THE OCCURRENCE AND INFLUENCING FACTORS OF SUICIDAL IDEATION AMONG PEOPLE WITH CARE EXPERIENCE

A cross-national comparison between England and Germany

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Declaration of Authorship

I, Petra Göbbels-Koch, hereby declare that this thesis and the work presented in it is entirely my own. Where I have consulted the work of others, this is always clearly stated.

Signed: ______________________ Date: 18th May 2022

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ABSTRACT

Suicide is the second leading cause of death among young people worldwide (World Health Organisation, 2014). People with care experience have an elevated risk of suicidal ideation and behaviour and dying by suicide compared to those without care experience (Evans et al., 2017).

However, the existing empirical information on suicidal ideation among care-experienced people, particularly young adults leaving care in England and Germany, is scarce. An in-depth understanding of factors influencing the development and coping strategies is required to help inform suicide prevention strategies within the care systems tailored to young people in care and the transition to adulthood. Furthermore, it remains unclear whether the knowledge about this topic applies beyond national borders due to the lack of cross-national comparative studies about suicidal ideation among people with care experience.

Therefore, this thesis addresses the following research questions: what is the occurrence of suicidal ideation among care-experienced young adults in England and Germany? Which factors do care-experienced young adults perceive as influencing suicidal ideation? This thesis applied a mixed-methods approach, consisting of a survey and semi-structured interviews with care-experienced adults from England and Germany, to answer these questions. Joiner's interpersonal-psychological theory of suicide (IPTS) informed the study, focusing on interpersonal factors influencing suicidal ideation. This study is the first that applied this suicide theory to people with care experience.

This study shows that the occurrence of suicidal ideation among care-experienced people is complex. Many participants reported having experienced suicidal thoughts from a young age and during the transition from care to adulthood. The results underline the importance of belongingness and caring relationships for care-experienced people.

This innovative thesis aims to deepen the understanding of suicidal ideation among care-experienced people in England and Germany. The findings highlight the necessity of holistic suicide prevention based on trauma-informed practices within the care system.

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1. INTRODUCTION

Young people are taken into state care when they cannot live with their family anymore due to various reasons which present a risk to their well-being. Some stay in the care system for several years and sometimes for most of their childhood and adolescence. Research has for decades looked at the living conditions, well-being and various outcomes of people with care experience and considered this group as vulnerable due to several investigated disadvantages and challenges before, during and after care (Stein, 2006a).

A unique and growing attention in research and practice has been drawn to the transition from care to adulthood (Ehlke et al., 2021; Stein, 2006a). Young people age out of care usually when they turn 18 years old. They are widely known as 'care leavers' in the international professional discourse. Generally, the development from adolescence to adulthood comes with social expectations of achieving an independent living, which is particularly a challenge for care leavers, as they face this transition at a younger age than their peers and have fewer social resources to rely on (Sievers et al., 2016). For many young people, adolescence and young adulthood contain instabilities and uncertainties concerning the future and identity (Arnett, 2007).

Statistics published by the World Health Organisation (WHO) show a global risk for young people to die by suicide, especially between the ages of 15 and 29 (World Health Organisation, 2018). Suicide prevention is on the global public health agenda. It is crucial to identify risks, deal with such threats and support young people, particularly those considered vulnerable, to allow them to develop a self-confident, satisfying life and future perspective. Research from several countries has identified people with care experience as at an increased risk of suicidal ideation and behaviour and dying by suicide (Evans et al., 2017; Vinnerljung et al., 2006).

However, as suicide rates, groups at risk and care systems differ from one country to another, it is questionable how far the results from one country are transferable to others. In addition, it remains unclear how far different national child welfare systems and structures of support influence the risk of suicide among care-experienced people. Despite the wealth of research about the outcomes of children in care, it is missing a homogenous cross-national study design based on primary data of lived experience to explore suicidal ideation among young adults in the transition from care to adulthood, in this case, from England and Germany. The two countries' care systems and leaving care experiences show certain similarities and differences,

making the comparison and exploration of the potential transfer of knowledge about this topic interesting.

Therefore, this thesis pursues two central aims to understand the risk and elements of suicidal ideation among people with care experience by conducting a cross-national study in Germany and England. Firstly, this project investigates the occurrence of suicidal ideation in young adults who have left the out-of-home care system in both countries. Secondly, the study explores factors influencing suicidal ideation, covering its development, prevention and coping strategies.

With a mixed-methods design of quantitative and qualitative approaches, the findings provide comprehensive insights into the experiences of suicidal ideation among care-experienced adults from both countries. Concerning the specific social conditions related to the care experience of young people, this thesis applies Joiner's (2005) interpersonal-psychological theory of suicide. This relatively novel suicide theory focuses on relational factors and has not yet been applied to a group of care-experienced people. The study focuses on suicidal ideation instead of suicidal behaviour, attempts or death by suicide. Based on the theoretical framework, suicidal ideation can be seen as the cognitive foundation of the risk of suicide. Exploring factors influencing both the occurrence of and coping with suicidal thoughts is fundamental to help inform suicide prevention tailored to people with care experience.

This thesis aims to deepen the understanding of suicidal ideation among care-experienced young people, with a specific focus on the impact of the transition from care in early adulthood on its development. Further to this, this research intends to contribute to developing evidence-informed practices of suicide prevention tailored to young people with care experience.

The thesis is structured as follows: after presenting a scoping review to provide an overview of the existing empirical research and the research gaps on this topic, a broader review of the literature presents the two care systems in England and Germany, including leaving care approaches, relevant information about the risk of suicide among young people with care experience, and suicide theories. The following part features the research questions, methodology and ethical considerations in conducting this study. After presenting the findings from the online survey and interviews, the final part features a discussion of the results in light of the existing literature and theoretical foundation. In addition, implementations for policy and practice and limitations of this study are discussed. The thesis closes with a conclusion, including suggestions for future research.

2. EMPIRICAL AND THEORETICAL BACKGROUND

To explore the research gaps and provide a brief overview of previous studies on suicidal ideation among people with care experience, focusing on those in the transition from care, this chapter starts with a short presentation of a scoping review. The relevant studies identified in the scoping review are then presented and contextualised in the broader existing literature about suicidal ideation, care experience and the transition from care. Apart from an overview of the (leaving) care systems of England and Germany and the known risk of suicide among people with care experience, the following sections present definitions of suicidal ideation and behaviour and a synopsis of theories of suicide. The chapter proceeds with a discussion of one selected suicide theory in light of the previous empirical work on the risk of suicide among young people with care experience. The chosen suicide theory provides the conceptual foundation of the empirical work presented in this thesis.

2.1 Identifying the empirical foundation and research gap: A scoping review

To find essential literature about the risk of suicide among young people leaving care in England and Germany and identify research gaps, a systematic approach of a literature search via a scoping study was conducted (Aveyard et al., 2016). In Figure 1, the PRISMA (‘Preferred Reporting Items for Systematic reviews and Meta-Analyses’) diagram visualises the selection process of articles (see Aveyard et al., 2016; Moher et al., 2009; PRISMA, 2019).

Five databases were searched (as of June 2019): Royal Holloway Library, PubMed, PubPsych, peDOCS and fachportal-paedagogik. Peer-reviewed articles that contained the following search terms and criteria were included: care leavers, children/young people in care, in foster/residential care, suicide/suicidal ideation/behaviour, England or Germany, published in English or German and published after 2000, because the Children (Leaving Care) Act 2000 was published at that time and provides a statutory foundation for leaving care support in England.

Studies from other countries were only included if they were considered suitable and relevant and fit the other criteria. Articles were excluded with the reversed or not relevant criteria, such as unaccompanied asylum-seeking minors, medical patients, elderly people in care, education and employment, homelessness, minority ethnic background or non-suicidal self-injury, newspaper articles or recensions. If a study solely looked at children still in care and focused

not intensively on the risk of suicide, it was also excluded. The following keywords in English and German were used in diverse combinations: suicid*, Suizid*, Selbstmord*, care leaver*, care leav*, children in care, young people in care, youth welfare, Jugendhilfe, Hilfen für junge Volljährige, Heim*, Pflegekind*, England, Germany and Deutschland.

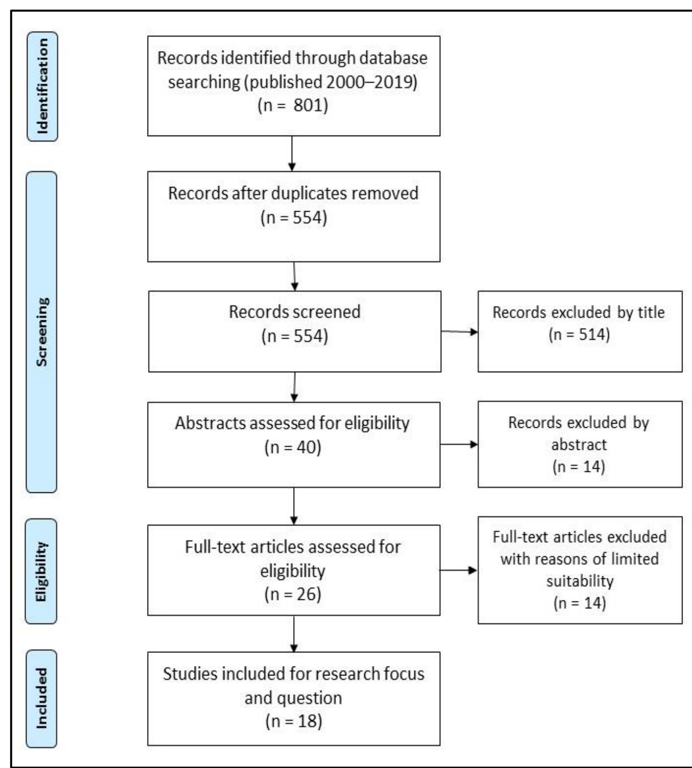

Figure 1: PRISMA diagram; template from prisma-statement.org (see Aveyard et al., 2016, Moher et al., 2009)

In total, 554 different articles published between 2000 and 2019 were listed. After selecting the results by title, date, language, access to full text and suitability, 26 studies were included for further review of the full texts. Eighteen out of 26 studies fitted the inclusion criteria and focused on suicides, suicidal ideation and behaviour among care-experienced people, including studies about both young people still in care and care leavers. Appendix 1 shows an overview of the 18 identified studies.

