was seen to be an important positive factor for young people, which assisted prosocial behaviour. Some individuals only gained attachments in care, highlighting the relief of finding a suitable placement to build attachments. These findings do not present the care system to be criminogenic, with attachments acting as a positive influence and protective factor against offending. Even those with attachments who offended acknowledged the central importance of attachments.

All residential participants were concluded to be a cohort of concern, with strong evidence of further impediments to attachments. These participants had varying durations in care,
with evidence of numerous failings of foster placements. The main finding showed an acceptance of ‘no one to love’ and a lack of belonging, making it easier to behave as they pleased, with no one to let down. Furthermore, this issue of being incapable of being loved provides a shocking contrast to the research domain’s focus on residential care and its ‘last resort’ status.

Through acknowledging the care leavers’ perspectives, we are presented with a distressing reality, with those who do not gain attachments and a sense of belonging having extremely low self-worth, perceptions of self and others and a preference of accepting life without attachments. Despite the preference for this placement type, all of these young people offended, and this is shown to correlate to the absence of secure attachments. These findings provide evidence of the importance of attachments and their link to criminality, with those in residential placements in need of intervention. The most crucial element is addressing the acceptance of ‘not being cared about’; these findings are horrific, and need to be brought to the forefront of social policy and academic debate. These young people felt this acceptance that they were ‘not cared about’ assisted their immediate emotional stability, offering them self-protection to avoid further internalised rejection, and an element of control. However, this was not seen to assist their resilience and improve their behaviour; instead, it escalated their behaviour and voided any acknowledgements of the consequences of their actions upon themselves and others. It is therefore crucial that research examines the importance of this internal coping mechanism when the social environment does not facilitate attachments, and what needs to change within the placement type to provide the tools to allow the young person to be resilient and less likely to offend (Ungar, 2011).

The foster participants, both male and female, had a variety of placement shifts, ranging from two to thirteen, and a range of different ages at the time of entering care, from four to fourteen years old. However, despite these differences, the conclusions remain similar. The
needs for secure attachments were striking, with the consequences of absence of attachments being of great concern both in terms of emotional stability and behavioural patterns. The young people expressed their thoughts and feelings to be directly linked to the absence of attachments, with high levels of isolation, often feeling unimportant and invisible. Such feelings were heightened within foster placements, with the young people often expecting to feel part of the family but finding this difficult to be fulfilled. Such conclusions are close to those presented by residential participants who had also experienced foster care, reinforcing the relief felt and sense of emotional protection when they were removed from an environment which encouraged the desire for attachments. The lack of attachments were shown to directly impact upon the young people’s ability to trust and respect their caregivers, resulting in huge barriers to discipline. The foster participants, like those who had experienced residential care, felt they had ‘no one to let down’, which was directly linked to their offending, and supports Social Control and Attachment Theories.

The quality of the attachment was presented as the most important predictor of offending, with some participants showing improvement in attachments and behaviour after care. The care leavers expressed these improvements to be as a consequence of having a ‘new start’ and being free from ‘careisms’, allowing control of their life and a chance to find direction themselves within their own lives. Through analysing the attachments and offending after care, one can conclude that those who only gained attachments after care and ceased to offend can directly provide evidence of the failings of the care system to provide these participants with the love and belonging so desperately needed. In contrast, those who experienced attachments throughout care and did not offend promote the quality of care offered within the UK, although this is only evident through foster and kinship placements. The remaining trajectories offer differing interpretations of the care experience, with those showing one or both outcomes to improve after care offering evidence of limitations of the
care experience in providing them with the suitable environments to assist their emotional and behavioural needs. The trajectories which show no positive change after care, in one or both outcomes, provide a less clear link between care and criminality. However, the care system’s inability to provide positive change within care is noted to be of concern. The social environment, in this case the placements which the care leaver experienced throughout care, is responsible for ensuring the young person is provided with the tools to facilitate resilience and prosocial behaviour. Not only will failure to do this impact upon their life within care, it can have detrimental effects on their life after care.

The LCT and carers offered similar views, with outcomes varying across placement types, highlighting better outcomes for kinship care and the most concerns within residential care. Those who enter foster care earlier and experience fewer placements can be seen in part to offend less, although this was not true for all participants. With those who experienced residential care being in most need of intervention, often as a consequence of a high volume of placement moves across foster settings, it is important to note that no participant went from kinship to residential settings, lending further support to the strengths of this placement type and the attachments present. The concerns of attachments, their influences upon the levels of risk and the subsequent link to criminality is not questioned. However, the ability for the care system to practically address these concerns, differs from the expectations of care leavers. Both the LCT and carers highlighted the impact of the pre-care experiences upon looked after children, and failed to acknowledge the system’s responsibility to address these concerns. If the system is unable to produce an environment which assists a young person, both emotionally and behaviourally, they should be made accountable for their failings.

Furthermore, the central measurement of criminogenic influences being based on the possession of attachment was something the LCT did not feel was fair, and referenced this requirement as unrealistic for all looked after children. Although one cannot expect
everyone in care to have loving relationships with their carers, the care system has the responsibility to uphold the safeguarding principles outlined in *Every Child Matters* (2003), ensuring every child is safe, happy, healthy, prosocial and able to achieve. Although we know the majority of this sample was ‘safe’, many were unable to recall happiness, and others were of real concern in terms of emotional health and behavioural outcomes. With this in mind, it is crucial that the social environment in which a young person resides provides the stability to ensure their experiences within care go beyond basic prevention from harm and towards ensuring a secure base that allows a sense of belonging.

The LCT and carers state that care does not cause criminality; instead, the criminogenic elements of care are associated with the inability of foster and residential care to address pre-care concerns and provide emotional and behavioural stability. However, these findings need to be challenged. Although they state that support is available, through providing the ‘building blocks’ for a young person to address both emotional and behavioural concerns, they claim that it is the responsibility of the looked after child or care leaver to utilise these ‘blocks’. If the system provides a young person with the appropriate ‘tools’ of support within an environment which works with the young person to utilise them, then they will have upheld their responsibility, and their care would not be noted as criminogenic. However, if the system fails to provide suitable support and interventions to address pre-care concerns and protect from further adverse influences, they are not void of responsibility, and instead have failed to provide the suitable environment to ensure emotional and behavioural stability.

Evidently, those in residential care face huge barriers to achieving meaningful relationships, and every effort has to be made to challenge this. The solutions for such concerns cannot be placed within a change of residential set up, for it is not realistic to expect staff members to take on this role. Instead, the changes need to come from within
the system. No young person should ever give up on the idea of forming attachments, and every effort needs to be made in assisting the emotional wellbeing of the young person, which in turn will assist with behavioural outcomes. Furthermore, these concerns were referenced by the LCT to be prevalent in many cases, however, the key response was not to blame the care system, but acknowledge the restrictions in place. For example, when a young person acts up or lashes out, the local authority has no choice but to move the young person, even when the carers are against this. However, the current system is fuelled with criminalisation of looked after children, particularly within residential placements, and therefore the system cannot be ‘blameless’ in these outcomes. It is their duty to ensure that looked after children are provided with suitable placements to address both their emotional and behavioural concerns. If these needs are not met, and the young person exhibits challenging behaviour, the young person is often moved on, causing further instability and in some cases unnecessary criminalisation. When this occurs, the care system is not only failing to address previous concerns, but also adding further criminogenic influences to the young person. The care environment needs to ensure they actively engage with young people, intervening with emotional and behavioural concerns from the onset. It is acknowledged that not all interventions will work, so when the system is presented with problematic behaviours they should move towards responsive parenting and away from criminalising the young person, allowing them to remain in the placement if suitable for them, and remain outside of the criminal justice system. Adopting responsive parenting measures will ensure that all carers understand that the behaviour presented by looked after children is often a response to previous negative experiences, and the importance of ensuring the placement is not broken when dealing with concerning behaviour (Wilson et al., 2003). Through adopting this parenting style the care system can ensure the young person is aware of their importance, despite challenging behaviour, and provided with a secure base to allow interventions outside the criminal justice system to take place.
Foster and residential carers, alongside the LCT professionals, echoed the concerns of placement breakdowns and feelings of difference being due to a lack of belonging. However, their experiences allow conclusions to be formed regarding the extent to which this can be helped. Foster carers gave detailed accounts of their willingness and longing for the young people to be part of their family, with residential carers facing barriers due to the clear status of a being a staff member.

The conclusions are clear, and very similar to those presented by the care leavers. There is a clear need for stability across the placement types and focus on ensuring all young people possess a sense of belonging. Furthermore, future work needs to focus on the differing experience of physical and emotional stability. Such focus will allow a clearer understanding of the mechanisms needed to ensure a young person’s stability is not only measured by the placement moves they experience, and highlight emotional stability as an outcome and clear predictor of offending behaviour.

Although there are successful non-kinship placements, there are key barriers. Within successful foster placements there are concerns with longevity and robustness of placements, with differences to what is expected within a family home. When behavioural concerns arose, placements were quick to terminate, and this often reinforced the feelings of rejection, a cycle to be presented fully within the models of understanding. However, there are TFCO-UK-A placements which focus on those with emotional and/or behavioural outcomes, with high levels of assistance working with the most challenging young people. Although these multidimensional approaches to care are welcomed, they too are limited. Although these placements will have many ways to address the emotional and behavioural concerns of a young person, there is a danger of further instability after the placement ends. Of course, the aim of MTFC is to prevent longer term emotional and behavioural problems, but this is not guaranteed, and when it does not work the cycle of
instability and its impacts upon the young person’s thoughts and feelings could impact upon their behaviour (Schofield et al., 2014).

There is an urgent need for multidimensional assistance within all placements. Every effort should be made to assist the young person in a way which best serves their interests, throughout their care experience. Thus, in-depth and well planned placements need to be at the forefront of policy development, to remove the risk associated with physical and emotional instability. It is hoped that with such developments, the less than desirable outcomes highlighted will be minimised.

Through the detailed analysis provided by carers and the LCT, one can conclude that there are system restrictions which present barriers to allowing all young people to experience secure attachments. This is down to the increased professionalization of the care system, which often discourages attachments to children in care, with the exception of kinship fostering (Marsh, 2008: 62). This is not to say that attachments are not valued, instead it highlights the position of the local authority in ensuring no further damage is experienced by the young person, as many placements, with the exception of kinship care, have the potential to break down, and therefore encouraging attachments can be seen to be harmful to both emotional and behavioural outcomes.

Evidently attachments have been a key predictor, indicating the need for young people in care to form meaningful relationships. However, the pre-care experiences coupled with the further failings of the system can often lead to young people having emotional instability, which puts them at a higher risk of offending. This is evident across both foster and residential placements, with the latter being more problematic. The aim of reducing criminality by providing such attachments is central to the research domain and social policy.
However, both the carers and LCT challenged the expectation of the care system to ensure emotional and behavioural stability for looked after children. They provided insights into the barriers, such as prolonged exposures to pre-care trauma. However, such observations cannot void the care system of responsibility. The very reasons for a young person being placed in care will present the care system with individuals who have experienced trauma, and to accept this as a barrier could be deemed fatalistic. Instead, the care system needs to acknowledge their responsibility and move away from the individual blaming approach which is so prevalent within research. A looked after child is placed into care to ensure they are protected and nurtured in a way which would be expected for non-looked after children. Failing to address the pre-care concerns, coupled with further adverse influences of the care system, such as instability and inappropriate reactions to behavioural concerns, does little to assist the young person, and suggests the care environment to be criminogenic.

9.2.2.2 Safeguarding and Maslow’s Hierarchy of Needs (1943)

The above conclusions highlight that care systems (at varying levels dependant on placement type) fail to produce a suitable environment for young people to develop meaningful relationships, therefore inhibiting the likelihood of resilience and increasing the risk of offending. The following section will highlight the ability of the care system to provide basic safeguarding principles and provide the needs attributed to self-actualisation, ensuring moralistic outcomes, free from offending.