The results contained academic papers with different methodological approaches, including quantitative and qualitative studies and literature reviews. Ten papers focused on care leavers and care-experienced adults. Six focused on children or adolescents who were still in care. Due to the study design and focus, two did not specify whether they referred to young people still in care or care leavers. Five papers presented information from England, whereby one paper was a literature review comparing outcomes of care leavers in England and France (Stein and Dumaret, 2011). The other four used primary or secondary data about suicide attempts and suicides among care-experienced adults from England (Bullock and Gaehl, 2012; Goddard and Barrett, 2008; Slater et al., 2015; Ward, 2011). However, they did not focus on suicidal ideation. A further five papers presented studies from other parts of the UK: three from Northern Ireland (Cousins et al., 2010; Daly, 2012; Hamilton et al., 2015), one from Scotland (Harkess-Murphy et al., 2013), one generally referring to the UK (Mallon, 2005). Six papers were from other countries: the USA (Pilowsky and Wu, 2006), Canada (Baiden and Fallon, 2018; Katz et al., 2011), Sweden (Berlin et al., 2011; Vinnerljung et al., 2006) and Finland (Kalland et al., 2001). No study from Germany was found. Two papers were unspecific about the origin due to one

being a general focus on a therapeutic approach for young people leaving care (Andrew et al., 2014) and one being a meta-analysis from studies about suicidal ideation and behaviour among young people in care from several countries, including England, Canada, the USA and Australia (Evans et al., 2017).

All selected studies mentioned the high risk of suicidal behaviour for care-experienced people, presented in more detail in the following sections. Furthermore, several studies from different countries highlighted that people with care experience show higher rates of suicidal ideation and behaviour or death by suicide compared to those without care experience (Berlin et al., 2011; Bullock and Gaehl, 2012; Evans et al., 2017; Katz et al., 2011; Pilowsky and Wu, 2006; Vinnerljung et al., 2006). The main factors identified to contribute to the risk of suicide were poor educational performance (Mallon, 2005), a low educational qualification, a lack of continuity of (former) care practitioners (Berlin et al., 2011), unemployment, male gender, adverse childhood experiences, and types and higher number of placements (Hamilton et al., 2015).

However, the dominant focus of the existing empirical work is on suicide attempts or death by suicide. Five papers focused, among other aspects, on suicidal ideation (Baiden and Fallon, 2018; Evans et al., 2017; Hamilton et al., 2015; Harkess-Murphy et al., 2013; Pilowsky and Wu, 2006), whereas only one of those refers to young people leaving care (Hamilton et al., 2015). None of those concentrated on suicidal ideation among young adults leaving care in England or Germany. No paper presented a cross-national comparison with primary data or influencing factors from a care-experienced young adult’s perspective.

This literature search was updated in April 2022. Five new relevant papers were published between June 2019 and April 2022. One study investigated conditions related to deaths by suicide among children and adolescents in the UK, including looked-after children (Rodway et al., 2020). The second paper presented a quantitative study from Sweden about the comparison of outcomes in adulthood, including suicidal behaviour and suicides, between former foster children and their siblings who lived with their families (Brännström et al., 2020). The third paper presented a study from France about the role of attachment with biological parents and foster carers and how it influences the risk of suicide among maltreated, care-experienced people in adulthood (Danner Touati et al., 2021). The remaining two were review papers covering an overview of mental health problems, including a higher prevalence of suicidal ideation and behaviour, among people with care experience (Engler et al., 2022; McKenna et al., 2021). McKenna et al. (2021) reported that among the 55 studies identified in their scoping

review on long-term mental health outcomes in adulthood of former youth involved in child welfare services, suicidal ideation and the death by suicide have received the least attention.

The little empirical coverage found in this review highlights a gap in research about suicidal ideation among young people leaving care during early adulthood in England and Germany. The review underlines the need to further investigate this topic due to the identified risk of suicide among this group from several countries, backing a cross-national comparison with primary data. There is a need to better understand the risk of suicide among young people aged out of care that aims to contribute to tailored suicide prevention strategies. Therefore, it is essential to investigate the occurrence of suicidal ideation among care-experienced young adults and which factors cause or reduce these suicidal thoughts.

The following theoretical and empirical background includes a selective literature review incorporating and supplementing the scoping study findings. The narrative synthesis aims to contextualise the research topic beyond the 18 studies identified in the scoping review by describing the group of interest, the care system in both countries and the phenomenon of suicidal ideation and behaviour. The more comprehensive empirical and theoretical background leads to the conceptual framework, fundamental argumentation for the research project and the identification of a more specific research focus.

2.2 Care experience and the transition from care to adulthood

Young people become looked-after by the state and enter the public care system, also referred to as out-of-home care, when it is not possible for them to live with their biological parents, either temporarily or permanently. This group is often interchangeably called 'looked-after children' or 'children in care' in the English literature and belongs to a broader term of 'people with care experience' (Gupta, 2016; The Care Inquiry, 2013a). This thesis uses the terms 'people with care experience' and 'care-experienced people' interchangeably.

Most young people become looked after because of childhood adversities such as maltreatment, family dysfunctions or breakdowns, and absent parenting like in cases of unaccompanied minors seeking asylum (Department for Education, 2018). The looked-after system is generally diverse with respect to the options of out-of-home placements: short-term to long-term placements, residential, foster or kinship care or adoption (Gupta, 2016). These interventions for out-of-home placements are based on safeguarding principles, preventing or mitigating the risk of harm as is necessary for the child's health and safety (Burns et al., 2017b, 2017a). The

further focus is on residential and foster care. This study does not include kinship care and adoption, inter alia, because they provide different relationships between child and carer compared to residential or foster care. Another reason for this omission is that non-consensual adoptions are not an option in Germany, which would not be suitable with respect to the planned cross-national comparison.

Young people leave the care system (residential or foster care) usually when they turn 18 years old, in some cases even earlier, from the age of 16 years. The term 'care leaver' is considered controversial due to the possible stigmatisation of this specific group. Hiles et al. (2014) interviewed young people leaving care who mentioned that they feel stigmatised and confused about their identity as care leavers (see also Adley and Jupp Kina, 2017). Sievers et al. (2016) mentioned that the English term care leaver is increasingly used in the international and non-English literature and professional communities, including Germany. They argue that this commonly used term is helpful to specify the focus on the situation of this group (Sievers et al., 2016). To avoid misunderstandings, the common term care leavers is used in this thesis as the following description of a specific group: older adolescents and young adults who have been in care at or after the age of 16 and are in the transition from care and eligible for leaving care support (usually up to age 21 or 25). The Department of Education defines care leavers as follows: "The cohort covers children looked after for a total of at least 13 weeks after their 14th birthday, including some time after their 16th birthday" (Department for Education, 2017, p. 15). These young people are supposed to develop their own independent life by the time they leave the care system (The Care Inquiry, 2013b). Statutory support for the transition process from the care system to adult life is defined as a duty of youth welfare authorities at least until care leavers turn 21 years of age, with the possibility of receiving further support until the age of 25 in England or until the age of 27 in Germany if certain conditions are met (see §41 SGB VIII, Children and Social Work Act 2017 c. 16).

Within this context, the transition from care relates to the expectation of living independently as an adult. Nevertheless, the transition from dependence during care to independence all at once is not realistic. Therefore, after leaving the last care placement, the period is often referred to as 'interdependence' instead of independence. Interdependence after leaving care indicates that young people leaving care are in a partly dependent relationship with social or professional support systems (Cameron et al., 2018; Mendes and Moslehuddin, 2006; Sievers et al., 2016). Independent living instead refers to a self-dependent final goal and a target outcome in further adulthood.

Arnett (2007) introduced the term 'emerging adulthood' as the development from adolescence to adulthood. This developmental stage, which covers the age between the late teens and the mid- to late 20s, is diverse and characterised by new responsibilities, instabilities in lifestyles and identity, and possible mental health issues for some. While some studies presented an increase in mental well-being (for example, by decreasing the rate of depression) and self-esteem between the ages of 18 to 25, others within this age group experience an increase in mental health issues. The latter group includes vulnerable subgroups such as young adults with care experience (Arnett, 2007).

Young people with care experience are considered a vulnerable population with reduced chances in life in several areas compared to their peers who grew up in their birth families and experienced ongoing parental support (Bullock and Gaehl, 2012; Sievers et al., 2016). Poorer educational or employment outcomes, health difficulties, unstable accommodation and financial situations, early parenthood, offending behaviour and changing relationships, for instance, are more likely for people with care experience than for others (Dixon, 2008; Gypen et al., 2017). Outcomes of young people with care experience are influenced by multiple factors such as living together with their siblings in care (Ashley and Roth, 2015) or (in)stability of placements and relationships (Bollinger et al., 2021; Ward, 2011).

Young people with care experience have higher rates of mental health disorders than the general population (Engler et al., 2022). Despite the higher need for mental health support, many countries show a lack of mental health service provisions for care-experienced young people. For instance, Baiden and Fallon (2018) reported issues in accessing mental health support for maltreated children involved in the child welfare system in Canada. The study showed that about three-quarters of maltreated children who engaged in self-harming behaviour and two-thirds who expressed suicidal ideation did not receive access to mental health support (Baiden and Fallon, 2018).

In Germany, collaborations between psychiatric services for youth and especially residential care exist. However, a further extension and intensification of this collaboration between these two systems would be still required to fill the existing gaps and better address the mental health needs of young people in care (Nützel et al., 2005). Schmid (2008) highlighted the risk for several social problems and complex disorders for young people leaving care. He criticised the gap in the transition from youth services to appropriate adult mental health services in Germany (Schmid, 2008).

Similarly, Briheim-Crookall et al. (2020a) also call for the need to improve the transition from child to adult mental health services in England. Several authors criticised that Children and Adolescent Mental Health Services (CAMHS) in England are underfunded (Callaghan et al., 2017), have long waiting lists for specialised services (York and Jones, 2017) and even restrict access to support for looked-after children if they are not in a stable care placement (Mooney et al., 2009). Stanley et al. (2005) criticised the fact that available long-term support was not provided and directed to those looked-after children with the highest mental health needs after initial assessment. Several researchers claim that while many children in care have mental health needs that would require the service by CAMHS, only a comparatively small number would access the service, although early interventions would counteract the risk of further deterioration of their mental health and socio-ecological problems in adulthood (Callaghan et al., 2017; York and Jones, 2017). Issues have been identified in the inter-agency collaboration between social work and other professions working with looked-after young people that can also affect the efficacy of service provision and, thus, outcomes (Kaip et al., 2022).

Despite opportunities for support after leaving care regulated by law, several researchers have reported discrepancies between policies and reality which often picture disappointment by young people with care experience. Compared to their peers, who live with their families of origin, young people in care are forced to become independent much earlier within a short time and have limited resources of support (Sievers et al., 2016; Strahl et al., 2012; The Care Inquiry, 2013b). Young adults leaving care often experience the depressing feeling of being left alone, not being prepared for an independent life, experiencing another breakdown and further instabilities in relationships and living conditions (Adley and Jupp Kina, 2017; Briheim-Crookall et al., 2020a; Sulimani-Aidan, 2014; Ward, 2011). Moreover, these young people have often experienced a precipitate leave and a sudden cut in support (Doll, 2017; Sievers et al., 2016).

The outcomes within this population vary. Stein (2006a, 2012) distinguishes between three groups of care leavers concerning their post-care outcomes: the first group is called 'moving on' and includes people who achieve positive outcomes and experienced more stability and continuity during care. They have achieved an independent lifestyle successfully. The second group are the 'survivors' who have experienced several placement and relationship breakdowns during care, are more likely to undergo times of homelessness, and just a few are in education or employment. They behold themselves as 'tough' and self-reliant and able to cope with problems. The third group, the 'victims' or 'strugglers', registers the most complex difficulties during life, including highly damaging pre-care experiences, disruption during care and worse

post-care outcomes. They undergo behavioural and mental problems earlier than their peers in the care system and face loneliness, social isolation and mental disorders as care leavers (Stein, 2012, 2006a).

In the first months after leaving care, many young people experience increased mental problems, including symptoms of suicidal ideation and behaviour (Stein and Dumaret, 2011; Ward, 2011). Research from different European countries has presented that care leavers are more likely to face additional challenges in their late teens or early adulthood, such as teenage pregnancy, unemployment, low educational qualification, homelessness, criminality or severe health problems (see Berlin et al., 2011; Cameron et al., 2018; Knight et al., 2006; Stein, 2006a; Stein and Dumaret, 2011; Wade and Munro, 2008). Mallon (2005) identified discontinuation of contact with previous carers and social workers after leaving care along with the fear of feeling abandoned by the care system, the lack of investment in the young people, self-doubt and fear of failure as post-care risk factors among care-experienced people with no or low educational background. The absence of a supportive social network and loneliness as common experiences among young people leaving care is repeatedly highlighted in the international literature, which explains that reliable social relationships are essential for a smooth transition from care to an in(ter)dependent living (Sievers et al., 2016; Sulimani-Aidan, 2014).

Although several countries have already undertaken research on people with care experience and their outcomes in their future life, international comparative studies on specific outcomes of young people in the transition from care to adulthood are still limited and have only received more interest during the last decade (Stein, 2012). The literature is missing a cross-national study design with the same standardised research tools to investigate the transition from care to adulthood and outcomes of young people leaving care which would make international comparisons possible (Harder et al., 2011). The current state of research on young people leaving care in Germany, especially regarding their mental health, shows gaps in knowledge about this group (Cameron et al., 2018). A cross-national study design between England and Germany about the risk of suicide among people leaving care based on primary data would contribute to filling some gaps in knowledge in each of the two countries and on an international basis.

Before focusing on one specific, little-investigated mental health concern among young adults with care experience, in this case, suicidal ideation, the following short overview presents the care systems in the two European countries in focus. Similarities and differences in leaving care in both countries are outlined afterwards.

2.2.1 England

The number of looked-after children in England has constantly increased in the last years. In March 2021, the Department of Education (2021) reported that 80,850 children in England were looked after, 1% more than in 2020, and a further 2% from the year before. Similarly, in March 2018, 75,420 children and adolescents were looked after by the state, 4% more than in 2017 from 72,000 (Department for Education, 2018). With 66% of these young people in 2021, the majority became looked-after because of abuse or neglect. Foster care remains the most prominent type of care in England. By 2021, 71% of all looked-after children in England were in foster placements, 14% were in residential placements such as secure units, children's homes or semi-independent living accommodation, 7% were placed with a parent while they were on a care order, 3% were placed for adoption, and the rest were in other forms of placements. Among these types, 7% of young people looked after were living in unregulated placements such as semi-independent living or living independently (Department for Education, 2021). This study will focus on the first two mentioned types of care placements: foster and residential care.

In England, 44,590 care leavers between 17 and 21 years old were registered between April 2020 and March 2021. The local authorities are supposed to stay in touch with the young person after leaving care. Local authorities reported that they were in touch with 73% to 95% of care leavers. The numbers vary by age group (Department for Education, 2021). However, these numbers must be interpreted with caution, as it is also counted as 'in touch' when the local authority had contact with the young person three months before and one month after the young person's birthday. The national statistical report does not explain the frequency and intensity of the contact between the local authority and a care leaver (Department for Education, 2018).

The youth welfare system and social work in England are based on child protection, risk management and risk minimisation (Evans and Kessl, 2016; Harder et al., 2013). Legal support from the youth care system is, in general, offered for people until the age of 21 (under special conditions also further), but many young people are not older than 18 years at the time they leave care (Hiles et al., 2014; The Care Inquiry, 2013b). The legal option of 'staying put' offers care leavers the opportunity to stay at the foster placement even after their 18th birthday until their 21st birthday or if they finish an educational or training programme, up to their 25th birthday (Department for Education, 2017). By law, ongoing support for care leavers is based on the *Children (Leaving Care) Act 2000*, *Care Planning, Placement and Case Review (England) Regulations 2010* and the *Children and Social Work Act 2017*. The latter describes

the principles of corporate parenting for every looked-after child and young person, meaning the legal responsibility of the local authority to provide adequate services with respect to the young person's needs, wishes and interests. Furthermore, the Act highlights that local authority must provide advice and support to young people until the age of 25, for example, with the individual 'pathway plan', a 'personal advisor' (PA) and be publishing information about local support services ('local offer for care leavers') (Sievers et al., 2016; Stein and Dumaret, 2011). Despite the provided legal preconditions for further support for several years after their 18th birthday, not every care leaver uses this support, they may struggle to access it and, therefore, must deal with all new challenges by themselves (Hiles et al., 2014; Sims-Schouten and Hayden, 2017).

For instance, Hiles et al. (2014) found that, inter alia, the authorisation of the request for staying put was uncertain and required a "fight for the necessary funding" (p. 6) together with the foster carers, as articulated by interviewed care leavers. The authors described that the preparation for the leaving care process did not always receive sufficient time, and gaps in the provision of mental health support occurred between child and adult mental health services. Some young people make the transition to adulthood by themselves without relevant resources such as parental support (Hiles et al., 2014). Findings from interviews published by Matthews and Sykes (2012) presented that some care leavers in England are not getting involved in planning their support (Matthews and Sykes, 2012). The Care Inquiry (2013) presented the views of care leavers, highlighting that leaving care is a vulnerable, overwhelming period for them with a lack of supporting people and long-lasting professional relationships, or with difficulty in communicating their own needs. The English studies by Adley and Jupp Kina (2017) and Ward (2011) support these findings.

In conclusion, the research examples show that some young people still miss out on the support they need and wish for in the transition from care to adulthood. However, the recent legislation *Children and Social Work Act 2017* had not yet been published and introduced when most of the studies presented were conducted.