When measuring the ability of the care system to provide ‘safety and security’, all participant groups stated their care experience provided ‘safety’. However, ‘security’ was noted by both the residential and foster care leavers to be of concern due to instability. The need to ensure all care leavers are ‘happy, healthy and free from poverty’ was partially upheld, with ‘health and poverty’ not being seen as a concerning factor within this sample.
However, emotional concerns were paramount within residential and foster placements, with all participant groups reflecting on a concerning level of unhappiness throughout their time in care. The ability of the care system to uphold the principle of ‘good education, fulfilling potential and ambitions’, was also seen as limited by both residential and foster participants. Again, the barrier to this principle being fulfilled was linked back to instability and low expectations, both of which have been shown to correlate with the presence of attachments. The final principle, ‘preparing the young person for adulthood with the ability to make positive contributions’, again was only noted to be partially fulfilled, with all participants except those who had experienced kinship care highlighting behavioural concerns impeding upon their ability to make positive contributions. As highlighted throughout this thesis, the strongest predictors of criminality within the care system are shown to be those who are hindered by pre-care experiences of problematic relationships and/or those who have emotional instability due to the care environment’s failure to address their pre-care concerns, or its production of further adverse influences. This coupled with the inability of the care system to uphold the basic safeguarding principles provides a disturbing depiction of the sample’s experiences, both in terms of wellbeing and risk of offending.

Through measuring the fulfilment of Maslow’s Hierarchy of Needs (1943) one can see the concerns within placement types and the impacts these have on the ability to possess self-actualisation with positive life outcomes. The model shows residential placements to be the most criminogenic in terms of providing the mechanisms of stability within this placement type, impeding these young people in fully fulfilling any needs beyond this point. Love and belonging is vital to ensure a young person has the mechanism in place to form esteem, and without these components there are real causes for concern. Foster placements do not hold the same level of concern, but the same conclusions can be used for this placement type, with stable caregivers promoting love and belonging being understood to also assist
this placement type. Although those in kinship care also offend, these conclusions do not highlight the care system as having failed these young people; instead, kinship care provides an example of the care system’s ability to provide the needs that are essential to positive outcomes. Therefore, these findings highlight the need to use Maslow’s Hierarchy of Needs (1943) to improve the monitoring of outcomes for those in care, alongside the safeguarding principles.

9.2.2.2.3 Attachment as a Critique: The importance of Attachments to Understand Risk

As highlighted within Chapter Two, both the use of the RPFP and its application within risk assessment and the importance of attachment theories are crucial when examining the link between care and crime. As evidenced within the findings, in both the quantitative and qualitative analysis both have provided strong conclusions of the impact of care upon criminal behaviour. However, the use of the RPFP as a sole measurement of criminality needs to be challenged, with its failure to acknowledge attachments at the forefront of its risk assessment.

Furthermore, the interview schedule, which was predominantly based on the twelve risk factors, constantly referred back to the influence of attachments upon the high levels of risk. Thus, the experience of limited, non-existent or problematic attachments increased the likelihood of many risk factors. Although the RPFP allowed a clear representation of the outcomes of risk experienced throughout a young person’s life, little was shown concerning the mechanisms which influenced this risk factor. However, through using attachment as a central point of investigation one can gain clear understandings of the system’s failings, with attachments having a direct influence upon offending and underpinning other elements of risk. Risks associated with Living Arrangements, predicted to be heavily influenced by the inability to form attachments, showed clear failings within both foster and residential placements, with an inability to provide stable placements
causing the participants to ‘act up’ due to their inability to feel like they belonged. This had clear consequences on the success of the placement, with placement breakdowns being prominent due to behaviour and the inability of the care system to respond appropriately to these concerns.

Similarly, Family and Personal Relationships, which measure the quality of relationships, were highlighted to be of concern. However, measuring the presence of risk alone did not highlight the overarching influence of this risk factor upon others. The qualitative enquiry, centred on attachment, showed the care system’s inability to address the pre-care concerns with attachments and provide an environment for all participants to gain positive relationships. This failure resulted in low levels of self-worth and self-esteem due to feelings of rejection. Furthermore, this lack of attachment impeded respect towards carers, in turn making discipline difficult due the young person’s perceptions of ‘not being cared about’ and therefore having ‘no one to let down’.

However, other risk factors can be present for a variety of reasons, and it is here where the use of attachment to investigate risk is crucial. For instance, Lifestyle was rated to be a huge concern within care, and upon further investigation this was noted to be heavily influenced by the absence of secure attachments before and during care, which increased the likelihood of problematic attachments with peers. This was particularly poignant in residential settings, with groups of young people forming friendships with other troubled adolescents, forming groups to feel ‘a sense of belonging’. This coupled with limited respect for carers and/or staff meant behaviour was more likely to become increasingly concerning.

Emotional and Mental Health were presented to be the biggest concern across the study, with 90% of the care leavers sample referencing emotional stability. However, looking at the risk alone did not show this to be directly linked to the system’s failings to address their pre-care experiences and attachment concerns. Many of the care leavers stated how
they had little confidence, self-esteem and self-worth, with feelings of not belonging and rejections being paramount within the sample. Not only did this further impact upon their emotional instability, it resulted in many young people not caring about what people thought of their behaviour, increasing the risk of self-destruction. The same concerns were presented when examining the Perceptions of Self and Others.

Finally, both Thinking and Behaviour and Motivation to Change were concerns due to a lack of belonging, and young people feeling they had ‘no one to let down’. Therefore, some participants did not feel they were accountable to anyone, making it difficult to change. Furthermore, having a lack of secure attachments resulted in little respect for carers and professionals’ assistance and guidance.

Although there have been improvements made within Asset Plus (2015), there is little expansion of the importance of attachments in understanding the presence of risk. Evidently, risk shows the areas of concern within a young person’s life, but it is crucial to understand why these risks are apparent in order to provide tailored interventions for young people in care.

This study has highlighted the importance of attachment in understanding the link between care and criminality, and offered insights into how attachment concerns can act as a predictor of risk. Therefore, this thesis provides evidence of the importance of focusing on attachment as a mechanism which predicts risk, moving away from the vague proxies for offending, and actually assisting with the understanding of causality. Through measuring attachment concerns evidence has been provided to explain ‘why’ looked after children experience high levels of risk, and this allows a clearer focus on what needs to change in order to reduce offending by looked after children (Armstrong, 2004; O’Mahony, 2009).
It is therefore vital that attachment is looked at in more depth within the RPFP, more specifically risk assessments, and it is hoped that this attachment focussed critique of the RPFP provides a valuable contribution in criminology, care literature and in practice.

9.3 Models of Understanding

The following models present visual conclusions of the relationships between social environments, personal environments and their impacts upon behaviour. The aim of such presentations is to provide visual guidance to assist the model of intervention for those who enter local authority care, to allow improved life chances free from offending.

9.3.1 Social and Personal Influences: Relationships and Psychological Impacts

As the research highlights, there are many influences upon a young person’s social environment, and these are seen to impact their personal environment and their thoughts and feelings, which in turn affect their behaviour. The following models present conclusions of the links identified, with summaries providing direct responses to the central research questions.

9.3.2 Influences on Social Environment

![Diagram showing relationships between Social Environment, Peers, Biological Parent(s), and Corporate Parent]

Figure 13

As highlighted throughout this research, across all participant groups there are three types of attachments which impact upon the social environment of a young person: peers [P],
biological parent(s) [BP] and the corporate parent [CP]. For the purpose of this research, the social environment is seen as the placement within care, with the corporate parent being used as an overall term, to include carers and staff. It is crucial to acknowledge the extent to which these influences are upheld in positive terms, to ensure that the placement succeeds. A young person should have positive outcomes in all areas, but it is absolutely vital that one element is in place in order for the placement to be successful. However, it is important to note that the social environment, more specifically the placement of the young person, has the responsibility to ensure the young person has the opportunity to develop attachments. If these attachments are not easily produced, it is vital that the placement provides suitable interventions in order to ensure the young person is able to remain within this placement, or if needed, is moved to a social environment which provides the attachments needed.

9.3.3 Cycle of Personal Environment

![Diagram](image)

**Figure 14**
The personal environment has been the central focus to this research, with the importance of emotional stability, gained through positive attachments, being vital in shaping positive experiences across the twelve risk domains and as a direct protection from offending. This
model highlights the important aspects of a young person’s personal environment, showing the cycle of influences. A young person’s thoughts on their experiences and present state will directly impact upon their feelings, the central component of this cycle, which is seen to directly impact upon their behaviour. If this is a positive impact, the influences will allow prosocial thoughts and emotional stability, again reconfirming positive behaviour. However, if the impact upon their behaviour is negative, this will provide further concerns within a young person’s thoughts and cause further concerns with their feelings. This model can be used to understand how thoughts and feelings can influence behavioural concerns and also provide an explanation for the influence of behaviour upon a young person towards the outcomes of thoughts and feelings [TF]. The social environment (placement) the young person is placed in is crucial for allowing positive thoughts, feelings and behaviours, and this influence will be presented below.

9.3.4 Impact of Social Environment to Personal Environment

![Diagram of the model showing the cycle of influences with BP (Behavioural Process), Thoughts, Behaviour, Feelings, and CP (Cognitive Process).]
This model shows a visual representation of the external impacts of the social environment upon the young person’s personal environment. As highlighted by Ungar (2011) in his work on social resilience, it is vitally important to shift the focus away from the ‘individual’ and towards the individual’s ‘social environment’ and the extent to which it provides the individual with the resources they need. If the resources provided are insufficient, or lack meaning, then it is more likely that the particular environment will fail to facilitate positive thoughts, feelings and behaviours (Ungar, 2011).

The impacts will vary depending on the individual’s circumstances, but the emotional influences of the social environment will impact upon the physical stability of a placement, with both having direct influences upon an individual’s personal environment and the impact upon behaviour. This model acts as a guide to highlight areas in which the care system can assist the young person’s behaviour, presenting the responsibilities of the system to ensure the correct interventions are in place to allow positive thoughts, feelings and behaviours. Although the ability to carry this out will differ between placement types, the overall areas of improvement remain the same. The care system has the responsibility to ensure a placement is suitable, with all young people in need of a tailored approach to fit their needs. Furthermore, and central to this research, the impacts of attachments upon peers, biological parent(s), carers and staff need to be a central focus of intervention throughout the care experience.

Thus, if the care system successfully encourages rebuilding of previous attachments and/or provides the environment suitable for new attachments, this will allow positive impacts upon the internal mechanisms of a young person and their behaviour. In addition, this model provides an illustration of how to measure the criminogenic influences of the care environment. If the care system provides at least one attachment and a suitable social environment, and in turn addresses the emotional stability within an individual’s personal environment, it cannot be deemed as producing criminal behaviour.
9.3.5 Circle of Impact: Social Environment – Personal Environment – Behavioural Response

Figure 16

The starting point can differ between the social environment, personal environment and behavioural response. The most prominent starting point is the social environment, as described above, however this can vary. Some young people can have a starting point of emotional instability that leads to behavioural concerns, which can then lead to a change in social environment and attachments. Alternatively, some young people can present behavioural concerns on entrance to care, and this can itself influence the social environment (placement) they receive, which then further impacts upon the thoughts and feelings of a young person, presenting a cycle of concern. The care system can only be deemed responsible for the future behavioural responses, and can change the cycle of concern by providing appropriate social environments with tailored interventions to assist the young person’s thoughts and feelings, whether as a result of pre-care concerns or those presented by the care experience itself. Furthermore, it is important to note that this cycle is not always negative. Instead, evidence has shown that with secure social environments, attachments are more likely to be formed, which then increases the likelihood of emotional
stability and decreases the risk of offending. This model not only provides illustrations of the points in need of intervention, it also provides evidence of the care system positively impacting upon the young person both internally and externally, as shown through their prosocial behaviour. Therefore, the system has the responsibility to ensure it provides a suitable social environment to all young people in care, allowing positive thoughts and feelings to reduce the likelihood of negative behavioural responses. Thus, the key mechanism of this cycle is centred around the social environment in which the looked after child is placed, either through responsibility to ensure positive thoughts, feelings and behaviour are maintained, or through the ability to provide a suitable placement which can assist in the positive changes needed for an individual within that placement.