2.2.2 Germany

The number of out-of-home placements for looked-after children in Germany was about 158,000 in 2020. Slightly more than half (53%) of those young people (83,482) were in residential care (§34 SGB VIII), and 33% (52,962) of the young people were in foster care (§33

SGB VIII). The remaining 14% (21,906) of the young people were in kinship care. About 18,000 young people who were 18 years old or older were still in residential care, and about 4,000 young adults lived in foster care, while about 20,000 young adults ceased accessing the support of residential or foster care in the same year (Statistisches Bundesamt, 2021a). The various out-of-home support services are part of the broad spectrum of statutory family and youth support services called *Hilfen zur Erziehung* (translated by International Youth Service of the Federal Republic of Germany [IJAB]: 'socio-educational support', see https://ijab.de/en/resources-for-practitioners/youth-work-translator-a-multilingual-glossary-of-specialist-terms), including family support, counselling and group services legally implemented in §§27–35 of the *8. Sozialgesetzbuch* (SGB VIII; translated by IJAB: *German Social Code VIII: The Child and Youth Service Act*).

Regarding fundamental characteristics of support for young people leaving care, Germany's youth welfare system and social work are part of a conservative welfare state with universal and right-based services and family-service orientation. Social work is predicated on social pedagogy, people's empowerment and positive risk-taking (Evans and Kessl, 2016; Harder et al., 2013). As Bain and Evans (2017) described, the interdisciplinary-informed principles of social pedagogy in the youth welfare system in Germany are not deficit-oriented but consider people's need for guidance to develop their capabilities. Social pedagogues focus on young people's development and empower them to manage their lives by building respectful and trusting relationships (Bain and Evans, 2017).

Like England, Germany also offers legal support from the youth welfare system for young people until the age of 21 (and also further). However, as mentioned before, many young people leaving care are not older than 18, and sometimes even younger (Harder et al., 2013; Hiles et al., 2014). The quantitative study by Klein (2021) reports that the average age of young people in Germany leaving (mainly residential) care was 18.5 years. About one third of the sample of 520 young people with care experience left care before their 18th birthday, one third left their last care placement when they were 18, and the last third were 19 years old or older when they left their last care placements. After leaving care, about two-thirds of the sample of care leavers moved into their own or a shared flat (Klein, 2021).

The German statutory 'support for young adults' is based on §41 SGB VIII. This article offers further pedagogical support to develop their personality and a self-dependent living based on the offers for young people under 18 years. Inter alia, the article contains access to pedagogical, therapeutic or counselling services, programmes for training and employment, social group

work, foster or residential care and support for living costs. Therefore, based on this article, young adults can request to stay in foster or residential care, including semi-independent accommodation, after their 18th birthday. The legal support for young adults intends to create person-centred aid based on the principle of participation (see §41 SGB VIII).

Köngeter et al. (2012) described that the approval of requests for support for young adults based on §41 SGB VIII is not compulsory. Therefore, the service arrangement varies from one welfare office to another and one young person to another. Apart from regional differences, the granting of support for young adults has declined since 2000 (Köngeter et al., 2012; Sievers et al., 2016). Similar to the reports from England, not every care leaver in Germany applies for support after their 18th birthday, for example, due to the required bureaucracy that presents a burden for young people (Klein, 2021; Sievers et al., 2016; Strahl et al., 2012). The study by Klein (2021) reported that 75% of the care-experienced sample applied for support for young adults based on §41 SGB VIII, with almost all (96%) requests approved.

However, in some cases of leaving care, a shift of responsibilities to other legal frameworks and institutions occurs. Schröer et al. (2016) call this sometimes-confusing shift for care leavers the bureaucratic 'transition jungle', as this also comes along with different laws and responsible authorities. Instead of the youth welfare office, care leavers often get in touch with, for example, job centres (regulated legally by the *SGB II: 2nd German Social Code Book 'Basic Income for Job Seekers'*) which provide programmes for education, training or employment and financial support but lack social pedagogical offers to address further needs (Sievers et al., 2016; Strahl et al., 2012).

Klein's (2021) quantitative study showed that about 80% of care leavers received some preparation for the time after leaving care, and about two-thirds of young people were involved in the planning of support after leaving care. However, adequate support following leaving care and connecting the transition process is not available for every care leaver. For instance, in 2011, 57% of care leavers did not receive any follow-up support from the youth welfare office (Nüsken, 2014).

In June 2021, the *Kinder- und Jugendstärkungsgesetz* (KJSG; translated by IJAB: *Act to Strengthen Children and Youth*), a revision of the SGB VIII, was published: this also contained a strengthening of rights for care leavers in Germany. The new law includes obligatory follow-up support for young people leaving care, a coming-back option after support has ended, and a reduction of the *Kostenheranziehung* (Achterfeld et al., 2021). Notably, the *Kostenheranziehung* (§91ff. SGB VIII) is a highly criticised approach. The approach allowed

the local authority that looks after a young person to keep up to 75% of the young person's wealth or income from a job or apprenticeship to cover the expenses of the young person's care. However, with the implementation of the KJSG in June 2021, this has been reduced to 25% of a young person's income (BAG KJS and BVkE, 2021; Loh and Vo, 2021). Loh and Vo (2021) highlighted that this approach often let young adults decide to terminate the support they received from the youth welfare office and dissuaded them from staying in care beyond age 18.

In summary, young adults leaving care in Germany face particular challenges, while having legal options to request support for the transition to adulthood. However, the current study and the reports by participants do not cover the changes by the KJSG established in June 2021.

2.2.3 Similarities and differences in the (leaving) care systems in England and Germany

The different numbers of looked-after young people in England and Germany may reflect different thresholds to enter the care systems. For instance, reasons for entry into out-of-home care cover threats to the child's welfare in both countries, but in Germany, further reasons are, among others, family conflicts or the child's social behaviour (Cameron et al., 2018). Generally, the main criteria for entering the looked-after system have many overlaps in both countries and are based on the risk for the child's well-being. The legal framework for young people leaving care shows similarities in both countries. Statutory child and youth support services for young adults are structured within the same age limits (18, 21 and 25 when in education or training) and focus on similar principles such as participation, advice and support, education or work and preparing them for independent living.

Differences are, for example, the legal obligation of the local authorities in England to provide a PA and an individual pathway plan for every former looked-after child, whereas this was not a legal duty for German welfare offices until 2021 (see §41 SGB VIII; Children Act 1989; Children and Social Work Act 2017). Doll (2017) describes that young people in care in Germany experience a sudden drop in their rights for support as soon as they turn 18 and leave care, which reflects the lack of legal obligation of the youth welfare offices for young adults.

Previous studies have already indicated similar experiences after leaving care in both countries: for example, some young people experience leaving care and the expectation of turning into an adult as a sudden, overwhelming moment that they did not feel prepared for (Daly, 2012; Goddard and Barrett, 2008; Strahl et al., 2012). They face the breakdown of relationships due

to the change of accommodation and responsibilities, which presents an additional experience of discontinuity (Sievers et al., 2016; Ward, 2011). With respect to the lack of support from the birth family, the relevance of at least one stable trustful relationship is considered beneficial for young people leaving care in England and Germany (Ehlke, 2013; Goddard and Barrett, 2008). Furthermore, similar risks for adverse outcomes such as low educational qualifications for employment, social exclusion and lack of a supportive network occur in both countries (Bullock and Gaehl, 2012; Jackson and Cameron, 2012; Köngeter et al., 2013; Strahl et al., 2012).

In addition, similarities between the two countries were found when looking at the mental health of young people leaving care. The quantitative study by Klein (2021) showed that more than 60% of the sample of young people in Germany experienced at least one major crisis after having left care. The majority reported that the crisis, mainly related to education and employment, occurred within the first year after leaving care. While most participants showed an optimistic future perspective, one third showed a decrease in their capabilities and, thus, adverse developments after leaving care (Klein, 2021). Klein's (2021) study did not present the impact of leaving care on young people's mental health. However, Schmid (2008) highlighted that care leavers in Germany often face social problems and have severe complex mental health disorders that require ongoing support in early adulthood.

Several studies available from England or other parts of the UK demonstrated that a high number of care-experienced young people show mental health issues while in and after leaving the care system, including suicidal ideation and behaviour (see Dixon, 2008; Goddard and Barrett, 2008; Hamilton et al., 2015; Sims-Schouten and Hayden, 2017; Ward, 2011). Briheim-Crookall et al. (2020a) showed that while most care leavers in England presented a medium to high well-being, about one quarter reported low life satisfaction compared to only 3% of the general same-age population. The publications '*Consultation on preventing suicide in England*' and '*Preventing suicide in England*' by HM Government (2011, 2012), based on public consultation in England in 2011, referred to care-experienced young people as vulnerable to mental health problems, including self-harm: "Looked after children and care leavers are four to five times more likely to self-harm in adulthood" (HM Government, 2012, p. 22). Previously, the published report of the consultation informing this publication in England stated that looked-after children and care leavers would have a four to five times higher risk of attempting suicide as adults than the general population (HM Government, 2011). This statement would need to be taken with caution, as the data sources producing these numbers were not evident in both publications. The research and information about suicidal ideation and behaviour among

young adults leaving care in both countries, especially Germany, and factors influencing their risk of suicide are scarce.

Previous cross-national comparisons are based on secondary data without the same study design and tools, limiting comparability. Despite cautions with cross-national assessments, as mentioned by Cameron et al. (2018), the cross-national research design with England and Germany offers opportunities to assess the similarities and differences of these two samples on specific outcomes and, additionally, whether different structures and practices influence various outcomes. Furthermore, it would give a broader insight into both national populations.

2.3 Suicidal ideation and behaviour

The WHO published in 2012 and 2014 that suicide was the second highest death cause among 15–29-year-old people globally (Fleischmann, 2016; World Health Organisation, 2014). Europe faces the highest mortality rate by suicide compared to other continents (World Health Organisation, 2017b). In 2020, after a decreasing trend for several decades, 9,206 suicides were registered in Germany (Statistisches Bundesamt, 2021b). In comparison, there were 9,041 suicides reported in Germany, with 185 suicides among young people under 19 in 2019 (Statista). In 2015, overall, 10,800 suicides were registered, with 215 suicides among young people under 19. For 18–19-year-old people in Germany, suicide belongs among the most common causes of death; with 22% among all other causes of death, this age group has the highest percentage of suicides compared to other age groups (Statista, 2018).

In 2017, the UK (England, Northern Ireland, Scotland and Wales) registered 5,821 suicides. England has the lowest proportion of suicide in the UK (Office of National Statistics, 2018). Despite the low suicide rate of people younger than 20 years compared to the general population in England, Rodway et al. (2016) "found an escalation of risk during the late teen years (ie, 18–19 years)" (Rodway et al., 2016, p. 757).

The rate of suicide attempts is higher than the number of suicides. A suicide attempt is a risk factor for suicide in the future (Joiner, 2005; World Health Organisation, 2018). Numbers for suicidal ideation are not available in the national statistics.

Several studies worldwide have investigated the experience of suicidal ideation and behaviour among care-experienced young people. For example, the following studies showed that care-experienced people have an elevated risk of suicide from a young age than those without care

experience. Taussig et al. (2014) investigated pre-adolescent looked-after children (9–11 years old) in the USA. They showed that 26% reported suicidal ideation and behaviour, five times more likely than the general population in the same age group (Taussig et al., 2014). The case-file study by Cousins et al. (2010) found that 10 out of 165 children in care aged 10–15 in Northern Ireland attempted suicide. Another study based on a systematic review and meta-analysis presented estimated predictions that suicidal ideation would occur in almost 25% of care-experienced children and young people compared to about 11% in the non-care experienced population (Evans et al., 2017). Two Canadian studies showed similar high rates of suicidal ideation and behaviour among groups with care experience (Kaspar, 2014; Katz et al., 2011). One representative American study presented that about 27% of US adolescents (12–17 years old) with a history of foster care experienced suicidal thoughts within 12 months compared to about 11% of adolescents not in care (Pilowsky and Wu, 2006).

People with care experience show higher rates of adverse mental health conditions, including a higher prevalence of suicidal ideation and behaviour also in adulthood (McKenna et al., 2021). Two Swedish quantitative studies compared specific outcomes of (adult) former looked-after children in long-term care with same-age peers of the general population of birth year cohorts from 1972/1973 to 1981/1982. They presented that care-experienced people were four to five times more likely to be hospitalised for suicide attempts and more females (14% care, 2% peers) than males (9% care, 1% peers) attempted suicide (Berlin et al., 2011; Vinnerljung et al., 2006). A recent study by Brännström et al. (2020) showed that former foster children in Sweden had a higher risk of suicide attempts and dying by suicide in adulthood compared to their siblings who lived with their families. The Finnish study by Kalland et al. (2001) showed that mortality rates due to substance misuse, accidents and suicide were higher among the population of young people up to early adulthood who were involved with the child protection system than in the general population. Among the 106 identified deaths, the researchers found 35 suicides of care-experienced young people aged 15–24 (Kalland et al., 2001).

The Australian study by Cashmore and Paxman (2007) investigated suicidal ideation and behaviour in a longitudinal study among young people in the transition from care to adulthood. The study showed that more care leavers reported suicidal ideation and suicide attempts shortly after the transition from care than after four to five years later. The authors found that young people who left care were less likely to report suicidal ideation if they felt supported by family or friends (Cashmore and Paxman, 2007).

Furthermore, several studies have explored suicidal ideation and behaviour or the death by suicide among young people with care experience across the UK. For instance, at the end of the 1990s, Gibbs and Sinclair (1998; 1999) investigated 48 English children's homes with a sample of 223 looked-after children. They noticed that almost one quarter of the participants from local authority children's homes reported suicidal thoughts, and more than one third of the sample mentioned attempted suicide or self-harm (Gibbs and Sinclair, 1998; Sinclair and Gibbs, 1999). A recent study by Rodway et al. (2020) investigated suicides among adolescents in the UK, including looked-after children. The researcher found that looked-after youth who died by suicide had higher rates of housing problems, social isolation, experiences of domestic violence, mental health conditions of family members, bereavement and drug misuse than those young people without care experience (Rodway et al., 2020).

A Northern Irish study published by Hamilton et al. (2015) presented that young people leaving the public care system (foster care and residential care) have a high vulnerability for suicidal ideation and behaviour. Young people leaving care were especially at greater risk if they were socially isolated and lacked social resources (Hamilton et al., 2015). In addition, the studies by Andrew et al. (2014) and Slater et al. (2015) could identify the elevated risk of suicide attempts among care leavers (Andrew et al., 2014; Slater et al., 2015). Stein and Dumaret (2011) reviewed several English and French studies that noticed suicidal tendencies among care leavers (Stein and Dumaret, 2011). Moreover, in evaluating the health, well-being and outcomes of young people leaving care, Daly (2012) and Dixon (2008) explored health difficulties and suicide behaviour in this particular group. After investigating 12 case files of suicide deaths of care experienced young people in Scotland, Cowan (2008) reported a lack of recorded professional intervention and prevention in cases of known self-harm and suicidal ideation and behaviour among care leavers. He called for greater attention to the risk of suicide among care leavers (Cowan, 2008). Reflection on all of these studies raises the following question: why are people with care experience vulnerable to suicidal ideation and behaviour?

The specific developmental stage that young adults leaving care face is essential to consider. Care leavers experience an early transition from adolescence to adulthood. Therefore, they enter the phase of emerging adulthood earlier than their peers. Boeninger and Conger (2012) highlighted that the risk for suicide among young adults in the stage of emerging adulthood is higher than among adolescents. They explained this development with the new combination of stressors and resources and a possible perceived difference between expectations and reality (Boeninger and Conger, 2012). Ageing out of care and moving into an in(ter)dependent adult life relates to stressful life changes, and some might struggle to find a new role and purpose in

their day-to-day life and set new routines, a difficulty which results in severe mental health problems (Arnett, 2007). These changes might be further risk factors for suicide.

Furthermore, young people with care experience might be more vulnerable to suicidal ideation and behaviour due to a childhood experience of, for instance, a mentally ill parent or disturbed family relations and experienced separation or losses (Wasserman, 2016a). Suicidal people "mask their vulnerability with such defences as fantasy of greatness that emphasize their independence and invulnerability, despite their great dependence and vulnerability […] [their] denial of real-life circumstances […] is another mean of self-defence against the own vulnerability" (Wasserman, 2016b, pp. 148–149). The perception of invulnerability and masking behaviour are redolent of Stein's (2006b) resilience framework and one of the defined groups of care leavers, the survivors. The survivors' paradoxical behaviour of a strong, invulnerable self-image despite their critical living circumstances might be misinterpreted by others (Stein, 2006b). For instance, social workers might assess their behaviour as provocative, rejecting or self-sufficient. If the response to their behaviour is rejection by professionals, care leavers may feel confirmed in being not loved, needed or wanted (Wasserman, 2016b). This vicious circle highlights the importance of sensibility in working with this group and knowing the different subgroups and risk factors.

To assess the risk of suicide and identify factors influencing suicidal ideation, it is essential to understand the phenomenon of suicide and related intents and behaviour. Therefore, this chapter proceeds by discussing the terminology of this phenomenon, followed by an overview of suicide theories. Then, the conceptual framework of this study is presented based on one selected suicide theory most suitable for investigating suicidal ideation among people with care experience.

2.3.1 Definition and terminology

Suicide, based on the combination of the Latin terms 'sui' (oneself) and 'caedere' (to kill), means the act of ending one's own life on purpose. Death by suicide is caused by self-injury with the intended result of death (Posner et al., 2014). Concerning the definition used by Posner et al. (2014), it "must be self-instigated or self-initiated, but not necessary self-inflicted" (Posner et al., 2014, p. 9). In Germany, based on the *Gesundheitsberichterstattung des Bundes* (Federal Health Monitoring System), the term 'suicide' is defined as "the deliberate destruction of one's own life, explainable as based on a free decision (appearing in hopeless situations, conviction

that it is futile to continue living) or as sickly compulsive act (in depressions and psychoses)" (Gesundheitsberichterstattung des Bundes, 2018). The Office of National Statistics in the UK published a definition of suicide that "includes all deaths from intentional self-harm for persons aged 10 and over, and deaths where the intent was undetermined for those aged 15 and over" (Office of National Statistics, 2017). HM Government (2015) uses the term 'suicide' as the death of intentional self-harm and injury, including those with uncertain intentions. The medical definition of suicide is the death from self-inflicted injury with the person's intention to die, based on ICD-10 (International Classification of Diseases) X60-X84 (intentional self-harm) and Y10-Y43 (the event of undetermined intent) (HM Government, 2015). The terminology of the phenomenon of suicide, suicidal ideation and behaviour shows variabilities and little consistency in existing literature, as Posner et al. (2014) criticised. The terminology and definitions of suicidal ideation and behaviour based on the US Centers for Disease Control and Prevention (CDC), as suggested by Posner et al. (2014), are used in this thesis.