9.3.6 Helical Model of Cycle of Impact of Social Environments – Personal Environment – Behavioural Response over Time

This final model encapsulates the findings of this thesis in its entirety. If a suitable social environment is provided to a young person, then their thoughts, feelings and behavioural response may be positive, and therefore the likelihood of removal from this placement is lower. However, in many cases, when a young person has behavioural concerns they are often moved, and this helical illustration shows the implications of behavioural concerns and/or offending on the social environment a young person is placed in over time. The spiral highlights the placement breakdowns, often as a consequence of behavioural
concerns, and is most closely related to the concerns of unsuccessful foster placements and the shift of social environment to a residential placement. This model shows the vicious cycle apparent within placements, with behavioural concerns unfolding over time and further declines evidenced both in emotional and behavioural terms. This model provides an overview of the ways in which the care system can improve, by ensuring mechanisms are in place to break the cycle.

It is vital that social environments are equipped to deal with the behavioural responses of a young person, and where appropriate for the young person, the placement should remain the same to avoid further damage to attachments. There is a need to move away from authoritarian parenting, centred around unnecessary removals and criminalisation, and to move towards responsive parenting, which allows a young person to remain in a placement and gain the suitable interventions (Fuentes et al., 2015). Furthermore, this will allow reinforcements of being ‘cared about’ and not ‘given up on’, which will positively impact upon the young person’s thoughts and feelings. Evidently, this cannot guarantee success for all young people, but by providing mechanisms like those displayed within TFCO-UK, this approach will allow improvements within their personal sphere and behaviour.

If changes are not made, the care system can be deemed criminogenic through its failures in addressing the concerns present in a young person’s experience, both in terms of emotion and behaviour, a finding which supports Schofield et al. (2012). The concerns are more prominent within those who transition from foster to residential placements, with further problems with emotional stability and behaviour with every placement change. Such illustrations cannot guarantee prosocial behaviour; however, if the system provides the mechanisms for change, it cannot be deemed to be criminogenic.

These models provide a way of understanding the extent to which care can be deemed criminogenic, by highlighting the responsibility of the care system to provide a suitable social environment (placement) to allow positive thoughts, feelings and behaviours. If the
placement does not provide the mechanisms to achieve these positive outcomes, one can identify system failings.

9.4 Recommendations for Research, Practitioners and Policy

This thesis has provided clear evidence of the inability of care to address pre-care concerns, often causing further adverse influences upon young people due to unsuitable placements, which fail to address both emotional and behavioural concerns. This is particularly true for those placements which do not facilitate the development of attachments. The following sections will present recommendations in order to improve the life transitions of looked after children and care leavers, and keep them free from offending.

9.4.1 Recommendations for Research

9.4.1.1 Theoretical Developments

It is vital that attachment is looked into in more depth within the RPFP, more specifically risk assessments, as this will enable the reasons ‘why’ risks are apparent to be more clearly identifiable, allowing more defined preventions and interventions to be carried out within care and leaving care services.

In addition, examining the importance of the social environment in assisting resilience within care (see Ungar, 2011) will allow a clearer understanding of the responsibility of the care placement to ensure it provides the suitable conditions to facilitate a young person to make positive changes in the face of adversity.
9.4.1.2 Methodological Developments

There is an urgent need for prospective longitudinal studies that are focused on attachment in care and its consequences. Such studies should ideally include the looked after young person, their carers and professionals throughout their time in care. It is felt that this would allow a clearer examination into the system’s responsibility to assist the young person as well as clear narratives of ‘what works’ within care, providing interventions when needed.

9.4.1.3 Parenting Styles and Attachment

It is vital that the importance of attachment and parenting styles are brought to the forefront of academic research. There is a clear need to provide further research into the importance of parenting styles in determining behavioural outcomes, examining the impact of permissive, authoritarian and responsive parenting in foster, kinship and residential care. This research will provide further evidence of the responsibility of the care system in producing prosocial behaviour.

In addition, there is a need to examine multifaceted attachments within each placement type and the impact on emotional and behavioural outcomes. Such research can build on this thesis by examining alternative attachments, to assist all young people to have a sense of belonging.

9.4.1.4 Psychological Interventions: Addressing Trauma

The impact of pre-care experiences has been evident throughout this thesis, but little is known of the details surrounding the quality of psychological interventions offered to young people in care. More research is needed to examine the differing levels of interventions experienced throughout an individual’s care experience and the impact this has upon emotional and behavioural responses.
9.4.2 Recommendations for Practitioners and Policy Makers

9.4.2.1 Care - Revolution

There is a need for a ‘care-revolution’, with mainstream family preservation and early intervention programmes providing alternatives to care. When care is the only option, there is a need to invest and plan for high quality care, massively recruiting foster and kin carers and providing tailored placements, based on responsive parenting techniques. This will allow the young people in care to be placed within a stable environment, which will provide the foundations for the young person to address any emotional and behavioural concerns, without the fear of being moved on.

There is a need to revolutionise residential care. This placement should not been as a ‘last resort’, as this can often lead young people to ‘give up’ on forming attachments, and this has been shown to heighten the risk of offending due to the young person having ‘no-one to let down’. Instead, there is a need to redefine the residential care experience by providing a social environment that moves away from the current model of authoritarian parenting leading to unnecessary criminalisation, and towards a model of responsive parenting, which understands that the behaviour of a young person is a response to their past experiences, and ensures the young person knows they are cared about. Furthermore, there is a need to improve the monitoring of all residential environments, ensuring safety and prevention from further harms. It is hoped that this will allow perceptions of residential care to change, moving away from an image of these institutions as ‘criminogenic warehousing facilities’ and towards one which sees them as providing a safe and responsive style of care.
9.4.2.2 Attachments

There needs to be a central focus on attachment within placements, listening to those cared for and their carers more closely and consistently. The entire system needs to focus on the preservation of old and creation of new quality attachments, whilst exploring the importance of multifaceted attachments for young people in care.

This research has shown that those in non–familial settings had difficulties in developing attachments, with those in foster care ‘not feeling a sense of belonging’ and those in residential care feeling they were ‘incapable of being loved’. When a placement does not mirror a family unit, particularly within residential settings, the system needs to provide multifaceted attachment training for both carers and looked after children, to highlight the value of various attachments and the importance of attachment within placements. Such developments could allow an environment which can ensure a young person has a suitable attachment, to a person or place, and therefore provides a setting which can facilitate positive developments both in terms of emotional and behavioural outcomes.

9.4.2.3 Improving Transitions into Adulthood

It is vital that all care leavers are cared for, cared about and able to care for themselves, to the highest standard (DfE, 2016). In order to achieve this, there is a need to develop leaving care services across the country.

Overall, the system needs to move away from the current ‘postcode lottery’ and ensure there are legislative commitments to providing the same level of support across the county. Specifically, pathway plans need to acknowledge the importance of emotional and mental health as a direct indicator of the ability of a young person to successfully transition out of care. There needs to be good quality emotional and practical support for all care leavers up
until the age of twenty-five, which should not be dependent on the educational status of a young person, and where desired ‘lifelong’ contact should be in place to allow a young person to have a contact who can signpost services to them. Such developments will allow care leavers to have longer transitions into adulthood, with a period of nine years to provide suitable interventions to ensure they leave the care system with the resources to be able to care for themselves, and if desired, have a hub of support throughout their lives.

Finally, there is a need for legislative commitments extending ‘Staying Put’ options for residential placements, on the basis of the changes highlighted within section 9.4.2.1. Through developing the ‘Staying Close’ option, currently under government consultation, those in residential care will be able to have the same support as offered to those in foster care.
Appendix A  ASSET risk assessment

First Phase

The following 12 dynamic risk factors are presented to young people who are asked to rate the extent to which the young person’s experienced risk factors are associated with the likelihood of offending.

Risk 1 - Living Arrangements
- Who you have been living with; Mother, Father, Step-parent, Foster carer/s, Sibling/s, Grandparent/s, Other family, By self, Partner, Own child(ren), Friend/s, Residents of home or institution, Other/s
- Suitability of living conditions; does not meet his/her needs (e.g. overcrowded, lacks basic amenities). Deprived household (e.g. dependent on benefits, entitlement to free school meals)
  - Living with known offender/s
  - Absconding or staying away (e.g. ever reported as missing person)
  - Disorganised/chaotic (e.g. different people coming and going)
  - Other problems (e.g. uncertainty over length of stay).

Risk 2 - Family and Personal Relationships
- Contact with: Birth mother, Birth father, Adoptive parent/s, Step-parent, Foster carer/s, Grandparent/s, Sibling/s, Partner, Own child(ren), Other family, Other significant adults (e.g. neighbour, family friend), Other/s
- Evidence of family members or carers with whom the young person has been in contact over the last six months being involved in criminal activity
- Evidence of family members or carers with whom the young person has been in contact over the last six months being involved in heavy alcohol misuse
- Evidence of family members or carers with whom the young person has been in contact over the last six months being involved in drug or solvent misuse
- Significant adults fail to communicate with or show care/interest in the young person
- Inconsistent supervision and boundary setting
- Experience of abuse (i.e. physical, sexual, emotional, neglect)
- Witnessing other violence in family context
- Significant bereavement or loss
- Difficulties with care of his/her own children
- Other problems (e.g. parent with physical/mental health problem, loss of contact, acrimonious divorce of parents, other stress/tension).
Risk 3 - Education, training and employment
- Engagement in education, training or employment (ETE): Mainstream school, Special school, Pupil referral unit, Other specialist unit, Community home with education, Home tuition, Work experience, Full time work, Part time work, Casual/temporary work Unemployed, New Deal, Pre-employment/life skills training, College /further education, Other training courses
- Other factors relating to engagement in ETE: Negative attitudes towards ETE, Lack of attachment to current ETE provision (e.g. wants to leave, cannot see benefits of learning) Bullied, Bullies others, Poor relationships with most teachers/tutors/ employers/colleagues, Negative parental/carer attitudes towards education/training or employment, Other problems (e.g. frequent changes of school/educational placement, school is unchallenging/boring, disability, lack of stable address meaning difficulties securing work, no money to buy books/tools/equipment).

Risk 4 - Neighbourhood
- Obvious signs of drug dealing and/or usage
- Isolated location/lack of accessible transport
- Lack of age-appropriate facilities (e.g. youth clubs, sports facilities)
- Racial or ethnic tensions
- Other problems (e.g. lack of amenities such as shops or post office, opportunities to sell stolen goods, red-light district, tension between police and local community).

Risk 5 - Lifestyle
- Lack of age-appropriate friendships
- Associating with predominantly pro-criminal peers
- Lack of non-criminal friends
- Has nothing much to do in spare time
- Participation in reckless activity
- Inadequate legitimate personal income
- Other problems (e.g. gambling, staying out late at night, loneliness).

Risk 6 – Substance use
- Use of: Tobacco, Alcohol Solvents (glue, gas and volatile substances e.g. petrol, lighter fuel), Cannabis, Ecstasy, Amphetamines, LSD, Poppers, Cocaine, Crack, Heroin, Methadone (obtained legally or illegally), Tranquilisers or Steroids
- Sees substance use as positive and/or essential to life
- Noticeably detrimental effect on education, relationships, daily functioning
- Offending to obtain money for substances
- Other links to offending (e.g. offending while under influence, possessing/supplying illegal drugs, obtaining substances by deception).
Risk 7 - Physical health
- Health condition which significantly affects everyday life functioning
- Physical immaturity/delayed development
- Problems caused by not being registered with GP
- Lack of access to other appropriate health care services (e.g. dentist)
- Health put at risk through his/her own behaviour (e.g. hard drug use, unsafe sex, prostitution)
- Other problems (prescribed medication, binge drinking, obesity, poor diet, smoking, hyperactivity, early or late physical maturation).