Three classes define the phenomenon of suicide, as proposed by the US National Institute of Mental Health: suicide (death as the outcome of an act intended to kill oneself), suicide attempt (the non-fatal act with a potential or supposed deadly outcome) and suicidal ideation (intent to die without a physical action) (Posner et al., 2014). In recent literature, the terms 'suicidal ideation' and 'suicidal behaviour' are often used to describe the phenomenon of suicidal thoughts and acts which intend suicide. Suicidal ideation can be distinguished between passive and active suicidal thoughts. Passive suicidal thoughts contain the perception that life is not worth living and the desire to die, while active ideation includes thinking of taking their own life and having a plan to attempt suicide (Van Orden et al., 2015). The term 'suicidal ideation and behaviour' describes the overall scope of thoughts, self-harm, attempts and accomplished acts to take someone's own life (O'Conner and Sheehy, 2000, in Hamilton et al., 2015). Suicidal behaviour also includes preparatory acts such as collecting pills, writing a suicidal note, giving things away or revising a will. The term 'self-harm' covers a great range of harmful behaviour that can be a way to cope with overwhelming behaviour, as Harvey et al. (2015) described. The most common forms of self-harm are self-cutting or self-poisoning apart from, for instance, scratching or self-hitting. Self-harm describes the behaviour and not the intention, which may not always be clearly distinguished between non-suicidal and suicidal self-injury (Harvey et al., 2015).

Terms such as suicidality, completed/successful suicide, failed attempt, parasuicide, suicidal gesture and suicidal threat have unclear, contradictory or redundant meanings. For instance, the term 'suicidality' includes suicidal thoughts and behaviour without distinction. Based on the

CDC's publications, Posner et al. (2014) recommended distinguishing these terms because they differ in appearance, interactive factors, outcomes and interventions. Nevertheless, suicidal ideation and behaviour cannot be circumscribed entirely from each other and appear converged (Wasserman, 2016c). Concerning the recommended terminology, in a context that refers to both suicidal thoughts and acts, the term 'suicidal ideation and behaviour' is used in this thesis.

Restrictions on the terminology of suicide are also mentioned by the WHO. They have published resources for media professionals and recommend a careful choice of terminology while reporting and publishing on the topic (World Health Organisation, 2017a). Apart from the terms mentioned above, the WHO recommends avoiding the phrase 'to commit suicide', as this would implicate suicide as a criminal act. Although the criminal reference may be the case in some countries, it is not applicable for the focused countries England (based on the Suicide Act 1961) and Germany (based on the Basic Federal Law) (*Suicide Act 1961*, 1961; Weilert, 2018; World Health Organisation, 2017).

In summary, a common terminology of suicide is necessary to achieve comprehension. This thesis uses the following general terms listed in Table 1.

Table 1: Terms and definitions of the phenomenon related to suicide

Term	Definition
Suicide	The death caused by a person's self-harm with the intent to end their own life
Suicide attempt	A person's non-fatal but possible or supposedly deadly action with the intent to die
Suicidal behaviour/ acts	All acts of a person with the intent to end their own life, including preparational actions
Suicidal ideation/ ideas/thoughts	All thoughts about the wish and intention to die and ending one's own life
Passive suicidal ideation	The perception that life is not worth living and having the desire to die
Active suicidal ideation	Thoughts of killing oneself and a plan (on how) to attempt suicide
Suicidal ideation and behaviour	Includes both thoughts and acts of a person with the intent to end their own life
Suicidal person	A person who experiences suicidal ideation and/or shows suicidal behaviour; this person experiences the wish to end their own life by suicide

2.3.2 Theories of suicide

Various models have been developed to explain the phenomenon of suicide. The theoretical views and understanding of the phenomenon of suicide vary, and no common explanation exists. These include biological models, psychodynamic ideas, sociological theories and psychosocial explanations.

Biological explanations are based on predispositions like neurotransmitter dysfunction (Selby et al., 2014). For example, the stress-vulnerability model and the role of neuroplasticity (the dynamic brain structures and functions) refer to constitutional predispositions for suicide which mark either the resilience or the vulnerability to psychological stress. Inefficient coping strategies for psychological stress would constrain emotions, memories, learning and decision-making abilities and further suicidal ideation and behaviour (Wasserman and Sokolowski, 2016). It is essential to mention that these theories do not provide a complete understanding of suicide and require further research, as Selby et al. (2014) mentioned.

Related to some theories from a psychodynamic approach, Shneidman (1996, 1998) published his psychache theory of suicide. The term ‘psychache’ is a combination of psychological pain. Shneidman understood suicide as an act to end a person’s pain. As long as no option to reduce this pain is found, the desire to end one’s own life by suicide increases (Selby et al., 2014; Shneidman, 1998). Similarly, the emotional dysregulation theory of suicide by Linehan (1993) relates to high emotional sensitivity to distressing triggers and the difficulty in regulating emotions. Self-injury, and in this relation also suicide, is understood as a method to escape from these negative emotional states. However, these approaches are also criticised as, for instance, the psychache theory lacks a detailed description of the development and possible mechanism and consideration of the severity of suicidal behaviour (Selby et al., 2014).

Similarities to the theoretical concepts of psychache and emotional dysregulation, but from the social-psychological field, can be found in the escape theory, established by Baechler (1980, cited in Selby et al., 2014) and further developed by Baumeister (1990). This understands suicidal ideation and behaviour as the individual tendency to escape from a negative, painful self-awareness. The escape theory describes the process which leads to suicide attempts, initiated by the perceived discrepancy between expected and actual outcomes, the lack of perspectives and the further development of negative cognition (Baumeister, 1990; Selby et al., 2014).

A well-known theory from sociology was established by the French sociologist Emile Durkheim in his publication *Le suicide: étude de sociologie* in 1897 and determined social factors as the leading causes of suicide (Selby et al., 2014; Thompson, 2004). Durkheim defined social integration and moral regulation as the most influential factors for suicide. Durkheim argued that suicide is the result of a disturbed regulation between the individual and society and distinguished between four societal types of suicides: the 'egoistic suicide' is the result of a lack of social integration and the feeling of being discarded; the 'altruistic suicide' occurs when the individual believes that the society would profit from the their death due to a too close emotional connection to society; the 'anomic suicide' follows from a lack of moral regulation which results in a deficit in economic value, meaningfulness and achievable goals that cause suicide; and the 'fatalistic suicide' is the result of extreme moral regulation which disables any kind of personal development and future aim (Selby et al., 2014; Thompson, 2004).

Turning from Durkheim's sociological theory and Baumeister's escape model of suicide to a clinical perspective, the hopelessness theory by Beck et al. (1974, 1973), and similarly by Abramson et al. (2002) shows similarities to Durkheim's anomic suicide and Baumeister's process of cognitions and emotions. Beck's hopelessness theory indicates hopelessness as a risk factor for suicidal ideation and behaviour. The theory describes how in case of thoughts and feelings of hopelessness people cannot improve their lives, they develop the desire to die by suicide (Beck et al., 1989; Selby et al., 2014). Based on this theory, Beck et al. (1974) developed the Hopelessness Scale, which proved to be helpful in predicting the risk of suicide.

A relatively novel theory of suicide was published by Joiner in 2005. His interpersonal-psychological theory of suicide (IPTS) combines the wish to die by suicide based on specific interpersonal states and one's ability to fulfil this longing. The IPTS is grounded in a three-way interaction of the following components (see Figure 2): perceived burdensomeness, thwarted belongingness and acquired capability (Selby et al., 2014).

Joiner (2005) defined perceived burdensomeness as the individual perception of being ineffective and incompetent, which constitutes a burden for beloved others. This feeling is related to shame and the focus on one's death as the only possible solution to the supposed problem one presents to loved ones. The second factor is thwarted belongingness which indicates social isolation. Aspects of social isolation are the experience of withdrawal from others, alienation, the lack of trusting other people and difficulties in achieving long-lasting relationships (Joiner, 2005). Van Orden et al. (2010) further defined "thwarted belongingness as loneliness and the absence of reciprocally caring relationships" (p. 582). Joiner (2005) drew

the connection to Durkheim's theory of the role of social integration in death by suicide, for example, altruistic and egoistic suicide. Both factors, perceived burdensomeness and thwarted belongingness, must co-exist simultaneously to develop the desire to end one self's life (suicidal ideation). In other words, if one of the aspects of personal effectiveness and social connectedness is present, the will to live is solid. When in addition to the desire to die due to the co-occurrence of thwarted belongingness and perceived burdensomeness, a person has the acquired ability to execute lethal self-harm (acquired capability), the risk of a suicide attempt or death by suicide is high (Joiner, 2005).

The Interpersonal Needs Questionnaire (INQ) and the Acquired Capability for Suicide Scale (ACSS) are tools to assess the IPTS factors (Ribeiro et al., 2014; Van Orden et al., 2012). As presented in section 3.4.2, the INQ is separated between the thwarted belongingness scale (TB) and perceived burdensomeness scale (PB). Several empirical studies have proven the interaction of all three factors for the risk and prediction of suicidal behaviour and, therefore, provide evidence for the validity of the IPTS (see Christensen et al., 2014; Ma et al., 2019; Schönfelder et al., 2019; Van Orden et al., 2012). Selby et al. (2014) evaluated Joiner's IPTS as "a valuable framework for understanding suicide and assessing suicide risk" (p. 297).

With close links to the IPTS, Castro and Kintzle (2014) reflected in their military transition theory on the role of transition from military service into the civil community on the risk of suicide among previous soldiers. They explain the risk of suicide among military veterans, inter alia, with changes in relationships, the need to develop a new identity within their new community, perceived burdensomeness and the ability to harm themselves lethally due to combat experiences (Castro and Kintzle, 2014).