Risk 8 - Emotional and Mental health
- Coming to terms with significant past event/s (e.g. feelings of anger, sadness, grief, bitterness)
- Current circumstances (e.g. feelings of frustration, stress, sadness, worry/anxiety)
- Concerns about the future (e.g. feelings of worry/anxiety, fear, uncertainty)
- Diagnosis of mental illness
- Affected by other emotional or psychological difficulties (e.g. phobias, eating or sleep disorders, suicidal feelings not yet acted out, obsessive compulsive disorder, hypochondria).
- Deliberate self harming
- Attempted suicide.

Risk 9 - Perception of self and others
- Difficulties with self-identity.
- Inappropriate self-esteem (e.g. too high or too low).
- Mistrust of others.
- See yourself as a victim of discrimination or unfair treatment (e.g. in the home, school, community, prison).
- Display discriminatory attitudes towards others (e.g. race, ethnicity, religion, gender, age, class, disability, sexuality).
- Perceive yourself as having a criminal identity.

Risk 10 - Thinking and behaviour
- Hold a lack of understanding of consequences (e.g. immediate and longer term outcomes, direct and indirect consequences, proximal and distal consequences)
- Impulsiveness
- Need for excitement (easily bored)
- Giving in easily to pressure from others (lack of assertiveness)
- Poor control of temper
- Inappropriate social and communication skills
- Destruction of property
- Aggression towards others (e.g. verbal, physical)
- Sexually inappropriate behaviour
- Attempts to manipulate/control others.
Risk 11 - Attitudes to offending
- Denial of the seriousness of his/her behaviour
- Reluctance to accept any responsibility for involvement in most recent offence/s
- Lack of understanding of the effect of his/her behaviour on victims (if victimless, on society)
- Lack of remorse
- Lack of understanding about the effects of his/her behaviour on family/carers
- A belief that certain types of offences are acceptable
- A belief that certain people/groups are acceptable ‘targets’ of offending behaviour
- Belief that further offending is inevitable.

Risk 12 - Motivation to change
- Hold an appropriate understanding of the problematic aspects of his/her own behaviour
- Shows real evidence of wanting to deal with problems in his/her life
- Understands the consequences for him/herself of further offending
- Has identified clear reasons or incentives for him/her to avoid further offending
- Shows real evidence of wanting to stop offending
- Will receive positive support from family, friends or others during any intervention
- Is willing to co-operate with others (family, YOT, other agencies) to achieve change.

Second Phase

Each of the responses are then scored, which then determines the overall risk of future offending.

<table>
<thead>
<tr>
<th>Score out of 48</th>
<th>0 - 8</th>
<th>9 - 14</th>
<th>15 - 23</th>
<th>24 - 32</th>
<th>33 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of Offending and/or re offending</td>
<td>Low</td>
<td>Low - Medium</td>
<td>Medium</td>
<td>Medium - High</td>
<td>High</td>
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Appendix B  LA Ofsted Report: Main Findings

<table>
<thead>
<tr>
<th>Record of main findings:</th>
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<tbody>
<tr>
<td><strong>Safeguarding services</strong></td>
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<tr>
<td>Overall effectiveness</td>
</tr>
<tr>
<td>Capacity for improvement</td>
</tr>
<tr>
<td><strong>Safeguarding outcomes for children and young people</strong></td>
</tr>
<tr>
<td>Good</td>
</tr>
<tr>
<td><strong>Ambition and prioritisation</strong></td>
</tr>
<tr>
<td>Outstanding</td>
</tr>
<tr>
<td><strong>Leadership and management</strong></td>
</tr>
<tr>
<td>Outstanding</td>
</tr>
<tr>
<td><strong>Performance management and quality assurance</strong></td>
</tr>
<tr>
<td><strong>Partnership working</strong></td>
</tr>
<tr>
<td><strong>Equality and diversity</strong></td>
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<tr>
<td><strong>Services for looked after children</strong></td>
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<tr>
<td>Overall effectiveness</td>
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<tr>
<td>Capacity for improvement</td>
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<tr>
<td><strong>How good are outcomes for looked after children and care leavers?</strong></td>
</tr>
<tr>
<td>Adequate</td>
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<tr>
<td>Good</td>
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<tr>
<td>Good</td>
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<tr>
<td>Outstanding</td>
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<tr>
<td><strong>Ambition and prioritisation</strong></td>
</tr>
<tr>
<td><strong>Leadership and management</strong></td>
</tr>
<tr>
<td><strong>Performance management and quality assurance</strong></td>
</tr>
<tr>
<td><strong>Equality and diversity</strong></td>
</tr>
</tbody>
</table>

Ofsted (2011).
Participant Information Sheet for Care Leavers

Research Title: “To what extent do different types of care environments have the propensity to be criminogenic?”

You are being invited to take part in a research study that explores experiences in different types of care environments and their influence on care leaver’s life and behaviour. Please read the following information carefully and feel free to discuss any part of it with me.

What is the research for? The research will help me write a PhD (an 80,000 word report that I will write and be examined on) in Criminology at The University of Manchester.

Who will carry out the research? Kimberley Marsh, Manchester University Law School. I am a research student and DO NOT work for the police, probation, Youth Offending Team or social services.

What is the point of the research? Some young people who have been in care are less likely to do well in school or work than people who haven't, and are more likely to have poorer health and be involved in offending. This is far from true of all care leavers and can be the basis of prejudice among the public. This research aims to describe the different balance of risk factors (bad experiences) and protective factors (good experiences) that young people have in care. I want to see whether this depends on their type of placement (foster care, kinship care or residential care) and how care leavers themselves think those experiences have influenced their lives. Do they think care has helped them or held them back? I'm interested in a lot of aspects of each care leaver's life but am particularly interested in law-breaking, whether minor or serious. I would like my research to give care leavers a voice and to help improve services.

Why is the research worth doing? Not much research has been done in this area, and hardly anyone has looked at how experiences of different types of care influence people’s later lives. Given that some care leavers do not do as well as people who haven't been in care, it's important to understand why this is the case so we can try and improve services and the lives of care leavers. A more balanced and positive view of care may help tackle prejudice in society.

Why have I been chosen? You have been chosen as you are a care leaver from the place where I am carrying out my research.

What does the interview involve? The interview will last about 1 hour and has three parts:

1. A short survey where you tell me some basic information about yourself, for example, the type(s) of placements you have experienced and details of your wider life, including your experience of crime as a victim and offender.

2. A short survey on twelve different aspects of your life in care, including living arrangements, relationships and education. You will be asked to state if any of the risk related aspects have been present in your life, before, during and after care. In addition you will be asked if you feel any of these aspects influenced any behavioural concerns and/or offending.
3. A short and informal conversation (interview) where you can tell me the story of your time in care and give your opinion of how, if at all, you think those experiences have shaped your life and your behaviour.

With your permission I would like to record this part of the interview.

What happens to the information collected? After the interview, I will take everything we have used back to my office at the University, remove your name from the surveys and put the information into a spreadsheet which will be password protected on a secure computer. I will only ever refer to you as a code number and will never use your name publicly. I will keep the paper copies of the survey in a locked filing cabinet at the University and will destroy them at the end of the research. I will listen to our interview recording, download that file onto the same protected computer and transcribe (type out) what we have said so I can re-read and analyse it. I will store and dispose of any paper transcripts in the same confidential way as the surveys. The results may be published in journal articles, presented at conferences, community forums and on a website. No one will be able to identify you from what I publish.

How is confidentiality maintained? The information you give is confidential. This means I will keep your information safe (see last section) and you will not be named or be able to be identified when I write up the research. I will be the only person to listen to your interview and will permanently delete the recording when the research ends in September 2013. Please note that I am very interested in what you have to say but as a researcher, I have an ethical obligation to notify the police should you discuss crimes you are currently involved in or are planning, so please do not do this.

What happens if I do not want to take part or if I change my mind? It is completely up to you whether or not you wish to take part and you are can withdraw from the research at any time without giving a reason.

Will I be paid for participating in the research? If you decide to take part you will be given a £20 high street voucher after the interview.

Where will the research be conducted? At a time and place that is convenient for you, for example, a local youth or leisure centre or a local authority office.

Will the outcomes of the research be published? I will use some of what you say as quotes in my PhD and may also use one or two of them in other writing and presentations I do after the PhD. I will choose quotes so that no-one will be able to identify you from what I write.

What happens if I’m upset or have a problem I need help with? If for some reason you become upset during the interview or want help with a problem you talk about, I can recommend a contact at the Leaving Care Team who may be able to help. In addition, contact details for help, advice and support will be given to you at the time of the interview.

What if something goes wrong? It is very unlikely that something should go wrong, or you should feel unhappy with the research. But if you do have concerns or wish to make a complaint about any aspect of the research, the university complaints procedures and names of contacts will be made available to you. To make a formal complaint about the conduct of the research you should contact the Head of the Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL.
Contact for further information If you have any questions about the research or require a copy of the final report, please feel free to contact myself:

Kimberley Marsh on 07818069790 or kimberley.marsh@manchester.ac.uk

You can also speak to my supervisor, Jon Shute, who is a Lecturer in Criminology: on 0161 275 4789 or jon.shute@manchester.ac.uk

Thank you for taking the time to read this.
If you are happy to take part in this study we would like you to complete the research consent form.
Participant Information Sheet for Carers

Research Title: “To what extent do different types of care environments have the propensity to be criminogenic?”

You are being invited to take part in a research study that explores experiences in different types of care environments and their influence on care leaver's life and behaviour. Please read the following information carefully and feel free to discuss any part of it with me.

What is the research for? The research will help me write a PhD (an 80,000 word report that I will write and be examined on) in Criminology at The University of Manchester.

Who will carry out the research? Kimberley Marsh, Manchester University Law School. I am a research student and DO NOT work for the police, probation, Youth Offending Team or social services.

What is the point of the research? Some young people who have been in care are less likely to do well in school or work than people who haven't, and are more likely to have poorer health and be involved in offending. This is far from true of all care leavers and can be the basis of prejudice among the public. This research aims to describe the different balance of risk factors (bad experiences) and protective factors (good experiences) that young people have in care. I want to see whether this depends on their type of placement (foster care, kinship care or residential care) and how care leavers themselves think those experiences have influenced their lives, with the addition of insights offered by carers and members of the Leaving Care Team. Do they think care has helped them or held them back? Are the same concerns voiced by all groups of participants? I'm interested in a lot of aspects of each care leaver's life but am particularly interested in law-breaking, whether minor or serious. I would like my research to give care leavers a voice and to help improve services, with supplemented views from carers and members of the Leaving Care Team.

Why is the research worth doing? Not much research has been done in this area, and hardly anyone has looked at how experiences of different types of care influence people's later lives. Given that some care leavers do not do as well as people who haven't been in care, it's important to understand why this is the case so we can try and improve services and the lives of care leavers. A more balanced and positive view of care may help tackle prejudice in society.

Why have I been chosen? You have been chosen as you have experience of looking after children and/or young people within at least one of the types of placements in need of research (Foster, Kinship and Residential).

What does the interview involve? The interview will last about 1 hour and has three parts:

1. A short survey where you tell me some basic information about your role as a carer, including the type(s) of placements you have given, duties, durations of stay and any experience you have in looking after young offenders.

2. A short survey on twelve different aspects of life in care, including living arrangements, relationships and education. Through your experience as a carer, you will be asked to state if you perceive any of the risk related aspects to be a problem for
children and/or young people before, during and after care. In addition you will be asked if you feel any of these aspects influence behavioural concerns and/or offending.

3. A short and informal conversation (interview) addressing your experiences as a carer. They will start with asking about the experiences of being a carer and how the pre-existing experiences of those who they look after affect the experiences for those that they look after. The questions will then go onto address both positive and negative experiences looking after young people and how they perceive each aspect of care and how it could aid protection from offending or heighten the risk. This will allow reflections on your own experience, welcoming examples of both successes and problems within the carer role and outcomes of those looked after. The questions will then move on to perceptions of the process of care and how this may aid or hinder transition into adulthood and life after for those who have been looked after. Finally the questions will shift focus onto the practicalities of being a carer, drawing upon their perceptions of the governments developments of the care system, working relations with social services and how the professionalization of acting as a carer has impacted on relationships with those looked after.

With your permission I would like to record this part of the interview.

What happens to the information collected? After the interview, I will take everything we have used back to my office at the University, remove your name from the surveys and put the information into a spreadsheet which will be password protected on a secure computer. I will only ever refer to you as a code number and will never use your name publicly. I will keep the paper copies of the survey in a locked filing cabinet at the University and will destroy them at the end of the research. I will listen to our interview recording, download that file onto the same protected computer and transcribe (type out) what we have said so I can re-read and analyse it. I will store and dispose of any paper transcripts in the same confidential way as the surveys. The results may be published in journal articles, presented at conferences, community forums and on a website. No one will be able to identify you from what I publish.

How is confidentiality maintained? The information you give is confidential. This means I will keep your information safe (see last section) and you will not be named or be able to be identified when I write up the research. I will be the only person to listen to your interview and will permanently delete the recording when the research ends in September 2013.

What happens if I do not want to take part or if I change my mind? It is completely up to you whether or not you wish to take part and you are can withdraw from the research at any time without giving a reason.

Will I be paid for participating in the research? There is no payment for taking part in this research.

Where will the research be conducted? At a time and place that is convenient for you, for example, a local youth or leisure centre or a local authority office.

Will the outcomes of the research be published? I will use some of what you say as quotes in my PhD and may also use one or two of them in other writing and presentations I do after the PhD. I will choose quotes so that no-one will be able to identify you from what I write.

What happens if I’m upset or have a problem I need help with? If for some reason you become upset during the interview or want help with a problem you talk about, I can recommend a contact within Social Services who may be able to help. In addition, contact details for help, advice and support will be given to you at the time of the interview.
What if something goes wrong? It is very unlikely that something should go wrong, or you should feel unhappy with the research. But if you do have concerns or wish to make a complaint about any aspect of the research, the university complaints procedures and names of contacts will be made available to you. To make a formal complaint about the conduct of the research you should contact the Head of the Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL.

Contact for further information If you have any questions about the research or require a copy of the final report, please feel free to contact myself:

Kimberley Marsh on 07818069790 or kimberley.marsh@manchester.ac.uk

You can also speak to my supervisor, Jon Shute, who is a Lecturer in Criminology: on 0161 275 4789 or jon.shute@manchester.ac.uk

Thank you for taking the time to read this.

If you are happy to take part in this study we would like you to complete the research consent form.
Research Title: “To what extent do different types of care environments have the propensity to be criminogenic?”

What is the research for? The research will help me write a PhD (an 80,000 word report that I will write and be examined on) in Criminology at The University of Manchester.

Who will carry out the research? Kimberley Marsh, Manchester University Law School. I am a research student and DO NOT work for the police, probation, Youth Offending Team or social services.

What is the point of the research? Some young people who have been in care are less likely to do well in school or work than people who haven't, and are more likely to have poorer health and be involved in offending. This is far from true of all care leavers and can be the basis of prejudice among the public. This research aims to describe the different balance of risk factors (bad experiences) and protective factors (good experiences) that young people have in care. I want to see whether this depends on their type of placement (foster care, kinship care or residential care) and how care leavers themselves think those experiences have influenced their lives. Do they think care has helped them or held them back? I’m interested in a lot of aspects of each care leaver's life but am particularly interested in law-breaking, whether minor or serious. I would like my research to give care leavers a voice and to help improve services.

Why is the research worth doing? Not much research has been done in this area, and hardly anyone has looked at how experiences of different types of care influence people’s later lives. Given that some care leavers do not do as well as people who haven’t been in care, it’s important to understand why this is the case so we can try and improve services and the lives of care leavers. A more balanced and positive view of care may help tackle prejudice in society.

Why have I been chosen? You have been chosen as you work for the Leaving Care Team and have experience of working with care leavers who would have experienced at least one of the types of placements in need of research (Foster, Kinship and Residential).

What does the interview involve? The interview will last about 1 hour and has three parts:

1. A short survey where you tell me some basic information about your experience of working with those in care and/or leaving care, including: information of your current role and previous roles (if applicable), information on the types of placements the young people you work with have experienced, demographics of these individuals (if applicable) and any experience you have had working with young offenders.

2. A short survey on twelve different aspects of life in care, including living arrangements, relationships and education. Through your experience as a member of the LCT, you will be asked to state if you perceive any of the risk related aspects to be a problem for children and/or young people before, during and after care. In addition you will be asked if you feel any of these aspects influence behavioural concerns and/or offending.

3. A short and informal conversation (interview) addressing experiences of working with those in care and/or care leavers. They will start with asking about your experiences of working with looked after children and/or care leavers and how the pre-existing experiences of those who have been looked after affect individuals experiences of care.
The questions will then go onto address both positive and negative experiences of working with young people and how you perceive each aspect of care and how it could aid protection from offending or heighten the risk. This will allow reflections of your own experience, welcoming examples of both successes and problems within your role and outcomes of those looked after. The questions will then move on to perceptions of the process of care and how this may aid or hinder transition into adulthood and life after for those who have been looked after. Finally the questions will shift focus onto the practicalities of working with looked after children and/or care leavers, drawing upon perceptions of the governments developments of the care system, working relations within social services and carers and how the professionalization of the care system has impacted on relationships with those looked after and/or care leavers.

With your permission I would like to record this part of the interview.

**What happens to the information collected?** After the interview, I will take everything we have used back to my office at the University, remove your name from the surveys and put all information into a spreadsheet which will be password protected on a secure computer. I will only ever refer to you as a code number and will never use your name publicly. I will keep the paper copies of the survey in a locked filing cabinet at the University and will destroy them at the end of the research. I will listen to our interview recording, download that file onto the same protected computer and transcribe (type out) what we have said so I can re-read and analyse it. I will store and dispose of any paper transcripts in the same confidential way as the surveys. The results may be published in journal articles, presented at conferences, community forums and on a website. *No one will be able to identify you from what I publish.*

**How is confidentiality maintained?** The information you give is confidential. This means I will keep your information safe (see last section) and you will not be named or be able to be identified when I write up the research. I will be the only person to listen to your interview and will permanently delete the recording when the research ends in September 2013.

**What happens if I do not want to take part or if I change my mind?** It is completely up to you whether or not you wish to take part and you are can withdraw from the research at any time without giving a reason.

**Will I be paid for participating in the research?** There is no payment for taking part in this research.

**Where will the research be conducted?** At a time and place that is convenient for you, for example, a local youth or leisure centre or a local authority office.

**Will the outcomes of the research be published?** I will use some of what you say as quotes in my PhD and may also use one or two of them in other writing and presentations I do after the PhD. I will choose quotes so that no-one will be able to identify you from what I write.

**What happens if I’m upset or have a problem I need help with?** If for some reason you become upset during the interview or want help with a problem you talk about, I can recommend a contact at the Leaving Care Team who may be able to help. In addition, contact details for help, advice and support will be given to you at the time of the interview.

**What if something goes wrong?** It is very unlikely that something should go wrong, or you should feel unhappy with the research. But if you do have concerns or wish to make a
complaint about any aspect of the research, the university complaints procedures and names of contacts will be made available to you. To make a formal complaint about the conduct of the research you should contact the Head of the Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL.

**Contact for further information** If you have any questions about the research or require a copy of the final report, please feel free to contact myself:

Kimberley Marsh on 07818069790 or kimberley.marsh@manchester.ac.uk

You can also speak to my supervisor, Jon Shute, who is a Lecturer in Criminology: on 0161 275 4789 or jon.shute@manchester.ac.uk

Thank you for taking the time to read this.

If you are happy to take part in this study we would like you to complete the research consent form.
Appendix D       Permission to Contact Form

Face to Face/Email Contact with the Leaving Care Team (to be signed by the Care Leaver)
I give permission for my details to be passed onto Kimberley Marsh so that she can contact me in regards to my expressed interest in taking part in the study entitled: “To what extent do different types of care environments have the propensity to be criminogenic?”

Name
___________________________________________________________________________________________

Signature
___________________________________________________________________________________________

Date
___________________________________________________________________________________________

Please hand/email over this document to the Leaving Care Team who will forward it to Kimberley Marsh.

Telephone Contact with the Leaving Care Team (to be signed by a member of the Leaving Care Team)
I confirm that (enter name of care leaver) _____________________________________________ has given permission for their details to be passed onto Kimberley Marsh so that she can contact them in regards to their expressed interest in taking part in the study entitled:

Name
___________________________________________________________________________________________

Signature
___________________________________________________________________________________________

Date
___________________________________________________________________________________________

Please email over this document to kimberley.marsh@manchester.ac.uk
Appendix E  Autobiography

My Name is Kimberley Marsh and I am currently a PhD Candidate in Criminology at The University of Manchester. My interest in different types of care environment stems from my own experience of foster placements before my permanent kinship placement with my Nan. During this time I experienced many positive aspects of the care system, as well as some that I felt were in need of improvement.

At the age of 18, I decided to study Sociology at The University of Surrey. I was given the opportunity to be a participant in research that looked at the educational achievement of care leavers. This was invaluable, as it allowed me to voice both my praise of the care system’s ability to support me in education as well as to highlight my broader concerns. This research then inspired me to carry out my dissertation in the same area, which also allowed care leavers to share their positive and negative experiences. My conclusions highlighted the importance of education and the need to have high expectations of care leavers as a group.

Following this, I was offered support from my leaving-care worker to study for an MSc in Criminology and Criminal Psychology at Portsmouth. This allowed me to move my research towards care and offending. The area was very under researched and offered few explanations of why offending seemed to be higher among care populations. When I came across research highlighting prejudice towards care leavers and low expectations of behaviour and achievement among the general public, I was determined to challenge such views. It became obvious to me that there couldn’t be an inevitable link between care, behaviour and achievement and that this needed to be examined further. I then carried out research looking into the risk and protective factors experienced within each type of care environment which allowed care leavers to share their own experiences. This work has led me to my current study which aims to compare the experiences of care leavers and carers in different placement types, and will also involve interviewing staff from the Leaving Care Team. My basic interest is in looking at how different care environments offer different mixes of positive and negative influences on young people in care. It is hoped the research will allow care leaver’s voices to be heard and give them a chance to tell their own story in their own words. The research has the potential to influence policy and practice and is intended to improve services in your LA and improve the experience and life chances of young people in care and beyond.
Appendix F  Consent Forms

Research Title: “To what extent do different types of care environments have the propensity to be criminogenic?”

Consent Form for Care Leavers

If you are happy to participate please complete and sign the consent form below

1. I confirm that I have read the information sheet on the above project, have had the chance to think about it, ask questions and have them answered

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason

3. I understand that all information will be treated as strictly confidential unless I talk about either current or planned offending

4. I understand that the interviews will be audio-recorded

5. I agree to the use of anonymous quotes when the research is written up

I agree to take part in the above project

Name of participant ___________________________ Date __________ Signature ___________________________

Name of person taking consent __________________ Date __________ Signature ___________________________
Research Title: “To what extent do different types of care environments have the propensity to be criminogenic?”

Consent Form for Carers

If you are happy to participate please complete and sign the consent form below

1. I confirm that I have read the information sheet on the above project, have had the chance to think about it, ask questions and have them answered

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason

3. I understand that the interviews will be audio-recorded

4. I agree to the use of anonymous quotes when the research is written up

I agree to take part in the above project

Name of participant ___________________________ Date ___________ Signature ___________________________

Name of person taking consent ___________________________ Date ___________ Signature ___________________________

_________________________ ___________________________ ___________________________
Research Title: “To what extent do different types of care environments have the propensity to be criminogenic?”