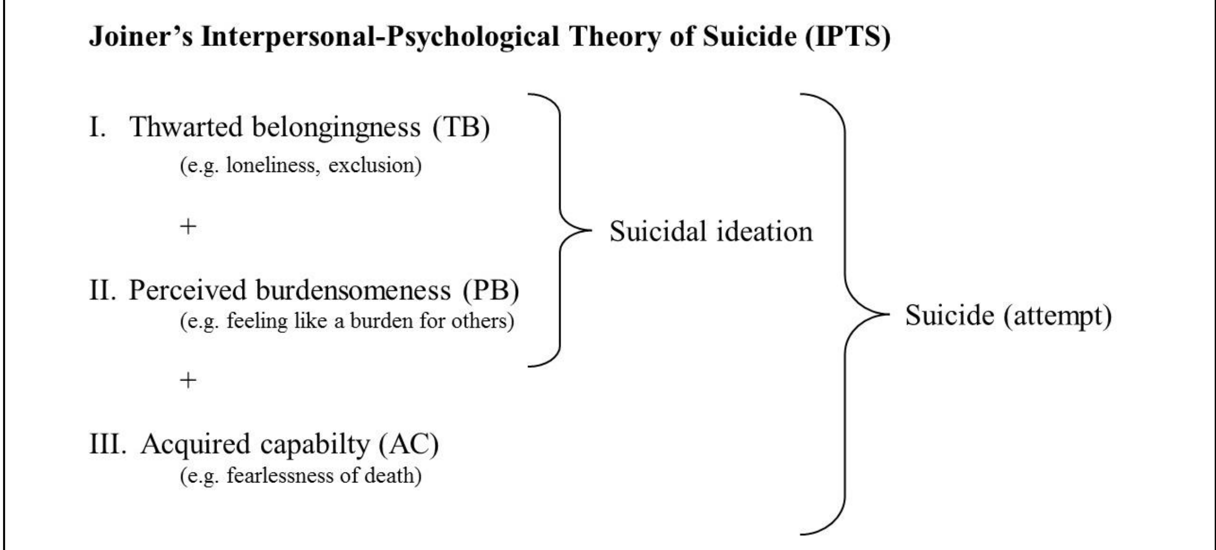

Figure 2: Three-way interaction of Joiner's (2005) interpersonal-psychological theory of suicide (IPTS) explaining the development of suicidal ideation and behaviour.

The framework published by Cramer and Kapusta (2017) provided interesting links between several suicide theories, including IPTS, that they use to develop their socio-ecological suicide prevention model (SESPM). The authors present a multi-level suicide risk theory consisting of four theories on four socio-ecological levels: Shneidman's concept of psychache on the individual level, Joiner's IPTS on the individual and interpersonal level, the military transition theory on the community level and finally, Durkheim's societal theory of suicide (Cramer and Kapusta, 2017). Their work shows that suicide theories often focus on specific socio-ecological factors to explain the risk of suicide but can also complement each other to gain a broader understanding.

2.4 From suicide theory to care leavers: A conceptual framework

Several suicide theories refer to emotional pain and social perceptions as causes for suicidal ideation and behaviour. Particularly adverse interpersonal experiences such as social isolation and lack of social support are often reported by young people leaving care. A recent Israeli study presented that social factors influence care leavers' life satisfaction (Refaeli et al., 2019). For the purpose of this study investigating the risk of suicidal ideation among young adults with care experience, especially in the transition from care, a suicide theory focused on social factors seems reasonable as a theory of choice due to the particular social experiences of the group of interest. Joiner's IPTS is the most suitable framework to assess suicide risk among people with care experience concerning relational components. It, therefore, provides the conceptual foundation to guide this study. Previous research implies that people with care experience are likely to experience thwarted belongingness and perceived burdensomeness (see Fulginiti et al., 2018; Schofield, 2002; Sulimani-Aidan, 2014; The Care Inquiry, 2013b). However, it remains to be investigated whether the IPTS factors can explain the elevated risk of suicide among this group.

Thwarted belongingness, the feeling that oneself does not belong to a valued group or being withdrawn, might be perceived due to the care experience. For instance, Schofield's (2002) psychosocial model highlights that belongingness, including unconditional interest, support and a place in the community, composes a central aspect of a care-experienced young person's outcomes in later life. The transition from care may contribute to the occurrence of thwarted belongingness. Young people ageing out of care are aware that they must leave their living space and the people they lived with. People who cared for them are not responsible for them

anymore. A return to this group in the role of being looked after is not possible. Former relationships with carers or other cohabiters will not last for many young people after leaving (Ward, 2011). Particularly, Dima and Skehill (2011) mentioned that some care leavers perceive that they suddenly have to leave and start their often self-dependent own life because of possible avoidance of reality prior to this moment. Some care leavers perceive social isolation and loneliness, as reported in several studies (Adley and Jupp Kina, 2017; Stein, 2006b; Sulimani-Aidan, 2014; Ward, 2011). Young people with care experience may feel alienated and different from others, as a lack of belongingness continues from childhood to adulthood (Butterworth et al., 2017). The lack of trusting other people and achieving long-lasting relationships due to social isolation, which draws a connection between childhood maltreatment and suicidal behaviour as described by Joiner (2005), relates to the experiences of some care leavers. Alternatively, as a form of belongingness, positive attachment to biological parents and foster carers can present a protective factor against the risk of suicide among care-experienced adults who had experienced childhood maltreatment (Danner Touati et al., 2021).

The Care Inquiry (2013b) presented the views of care leavers*:* "Some of them [care leavers] said they [care leavers] felt at their most vulnerable because, if things went wrong, there were few people to turn to and they felt like a burden" (p. 19). Perceived burdensomeness as the individual perception of being incompetent and a burden to others is related to self-blame and the feeling of shame (Van Orden et al., 2010). Adley and Jupp Kina (2017) examined the feeling of shame among care leavers by rejecting or asking for support. The researchers explained this emotional state with the personal will to prove their ability to manage their own lives (Adley and Jupp Kina, 2017). Perceiving themselves as incapable of handling an independent living would cause them to feel like a burden to others, such as former key workers or carers who are not responsible for them anymore, if they would reach out to them for support. They may not consider asking for help from new professional support such as the PA because of their lack of trust and building new trustful relationships. Perceiving themselves as a burden might cause emotional stress and, accordingly to Joiner's concept, would pose a risk factor for developing suicidal ideation in young people leaving care.

Moreover, many care-experienced people are considered to engage in self-harming behaviour (Furnivall, 2013; Harkess-Murphy et al., 2013). Transitions, such as from care, can cause distress that triggers self-harming behaviour to cope with thoughts and feelings (Harvey et al., 2015). Therefore, people with care experience may have acquired the capability to harm themselves lethally due to an increased fearlessness of death in their self-harming behaviour (Wadman et al., 2017), which increases the risk of suicide in combination with suicidal ideation,

especially after the transition from care. While the current study does not focus on suicidal self-harm, the factor of acquired capability due to self-harming behaviour is part of the theoretical foundation of this study and important to acknowledge to understand the risk of suicide among people with care experience. The current study focuses on suicidal ideation only, with the intent to help inform suicide prevention strategies in social work and the care system to address the cognitive component before acting on such thoughts.

Joiner's theoretical explanation of the development of suicidal ideation due to the co-occurrence of thwarted belongingness and perceived burdensomeness applies in many ways to young people in the transition from care. This approach provides a valuable framework for empirical assessment, which has been tested among diverse clinical and non-clinical groups (with the INQ) and is proven as valid and reliable in investigating both factors related to suicidal ideation (Forkmann and Glaesmer, 2013b; Hallensleben et al., 2016; Van Orden et al., 2012). The INQ-15 is accessible online and available in several languages, including German (Forkmann and Glaesmer, 2013a).

Schönfelder et al. (2021, 2019) identified a relationship between suicidal ideation and behaviour and childhood abuse, a common reason for many young people to enter the care system. With a clinical sample from Germany, the authors investigated the connection of suicidal ideation and behaviour in adulthood with emotional, physical and sexual childhood abuse using, among other tools, the INQ to explore the link further under consideration of the IPTS factors. The authors considered the IPTS a promising theoretical foundation for investigating underlying mechanisms of the risk of suicide (Schönfelder et al., 2021, 2019).

Using a theory focusing on social constructs as a risk of suicidal ideation is especially interesting for a population with exceptional social experiences. It provides the opportunity to assess whether interpersonal factors are part of the cause of suicidal ideation among young people with care experience and how the constructs of thwarted belongingness and perceived burdensomeness play a role within this population. Most empirical studies about suicidal ideation and behaviour among people with care experience have neglected to apply suicide theories to investigate this topic. The exceptional research by Cashmore and Paxman (2007) is one of the very few that used a questionnaire based on the suicide theory, namely the Hopelessness Scale by Beck et al. (1974), to explore suicidal ideation and behaviour among a care-experienced group. Moreover, as the literature review shows, the INQ has not been applied in empirical studies about suicidal ideation among people with care experience.

In summary, the literature review has presented that young people with care experience are vulnerable to experiencing suicidal ideation and behaviour. The transition from care especially appears to be a risk factor in increasing the risk of suicide in early adulthood. It remains unclear how far the risk of suicide among care-experienced people differs between countries, in this case Germany and England. The IPTS provides a promising theoretical foundation for this study to explore the occurrence and factors influencing suicidal ideation among people with care experience considering their care-related interpersonal experiences.

3. RESEARCH QUESTIONS, METHODOLOGY AND METHODS

The study's primary aim is to investigate the occurrence and influencing factors of suicidal ideation among care-experienced young people and adults in England and Germany. As people try to find causal explanations for situations or conditions they experienced (see Kelley, 1973), this study aims to explore what people with lived experience perceive as causes and protective or coping factors for their suicidal thoughts. The study addresses the following two key questions:

I. What is the occurrence of suicidal ideation among care-experienced young adults in England and Germany?

II. Which factors influence suicidal ideation in care-experienced young people? Specifically:

a. Which factors do care-experienced young adults perceive as causative for the occurrence of suicidal ideation?

b. Which factors do care-experienced young adults perceive as helpful for coping with suicidal ideation?