Consent Form for Leaving Care Team

If you are happy to participate please complete and sign the consent form below

1. I confirm that I have read the information sheet on the above project, have had the chance to think about it, ask questions and have them answered

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason

3. I understand that the interviews will be audio-recorded

4. I agree to the use of anonymous quotes when the research is written up

I agree to take part in the above project

Name of participant ___________________________ Date ___________ Signature ___________________________

Name of person taking consent ___________________________ Date ___________ Signature ___________________________

_________________________ ___________________________ ___________________________
Appendix G Interview Schedules

Interview Schedule for Care Leavers

Name:

Type of Placement:

Section 1 – About you/ Background

Introduction

The first two sections are being asked to everyone and they are just a way of summarising things, so I’d like to ask you a few questions about your life before I open up the interview for you to share you experiences.

General

Age:

Sex:

Ethnicity:

What are you doing now? (Education, training, employment)

Time in care

Age at first placement:

Time spent in care (years/months):

Number of placement(s) and the age you were whilst in each:

Type(s) of placement:

Preferred placement:

Behavioural Outcomes

How would you describe your behaviour before you entered care?
  • Did people have concerns about your behaviour?

Did you behaviour change when you were put into care? If so what changes were apparent?

How would you describe your overall behaviour within your time in care?
  • Did people have concerns about your behaviour?

Finally how would you describe your behavioural outcomes and attitudes as a care leaver?
  • Did people have concerns about your behaviour?
Victimisation
Below is a list of criminal offences that some people are victims of, could you please tick the relevant box(es) if you have experienced any of these offences against you (before, during or after care).

<table>
<thead>
<tr>
<th>Type of Offence</th>
<th>Before Care</th>
<th>During Care</th>
<th>After Care</th>
<th>Prefer Not to Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABH (Actual Bodily Harm)</td>
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<tr>
<td>Assault</td>
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<td>Burglary</td>
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<td>Criminal Damage</td>
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<td>Domestic Violence</td>
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<tr>
<td>Driving Offences</td>
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<tr>
<td>Gang Crime</td>
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<tr>
<td>GBH (Grievous Bodily Harm)</td>
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<tr>
<td>Gun Crime</td>
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<tr>
<td>Homophobic Crime</td>
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<td>Harassment</td>
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<td>Knife Crime</td>
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<td>Mugging</td>
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<tr>
<td>Racial Hate Crime</td>
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<tr>
<td>Rape and Sexual Assault</td>
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<tr>
<td>Religious Hate Crime</td>
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<td>Robbery</td>
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<td>Theft</td>
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<td>Trespassing</td>
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<td>Vandalism</td>
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<td>Other, please state</td>
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</table>
Offending

Below is a list of criminal offences that some people commit, could you please enter the charges (eg. Caution, community service) given in the relevant box(es) if you committed any of the offences before, during or after care, alongside the age in which you committed the offence. Please only share information you feel comfortable with in line with the information that was provided in the information sheet, in which you signed your consent to.

<table>
<thead>
<tr>
<th>Types of Offences</th>
<th>Before Care</th>
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<td>ABH (Actual Bodily Harm)</td>
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<td>Drug Dealing</td>
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<td>Fraud</td>
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<td>GBH (Grievous Bodily Harm)</td>
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<td>Racial Hate Crime</td>
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<td>Rape and Sexual Assault</td>
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<td>Other, please state</td>
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Why do you feel you committed these offences?
Name:

Type of Placement:

Section 2

The overall Care Experience and its impact on behaviour

The following 12 aspects of life are known to relate to offending behaviour. Have these aspects been present in your life?

1 = No
2 = Yes, Slightly
3 = Yes, Definitely

Please enter 1, 2 or 3 in the boxes below for each of the 12 aspects before, during and after care.

Do you feel this influenced any behavioural concerns and/or offending?

If so please tick the box ‘Influenced Bad Behaviour and/or Offending’ next to the period of your life that involved this problem.

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<tr>
<th>Aspect</th>
<th>Before Care</th>
<th>Influenced Bad Behaviour and/or Offending</th>
<th>During Care</th>
<th>Influenced Bad Behaviour and/or Offending</th>
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<td>12. My Motivation to change is/was minimal.</td>
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Which of these experiences do you feel made you offend/offend more?

Which of these experiences had little impact on your offending behaviour?
Section 3 – Open ended questions

Pre Care Experiences

Could you start by telling me about your life before entering care?

- What experiences do you think were positive?
- Alternatively, what areas were negative?

Do you see any of these experiences as influential to your behaviour and/or offending?

I would like to ask you about the circumstances in which you entered care? Please only answer this if you feel comfortable.

Entering Care

Can you give me a brief description of entering care?

- How did it make you feel?
- What effect do you feel entering care had on your life?

Do you feel that entering care had an impact on your behaviour and/or offending? Why was this case?

During Care

Could you give me a brief description of your time in care, highlighting time spent, types of placements, changes in placement and reasons for these?

What was it like spending time in care?

- How do you feel this compares with children growing up at home with their parents?
- Can you describe your living arrangements whilst in care?

- Would you describe your placements as offering stability or were you moved around a lot?
- If you experienced many placements, how did this affect you?

Do you think your relationships altered through being in care? If so was this positive or negative change?

- Did these changes make you feel happier or did they cause problems?
- How did this influence your behaviour?

How would you describe your educational experience? Did this change whilst you were in care?

- Did you receive high expectations, encouragement and support throughout your education?
- How did this influence your behaviour?
How would you describe the discipline and supervision within your placement(s)?

- Did this influence your behaviour?
- Was it easy to break rules?
- Did you care about what carers thought about you?

What aspect of your time within care do you feel was the most positive?

What aspect of care do you feel was the most negative?

Do you think your time spent in care had influence on your behaviour and/or offending? If so why?

- Looking back at your overall experience what aspect would you reflect to be the most positive influence in relation to your behaviour?
- And the most negative influence?
- Do you think your situation would have been different if you had not spent time in care?

Leaving Care and Transitions to Adulthood

Can you describe your experience of leaving care?

- Did you keep in contact with your carers?
- Who supported you?
- How were/are you supported?
- How were/are you supporting yourself?
- Did you feel ready to leave care?
- What aspect(s) of your time in care has helped your ability to live independently?
- Alternatively what experience(s) within care do you feel have had a negative effect on your transition to adulthood?
- In regards to your transition out of care, what aspect has been the most positive?
- Alternatively the most negative?

Have any of these experiences had an effect on your behaviour and/or offending?

Present situation and future

Can you briefly describe your present situation?

Are any of these aspects having influence on your behaviour?

What are you future plans?
Summary

In general what has been the most negative aspect of your experiences in relation to your behaviour and/or offending?

Positively, what do you feel the care experience offered?

Do you think the care experience made things better or worse in relation to your behaviour and/or offending?

What do you think is needed to aid the problem of offending within care and after?

Is there anything else you would like to add in relation to you care experience and its influences on behaviour and/or offending?

*****Thank you for taking part in this interview. All information will be held***** confidentially and you have the right to withdraw from the research at any point.
Interview Schedule for Carers

Name:

Type of care environment you offer your care at present:

Previous types of care environment you have worked in:

Section 1 – About you/ Background

General

Age:

Sex:

Ethnicity:

Occupation:

Details of your role as a carer

Age of children and/or young people you care for:

Time children/young people spend in your care (range in the form of years/months):

Number of placement(s) you have given and/or children/young people you have cared for:

Specifics of those looked after if applicable, e.g. siblings, behavioural difficulties, mental and/or physical disabilities:

Have you ever looked after children/young people with extreme behavioural concerns or those who have offended?
Name:

Type of Placement(s) Offered:

Section 2

The overall Care Experience and its impact on behaviour

The following 12 aspects of life are known to relate to offending behaviour. In your experience as a carer, which of these aspects do you perceive to be a problem?

1 = No
2 = Yes, Slightly
3 = Yes, Definitely

Please enter 1, 2 or 3 in the boxes below for each of the 12 aspects before, during and after care. If your experience doesn’t cover all the aspects, please just leave the box blank.

Do you feel this influenced any behavioural concerns and/or offending?

If so please tick the box ‘Influenced Bad Behaviour and/or Offending’ next to the period of your life that involved this problem.

<table>
<thead>
<tr>
<th>1. Children/Young People’s living arrangements are/were chaotic and unstable</th>
<th>Before Care</th>
<th>Influenced Bad Behaviour and/or Offending</th>
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<p>| 2. Children/Young People’s family and personal relationships are/were minimal and problematic | | | | | | |</p>
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Which of these experiences do you feel make those who have been in care and/or care leavers offend/offend more?

Which of these experiences do you perceive to have little impact on offending behaviour of those in care and/or care leavers?
Section 3 – Open ended questions

Pre Care Influences

How would you describe the impact of the pre care experiences of those you look after?

- Do you feel this has an impact on their behaviour?
- What do you feel are the main difficulties faced by these children and/or young people?

What mechanisms are in place to help these children and/or young people overcome these adversities?

How would you describe the support you receive in addressing these circumstances?

Entering Care

Can you give a brief description of the process of entering your care?

- How do children and/or young people react to this change in their living arrangements?

Are behavioural problems of a particular concern for those who enter your care?

During Care

Can you describe the main placements you offer?

- Do you feel you are able to offer stability for the children and/or young people?
- How do you feel numerous placement moves impact on the children and/or young people?
- How do you feel this differs from the children and/or young people living with their parents?

How does the process of being in care impact in the children and/or young people's relationships?

- Do you think this influences their behaviour?

How do you encourage the education of the children and/or young people in you care?

- How are you supported with this?

How do you discipline the children and/or young people whom you look after?

- Do you feel your position as a carer limits this discipline?

What positive reflections do you have on the experiences of the children and/or young people of whom you look after?

What do you feel are the main barriers for them?
What aspects of care do you feel has the most positive influence on behaviour and/or offending?

Alternatively, what do you feel is the most negative influence on behaviour and/or offending?

What could be done to improve the outcomes of these aspects in relation to the children and/or young people whom you look after?

**Leaving Care and Transitions to Adulthood**

How would you describe the experiences of children and/or young people who are leaving care?

- Do you keep in touch with the children and/or young people you have looked after into adulthood?
- What support do they have?
- What are the main barriers?
- What aspects of care do you feel aids young people’s transition into adulthood?
- Alternatively what do you feel the main problems are?

Do you think the experience of leaving care has effects on behaviour and offending?

**Being a Carer**

How would you describe the government’s developments of the care system?

- What do you feel needs to be done to improve the care system further?
- Do you feel that the professionalization of the role as a carer has impacted on the attachments that can be made to the children and/or young people you care for?

Do you feel you get enough support and guidance from Social Services?

**Summary**

In general what has do you feel is the most negative aspect of the care experience in relation to its influences on behaviour and/or offending?

Positively, what do you feel the care experience offered?

Do you think the care experience makes things better or worse in relation to behaviour and/or offending?

What do you think is needed to aid the problem of offending within care and after?

Is there anything else you would like to add in relation to you care experience and its influences on behaviour and/or offending?
Thank you for taking part in this interview. All information will be held confidentially and you have the right to withdraw from the research at any point.

Interview Schedule for Leaving Care Team (LCT)

Name:
Job title:
Previous job title(s):

Section 1 – About you/Background

General
Age:
Sex:
Ethnicity:

Details of your role
Details of current role:
Details of previous role(s):
Time you work with children/young people (range in the form of years/months):
Type of placement(s) the children/young people you work with have experienced:
Number of placement(s) the children/young people you work with have experienced (range in the form of years/months):
Age of children/young people you work with:

Specifics of the needs of those you work with if applicable, e.g. behavioural difficulties, mental and/or physical disabilities, educational needs, transitional assistance.

Have you ever looked after children/young people with extreme behavioural concerns or those who have offended?
Section 2

The overall Care Experience and its impact on behaviour

The following 12 aspects of life are known to relate to offending behaviour. In your experience as a member of the LCT, which of these aspects do you perceive to be a problem?

1 = No
2 = Yes, Slightly
3 = Yes, Definitely

Please enter 1, 2 or 3 in the boxes below for each of the 12 aspects before, during and after care. If your experience doesn't cover all the aspects, please just leave the box blank.

Do you feel this influenced any behavioural concerns and/or offending?

If so please tick the box ‘Influenced Bad Behaviour and/or Offending’ next to the period of your life that involved this problem.

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<td>Attitudes to offending are/were poor, wanting to do what they want/wanted and not thinking about the victim(s)</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Which of these experiences do you feel make those who have been in care and/or care leavers offend/offend more?

Which of these experiences do you perceive to have little impact on offending behaviour of those in care and/or care leavers?

Section 3 – Open ended questions

**Pre Care Influences**

How would you describe the impact of the pre care experiences for children and/or young people who enter the care system?

- Do you feel this has an impact on their behaviour?
- What do you feel are the main difficulties faced by these children and/or young people?
- What mechanisms are in place to help these children and/or young people overcome these adversities?
- How would you describe the support Social Services provide in addressing these circumstances?

**Entering Care**

Can you give a brief description of the process of children entering the care system?

- In your experience, how do children and/or young people react to this change in their living arrangements?

Are behavioural problems of a particular concern for those who enter your care?

**During Care**

What are the most prevalent types of care that children and/or young people enter?

Do you feel the care system offers stability for the children and/or young people?

- How do you feel numerous placement moves impact on the children and/or young people?
- How do you feel this differs from the children and/or young people living with their parents?
• How does the process of being in care impact in the children and/or young people’s relationships?
• Do you think this influences their behaviour?

What mechanisms are in place to ensure children and/or young people achieve within education?

Do you feel that carers can offer the discipline that families can, if not why?

What positive reflections do you have on the experiences of the children and/or young who are in care?

What do you feel are the main barriers for them?

What aspects of care do you feel has the most positive influence on behaviour and/or offending?

Alternatively, what do you feel is the most negative influence on behaviour and/or offending?

• What could be done to improve the outcomes of these aspects in relation to the children and/or young people within care?

Leaving Care and Transitions to Adulthood

How would you describe the experiences of children and/or young people who are leaving care?

• How does the Leaving Care Team (LCT) encourage the education of the children and/or young people in your care?
• What support does the Leaving Care Team offer them?
• What are the main barriers?
• What do you feel aids young people’s transition into adulthood?
• Alternatively what do you feel the main problems are?

Do you think the experience of leaving care has effects on behaviour and offending?

Working for the Leaving Care Team (LCT)

How would you describe the government’s developments of the care system?

• What do you feel needs to be done to improve the care system further?
• Do you feel that the professionalization of the role as a carer has impacted on the attachments that can be made to the children and/or young people who are in care/leaving care?

How would you describe the working relations between Carers, Social Services and the Leaving Care Team?

• Do you feel you get enough support and guidance from Social Services to allow your work with care leavers to be as beneficial as possible?
Summary

In general what has do you feel is the most negative aspect of the care experience in relation to its influences on behaviour and/or offending?

Positively, what do you feel the care experience offers?

Do you think the care experience makes things better or worse in relation to behaviour and/or offending?

What do you think is needed to aid the problem of offending within care and after?

Is there anything else you would like to add in relation to you care experience and its influences on behaviour and/or offending?

******Thank you for taking part in this interview. All information will be held****** confidentially and you have the right to withdraw from the research at any point.
Appendix H  Contact Details for Help, Advice and Support

AMSOSA UK (Adult Male Survivors of Sexual Abuse) - 0845 430 9371

A national helpline and support group for male survivors 17 and over of rape and childhood abuse.

Anger Management - 0845 1300 286

Part of the British Association of Anger Management, their national phone number above is available five days a week, 9am to 5pm. You'll find information about anger management therapy and programmes.

Care Leavers Association - 0161 236 1980

The Care Leavers Association provides advice to care leavers and directs them to services that can help. They help young people still in care, or who have just left care, who want to know about their entitlements or to get advice on certain issues, such as housing, education and employment etc. In addition they also offer advice and support to older adults, who were in care as children, on issues such as access to records, abuse in care and family tracing. If they do not have the resources in-house to deal with an enquiry – they will direct people to organisations that can provide further help and information.

Care Leavers Foundation - 01678 540 598

The Care Leavers' Foundation belief in extending some of the support, encouragement and financial assistance that most people take for granted. They make modest but vital grants to care leavers aged 18-29 who are in crisis, or who want to take control of their lives and develop new skills.

Childwatch - 01482 325 552

Free and confidential counselling for young people and adults who have suffered abuse, physical, mental, emotional, sexual.

Criminal Injuries Compensation Authority - Helpline 0800 358 3601

In order to claim compensation the victim would have had to report the crime to Police and co-operated in the investigation e.g. by giving evidence or by helping police identify the suspect.

Cruse Bereavement Care - 0870 167 1677

The registered charity provides a phone number for people suffering from grief. They provide emotional support for the bereaved and practical information for issues surrounding the death of a loved one.

First Steps to Freedom - 0845 120 2916

Their helpline is open from 10am to 2am and provides fact sheets and information such as audio tapes and books that may prove helpful to those suffering from anxiety related conditions.
**Jobcheck - 0870 608 4567**

Helpline for ex-offenders, prisoners, probation staff and employers. Cover a range of issues that affect ex-offenders seeking employment including when a conviction becomes spent, how to find local sources for help, information about the Criminal records Bureau and how to disclose a criminal record to an employer.

**Nacro-Resettlement Plus Helpline - 0800 018 1259**

Information and advice for prisoners, ex-offenders, their families and friends.

**NAPAC (National Association for People Abused in Childhood) - 0800 085 3330**

Provides referrals and free extracts from the DABS Resource Packs to survivors.

**National Domestic Helpline - 0808 200 0247**

Operated in partnership with Refuge and Women's aid, this is a free, 24hr telephone line that provides confidential support and advice to victims of domestic abuse and violence.

**National Alcohol Helpline - 0800 917 8282**

Also known as Drink-line, they're available Monday to Friday, 9.00am to 11.00pm. Operators provide support to people concerned about their drinking habits and offer information and alcohol misuse advice.

**No Panic - 0808 808 0545**

A voluntary charity that provides help to those suffering from panic attacks, phobias and anxiety related issues. Their free-phone telephone service is available seven days a week, 10am - 10pm.

**Prison Advice & Care Trust - 020 7735 9535**

Advice, information and support to the families of prisoners, prisoners and ex prisoners.

**Rape & Sexual Abuse Support Centre - Helpline 0808 802 9999, Counselling 020 8683 3311**

Helpline support and information for all survivors of rape or childhood sexual abuse.

**Samaritans - 08457 90 90 90**

They're available 24 hours a day and provide confidential support for people in emotional distress. They offer an unbiased, non judgemental service and can be contacted by telephone, letter, e-mail and mini-com. There's also a face-to-face service, available at their branches.
Sane Line - 0845 767 8000
Operated by the charity organisation, SANE, this help-line is open 1pm to 11pm everyday and provides depression support and help. All calls are answered by trained volunteers. They also give information and advice about seeking help for depressive illness.

Sexual Violence Legal Advice Line - 020 7251 8887
Mondays 11am-1pm and Tuesdays 10am-12 noon. Free confidential legal advice to women on sexual violence issues including rape, sexual assault, child sex offences, family related sex offences, trafficking, general criminal legal advice.

Support Line - 0208 554 9004
Member of the Telephone Help-lines association, Support Line offers help to individuals on any issue. They provide non-judgemental, confidential support and advice to enable the caller to find ways of coping with a particular problem. They can also be contacted by post/email.

Talk To Frank - 0800 776 600
Also known as the National Drugs helpline, their telephone service is open 24hrs a day, seven days a week and provides information about drug abuse treatment and the help available to users and their families.

Victim Support line - 0845 30 30 900
It is there for people to talk about their experience of crime anonymously and in confidence. Supportline volunteers can give you emotional support and information over the phone and put you in touch with our local offices and with other organisations that can help you.
### Appendix I - The Guiding Principles of the Data Protection Act (1998) and Ethical Response

<table>
<thead>
<tr>
<th>Principle</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data must be processed fairly and lawfully.</td>
<td>In order to ensure the data was processed fairly, the researcher used the same thematic analysis with Atlas Ti for the interviews and SPSS analysis for the ASSET data. All of the data will be processed in lines with the eight principles and ethical criteria of confidentiality. In addition, due to the discussion of offending the participants were informed of the issues of disclosure and the researcher's responsibility to report disclosures that present risk of serious harm to others. The full discussion of disclosure can be found below.</td>
</tr>
<tr>
<td>Data must be collected and processed for only one or more specified purposes. In other words, we must not collect data for one reason and then use it for something else.</td>
<td>The data collected was only used as set out within the UREC and RGA applications and supporting documents. The researcher confirmed that if there were alterations within the research analysis they would submit an additional application before carrying out any alterations.</td>
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<tr>
<td>Data we hold must be adequate for its purpose or purposes but not excessive or irrelevant.</td>
<td>The Interview Schedule was produced to ensure that only information necessary for the research was approached.</td>
</tr>
<tr>
<td>Data must be accurate and, where necessary, kept up-to-date.</td>
<td>Full transcriptions were made by the researcher to ensure all information was correct and double checked. The ASSET data was gained through the YOT and therefore had already been collected in line with the Data Protection Act (1998).</td>
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<td>Principle</td>
<td>Response</td>
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<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>We must not keep data for longer than necessary.</td>
<td>The researcher remained the main custodian of the data generated through the study until her tenure as a PhD student is completed, thereafter the researchers supervisor will have the data for a period of 5 years in line with recommendations.</td>
</tr>
<tr>
<td>We must process data in accordance with the rights of the data subject under the Act.</td>
<td>The data processed was done so in accordance to the privacy of the participant and all the governing principles of the Data Protection Act (1998).</td>
</tr>
<tr>
<td>Data must be kept securely and we must guard against its accidental loss.</td>
<td>Please see the discussion of confidentiality and anonymity above, showing how all data was kept securely and protected against lost at all times.</td>
</tr>
<tr>
<td>We must not transfer personal data outside the European Economic Area unless the Country receiving it has an adequate level of protection for the rights and freedoms of data subjects.</td>
<td>None of the personal data was transferred away from the researcher.</td>
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</table>


## Appendix J  SPSS Overall Mean Risk Levels

**SPSS Overall Mean Risk Levels***

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<thead>
<tr>
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<th>After Care</th>
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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3= Yes, Definitely
**SPSS Foster Mean Risk Levels***

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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3= Yes, Definitely
### SPSS Kinship Mean Risk Levels

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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3= Yes, Definitely*
**SPSS Residential Mean Risk Levels**

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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3 = Yes, Definitely*
### Appendix K

**Breakdown of Risk Factors: Across Placement Types**

**Living Arrangements***

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<tr>
<td>Foster</td>
<td>90.9% (n=10)</td>
<td>81.8% (n=9)</td>
<td>45.5% (n=5)</td>
</tr>
<tr>
<td>Kinship</td>
<td>50% (n=2)</td>
<td>0% (n=0)</td>
<td>25% (n=1)</td>
</tr>
<tr>
<td>Residential</td>
<td>83.3% (n=5)</td>
<td>100% (n=6)</td>
<td>66.7% (n=4)</td>
</tr>
<tr>
<td>Overall</td>
<td>81% (n=17)</td>
<td>71.4% (n=15)</td>
<td>47.6% (n=10)</td>
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*Foster n=11, Kinship n=4, Residential n=6 and Overall n=21

**SPSS Mean Risk for Living Arrangements***

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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3= Yes, Definitely

**Family and Personal Relationships***

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<th>During Care</th>
<th>After Care</th>
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<tbody>
<tr>
<td>Foster</td>
<td>81.8% (n=9)</td>
<td>72.7% (n=8)</td>
<td>27.3% (n=3)</td>
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<tr>
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<td>0% (n=0)</td>
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<tr>
<td>Residential</td>
<td>100% (n=6)</td>
<td>83.3% (n=5)</td>
<td>66.7% (n=4)</td>
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<tr>
<td>Overall</td>
<td>81% (n=17)</td>
<td>61.9% (n=13)</td>
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*Foster n=11, Kinship n=4, Residential n=6 and Overall n=21

**SPSS Mean Risk for Family and Personal Relationships***

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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3= Yes, Definitely
### EET*

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<td>Overall</td>
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<td>66.7% (n=14)</td>
<td>42.9% (n=9)</td>
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*Foster n=11, Kinship n=4, Residential n=6 and Overall n=21

### SPSS Mean Risk for EET*

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<td>1.45</td>
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<tr>
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<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Residential</td>
<td>1.33</td>
<td>2.5</td>
<td>1.83</td>
</tr>
<tr>
<td>Overall Mean</td>
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<td>1.57</td>
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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3 = Yes, Definitely

### Neighbourhood*

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<td>75% (n=3)</td>
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<tr>
<td>Residential</td>
<td>66.7% (n=4)</td>
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<td>100% (n=6)</td>
</tr>
<tr>
<td>Overall</td>
<td>66.7% (n=14)</td>
<td>42.9% (n=9)</td>
<td>66.6% (n=14)</td>
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*Foster n=11, Kinship n=4, Residential n=6 and Overall n=21

### SPSS Mean Risk for Neighbourhood*

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<th>After Care</th>
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<tbody>
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<td>Kinship</td>
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<tr>
<td>Residential</td>
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<td>2.5</td>
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<tr>
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<td>1.57</td>
<td>1.90</td>
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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3 = Yes, Definitely

### Lifestyle*

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<td>25% (n=1)</td>
<td>50% (n=2)</td>
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<tr>
<td>Residential</td>
<td>33.3% (n=2)</td>
<td>83.3% (n=5)</td>
<td>50% (n=3)</td>
</tr>
<tr>
<td>Overall</td>
<td>42.9% (n=9)</td>
<td>61.9% (n=13)</td>
<td>47.6% (n=10)</td>
</tr>
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*Foster n=11, Kinship n=4, Residential n=6 and Overall n=21
### SPSS Mean Risk for Lifestyle*

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<th>After Care</th>
</tr>
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<tr>
<td>Foster</td>
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<td>2.18</td>
<td>1.81</td>
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<td>Kinship</td>
<td>1.25</td>
<td>1.5</td>
<td>1.75</td>
</tr>
<tr>
<td>Residential</td>
<td>1.5</td>
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<tr>
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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3= Yes, Definitely

### Substance Use*

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<th>After Care</th>
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<tbody>
<tr>
<td>Foster</td>
<td>54.5% (n=6)</td>
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<td>45.5% (n=5)</td>
</tr>
<tr>
<td>Kinship</td>
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<td>25% (n=1)</td>
<td>50% (n=2)</td>
</tr>
<tr>
<td>Residential</td>
<td>33.3% (n=2)</td>
<td>100% (n=6)</td>
<td>83.3% (n=5)</td>
</tr>
<tr>
<td>Overall</td>
<td>42.9% (n=9)</td>
<td>71.4% (n=15)</td>
<td>57.1% (n=12)</td>
</tr>
</tbody>
</table>

*Foster n=11, Kinship n=4, Residential n=6 and Overall n=21

### SPSS Mean Risk for Substance Use*

<table>
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<th>During Care</th>
<th>After Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster</td>
<td>1.9</td>
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<td>1.72</td>
</tr>
<tr>
<td>Kinship</td>
<td>1.25</td>
<td>1.25</td>
<td>1.75</td>
</tr>
<tr>
<td>Residential</td>
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<td>2.33</td>
</tr>
<tr>
<td>Overall</td>
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<td>2.19</td>
<td>1.90</td>
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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3= Yes, Definitely

### Physical Health*

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<th>After Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster</td>
<td>72.7% (n=8)</td>
<td>54.5% (n=6)</td>
<td>36.4% (n=4)</td>
</tr>
<tr>
<td>Kinship</td>
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<td>0% (n=0)</td>
<td>0% (n=0)</td>
</tr>
<tr>
<td>Residential</td>
<td>50% (n=3)</td>
<td>66.7% (n=4)</td>
<td>50% (n=3)</td>
</tr>
<tr>
<td>Overall</td>
<td>61.9% (n=13)</td>
<td>47.6% (n=10)</td>
<td>33.3% (n=7)</td>
</tr>
</tbody>
</table>

*Foster n=11, Kinship n=4, Residential n=6 and Overall n=21
### SPSS Mean Risk for Physical Health*

<table>
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<th>After Care</th>
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<tbody>
<tr>
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<td>1.81</td>
<td>1.54</td>
</tr>
<tr>
<td>Kinship</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Residential</td>
<td>1.83</td>
<td>2.33</td>
<td>1.66</td>
</tr>
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<td>1.47</td>
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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3= Yes, Definitely

### Emotional and Mental Health*

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<th>During Care</th>
<th>After Care</th>
</tr>
</thead>
<tbody>
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<td>Foster</td>
<td>90.9% (n=10)</td>
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<td>72.7% (n=8)</td>
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<td>100% (n=4)</td>
<td>100% (n=4)</td>
</tr>
<tr>
<td>Residential</td>
<td>33.3% (n=2)</td>
<td>100% (n=6)</td>
<td>83.3% (n=5)</td>
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*Foster n=11, Kinship n=4, Residential n=6 and Overall n=21

### SPSS Mean Risk for Emotional and Mental Health*

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<th>After Care</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Residential</td>
<td>1.66</td>
<td>3</td>
<td>2.5</td>
</tr>
<tr>
<td>Overall Mean</td>
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<td>2.66</td>
<td>2.19</td>
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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3= Yes, Definitely

### Perceptions of Self and Others*

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<th>During Care</th>
<th>After Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster</td>
<td>54.5% (n=6)</td>
<td>81.8% (n=9)</td>
<td>63.6% (n=7)</td>
</tr>
<tr>
<td>Kinship</td>
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<td>50% (n=2)</td>
<td>50% (n=2)</td>
</tr>
<tr>
<td>Residential</td>
<td>33.3% (n=2)</td>
<td>66.7% (n=4)</td>
<td>50% (n=3)</td>
</tr>
<tr>
<td>Overall</td>
<td>38.1% (n=8)</td>
<td>71.4% (n=15)</td>
<td>57.1% (n=12)</td>
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*Foster n=11, Kinship n=4, Residential n=6 and Overall n=21
### SPSS Mean Risk for Perception of Self and Others*

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<th>After Care</th>
</tr>
</thead>
<tbody>
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<td>Residential</td>
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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3= Yes, Definitely

### Thinking and Behaviour*

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<th>After Care</th>
</tr>
</thead>
<tbody>
<tr>
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<td>36.4% (n=4)</td>
</tr>
<tr>
<td>Kinship</td>
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<td>50% (n=2)</td>
<td>25% (n=1)</td>
</tr>
<tr>
<td>Residential</td>
<td>50% (n=3)</td>
<td>100% (n=6)</td>
<td>66.7% (n=4)</td>
</tr>
<tr>
<td>Overall</td>
<td>38.1% (n=8)</td>
<td>71.4% (n=15)</td>
<td>42.9% (n=9)</td>
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</tbody>
</table>

*Foster n=11, Kinship n=4, Residential n=6 and Overall n=21

### Attitudes to Offending*

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<th>After Care</th>
</tr>
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<tbody>
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<td>27.3% (n=3)</td>
<td>27.3% (n=3)</td>
</tr>
<tr>
<td>Kinship</td>
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<td>50% (n=2)</td>
<td>50% (n=2)</td>
</tr>
<tr>
<td>Residential</td>
<td>50% (n=3)</td>
<td>83.3% (n=5)</td>
<td>33.3% (n=2)</td>
</tr>
<tr>
<td>Overall</td>
<td>33.3% (n=7)</td>
<td>47.6% (n=10)</td>
<td>33.3% (n=7)</td>
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*Foster n=11, Kinship n=4, Residential n=6 and Overall n=21
SPSS Mean Risk for Attitudes to Offending*

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<tbody>
<tr>
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<td>1.54</td>
<td>1.36</td>
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<tr>
<td>Kinship</td>
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<td>Residential</td>
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<td>Overall Mean</td>
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<td>1.47</td>
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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3= Yes, Definitely

Motivation to Change*

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<th>After Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster</td>
<td>27.3% (n=3)</td>
<td>36.4% (n=4)</td>
<td>36.4% (n=4)</td>
</tr>
<tr>
<td>Kinship</td>
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<td>50% (n=2)</td>
<td>50% (n=2)</td>
</tr>
<tr>
<td>Residential</td>
<td>33.3% (n=2)</td>
<td>83.3% (n=5)</td>
<td>33.3% (n=2)</td>
</tr>
<tr>
<td>Overall</td>
<td>23.8% (n=5)</td>
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<td>38.1% (n=8)</td>
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*Foster n=11, Kinship n=4, Residential n=6 and Overall n=21

SPSS Mean Risk for Motivation to Change

<table>
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<th>After Care</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1.54</td>
</tr>
<tr>
<td>Kinship</td>
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<td>1.5</td>
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<td>Residential</td>
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*Care Leaver SPSS Calculated Mean Tables: 1 = No Risk Experienced 2 = Yes, Slightly 3= Yes, Definitely
Appendix L

Mean Level of Influences to Offending Expressed by Risk Factor for Foster Placement Participants and Overall Care System: Before, During and After Care*

<table>
<thead>
<tr>
<th></th>
<th>Foster: Before Care</th>
<th>Overall: Before Care</th>
<th>Foster: During Care</th>
<th>Overall: During Care</th>
<th>Foster: After Care</th>
<th>Overall: After Care</th>
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</thead>
<tbody>
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<td>Living Arrangements</td>
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<td>1.55</td>
<td>1.57</td>
<td>1.27</td>
<td>1.24</td>
</tr>
<tr>
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<td>1.64</td>
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<td>1.43</td>
<td>1.27</td>
<td>1.24</td>
</tr>
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<td>1.36</td>
<td>1.43</td>
<td>1.09</td>
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<td>1.62</td>
<td>1.27</td>
<td>1.38</td>
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<td>1.36</td>
<td>1.33</td>
<td>1.27</td>
<td>1.19</td>
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<td>1.36</td>
<td>1.38</td>
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<td>1.67</td>
<td>1.36</td>
<td>1.43</td>
</tr>
<tr>
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<td>1.27</td>
<td>1.52</td>
<td>1.18</td>
<td>1.29</td>
</tr>
<tr>
<td>Motivation to Change</td>
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<td>1.24</td>
<td>1.36</td>
<td>1.57</td>
<td>1.18</td>
<td>1.19</td>
</tr>
</tbody>
</table>

*Care Leaver SPSS Calculated Mean Influence by Risk Factor: 1= No influence, 2= Influence
Mean Level of Influences to Offending Expressed by Risk Factor for Kinship Placement Participants and Overall Care System: Before, During and After Care*

<table>
<thead>
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<th>Risk Factor</th>
<th>Kinship: Before Care</th>
<th>Overall: Before Care</th>
<th>Kinship: During Care</th>
<th>Overall: During Care</th>
<th>Kinship: After Care</th>
<th>Overall: After Care</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1</td>
<td>1.57</td>
<td>1</td>
<td>1.24</td>
</tr>
<tr>
<td>Family and Personal Relationships</td>
<td>1</td>
<td>1.62</td>
<td>1</td>
<td>1.43</td>
<td>1</td>
<td>1.24</td>
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<tr>
<td>EET</td>
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<td>1.25</td>
<td>1.43</td>
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<td>1.24</td>
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Bibliography