The knowledge about factors that care-experienced young adults perceived as influencing suicidal thoughts based on lived experience could help align professional support to young people in and after leaving care, both as a prevention and intervention. A deeper understanding of the risk for suicide is vital, as intentions might not be evident because many young people do not express suicidal thoughts before attempting or dying by suicide (Rodway et al., 2016). Munro et al. (2021) highlighted the heterogeneity and resilience of care-experienced people. Compared to their peers without care experience, they might experience additional challenges which require tailored support to promote their life chances (Munro et al., 2021). This project aims to fill an academic void in cross-national knowledge about specific outcomes and living conditions of care-experienced young people. In this case, the focus lies on suicidal ideation and the subjectively perceived factors influencing such thoughts. The collected information aims to contribute to informing suicide prevention guidelines tailored to young people in and leaving care.

3.1 Methodology

The philosophical approach underpinning this research is critical realism. With an epistemological and ontological perspective of critical realism, the study aims to identify tendencies (‘demi-regularities’) of suicidal ideation among care-experienced young people in two countries and mechanisms that influence the development of suicidal thoughts or coping strategies, including protective factors. A critical realist framework allows previous theories to guide the research questions as an initial starting position for the investigation and analysis (Fletcher, 2017). The interpersonal-psychological theory of suicide (IPTS) guided the study as an initial foundation of the theoretical framework. As described earlier (see sections 2.3.2 and 2.4), this initial theoretical approach was chosen for this research because it enabled an exploration of interpersonal factors that influence the occurrence of suicidal ideation and are particularly interesting regarding (leaving) care experience. Hence, by applying the IPTS, the Interpersonal Needs Questionnaire (INQ) helps to explore the occurrence of suicidal ideation in relation to these factors as potential demi-regularities, on the one hand. On the other hand, the theory helps to investigate in depth whether these factors can be identified as ‘underlying mechanisms’ by using qualitative methods. This study is the first to apply this suicide theory to the population of care-experienced young adults, as far as known based on the previous literature review. As Fletcher (2017) mentioned, “CR [critical realism] aims to find the best explanation of reality through engagement with existing (fallible) theories about that reality” (p. 186).

Critical realism, whose origins were developed by Roy Bhaskar (1998) in the 1970s, emerged from positivism and constructivism/interpretivism and is increasingly used as a philosophical framework within social sciences (Hoddy, 2019; Zachariadis et al., 2013). Critical realism received attention regarding its methodological development with respect to its application in research design, as several research publications about diverse social topics show (see Craig and Bigby, 2015; Fletcher, 2017; Hoddy, 2019; Meyer and Lunnay, 2013; Zachariadis et al., 2013). For example, Zachariadis et al. (2013) applied the use of critical realism in a mixed-methods study. They mentioned the various critical realist assumptions that justify the application of both quantitative (‘extensive’) and qualitative (‘intensive’) methods. They argued that this approach based on the critical realist methodology “is to use extensive methods to identify and establish demi-regularities with data patterns, which are then used to guide intensive research that will uncover the mechanisms, agencies, and social structures that produce the behavior observed” (Zachariadis et al., 2013, p. 864).

In general, Bhaskar's critical realist approach is based on three main steps in science: the identification of phenomena, the development of explanations for those phenomena and the testing of these explanations, which lead to the identification of underlying ('generative') mechanisms which produce the observed phenomena/event (Bhaskar, 1998). Several studies have applied critical realism as a methodological approach to identify and explain various phenomena and their underlying mechanisms (see Craig and Bigby, 2015; Danermark et al., 2002; Fletcher, 2017; Hoddy, 2019).

This critical realism-informed thesis applied a mixed-methods approach to identify tendencies (demi-regularities) and influencing factors (underlying mechanisms) of suicidal ideation among care-experienced young people. IPTS was used as the main component of the initial theoretical framework. The following sections present the applied quantitative and qualitative methods to address the research questions.

3.2 Mixed-methods approach and cross-national study design

To provide a comprehensive and in-depth insight into this specific situation of care-experienced young adults, a mixed-methods approach was applied, consisting of an online survey and semi-structured interviews. Mixed-methods research is defined as a process of collecting and analysing data, integrating these findings and drawing conclusions by using a combination of quantitative and qualitative approaches in a single study (Tashakkori and Creswell, 2007). The first research question is approached mainly quantitatively with an online survey in addition to a partly qualitative assessment of the range of suicidal ideation. The second key research question integrates quantitative and qualitative information with a specific focus on the in-depth qualitative investigation based on semi-structured interviews.

This approach combines diverse perspectives of the issue of interest: the hypotheses and possible tendencies of interest can be investigated via a quantitative method, while a qualitative method can capture the individual perspectives to identify underlying mechanisms. Based on reoccurring open-ended questions in the online survey and the interviews, more detailed descriptions of the investigated experiences and hints for patterns of possible factors influencing suicidal ideation identified in the interviews would be able to be given (Blaxter et al., 2010). This approach was used to meet the multi-lateral necessity requiring both the quantitative results to provide a broader picture identifying demi-regularities and the qualitative in-depth views of care-experienced young adults about their experiences of suicidal ideation. The

combination reveals the relevance of this issue and potential influencing factors that either caused or reduced suicidal ideation among people with care experience.

Haight and Bidwell (2016) highlighted that “social workers are keenly aware of the complexity of social issues” (p. 1) and that mixed-methods research can help “to better understand complex human experiences and social structures” (p. 9). The topic under investigation combines two highly complex experiences: suicidal ideation and care experience. As described by Neuman (2006), the parallel triangulation of methods helped to view this matter from different angles. This approach offers a more comprehensive investigation of suicidal ideation among care-experienced young people due to combining these techniques. Therefore, this mixed-methods research contributes to new insights and a holistic, socio-ecological, in-depth understanding of this issue (Haight and Bidwell, 2016), thus addressing this study’s purpose.

The cross-national perspective contributes to a broader picture of the care-experienced population. First, the results would contribute to the body of knowledge in each country, which might be useful for further developing evidence-informed practice with young people in care and after leaving care as young adults. Second, differences in the results by viewing both countries would indicate whether the information about the population from research and politics can be transferred cross-nationally and show how far different national support systems, structures and practices influence suicidal ideation. Third, combining the responses from both countries would allow a more extensive and versatile sample. The cross-national perspective would contribute to evaluating the risk of suicidal ideation among young people with care experience from an international perspective.

Germany and England were chosen for the cross-national approach because of several differences and similarities of interest: as mentioned above, both countries have different welfare systems with different orientations concerning child protection and family orientation. Despite the same safeguarding principles to protect children from harm, the role of the family and access to support services differ. Among others, these differences might explain which factors influence young people’s mental health in and leaving care. Furthermore, the principle of social pedagogy is dominant in the youth welfare system in Germany and would provide different principles and professional relationships with the work of looked-after children. Moreover, the number of looked-after children in residential care is higher in Germany than in England. By choosing Germany, the cross-national perspective would offer more participants for the study from residential care, while more participants from England may contribute with experiences from foster care. Another reason is the statutory support for young adults leaving

care. Both countries offer support for young people leaving care within the age limits of 21 and 25 years (and even 27 years for people with disabilities in Germany). However, leaving care support is organised differently in both countries. By including those two countries, the access to support for young adults leaving care might play a role in identifying influencing factors and as a possible explanation for differences.

Therefore, comparing these two countries is highly interesting from an international perspective that could contribute to a possible exchange and transferability of knowledge about this topic. The cross-national approach can inform the further development of suicide prevention within both countries' (leaving) care systems.

The terms 'participants/group/sample from England/Germany' and 'English/German group/sample/participants' are used interchangeably in the cross-national approach. They only refer to the country in which the participants were in care and lived at the time of participation and do not imply nationalities.

The mixed-methods approach and cross-national perspective created an innovative study design to investigate suicidal ideation among young people who have already left care. It aims to provide a comprehensive picture of this phenomenon.

3.3 Sampling: The challenges and stages during a pandemic

Before describing the study design of the online survey and interviews in detail, the sampling process and, therefore, the access to potential participants for this study are illustrated. Apart from explaining how participants were reached, it is important to keep in mind the circumstances of the time the study was conducted that shaped the project regarding its schedule, methodical amendments, recruitment efforts and expected sample sizes.

The initial sample characteristics targeted young adults with care experience between 18 and 26 years who had been in foster or residential care in England or Germany on or after their 16th birthday. The initial age range was oriented on the maximum age of possible legal support for care leavers in Germany based on SGB VIII (up to 25 years of age) and similar English legislation. The focus was on the transition from care to early adulthood.

To reach a high number of potential participants in both countries, a large number of relevant organisations and gatekeepers who have access to care-experienced young adults were contacted to support the sampling process. Relevant organisations were local authorities that

offer a leaving care service, residential care providers, foster care agencies, NGOs that provide services for care leavers, care-experienced peer networks and advocacy groups. Additionally, representatives of the care-experienced community were contacted: these were individuals who engage in initiatives for care leavers and have contact with care-experienced people, inter alia, via followers or closed groups on social media. In addition, relevant professional and academic contacts were approached to establish supporting collaborations in the sampling process. The use of these collaboration partners was essential to reach the considered hard-to-reach group of care-experienced adults.

Initial contact with potential collaboration partners was established mainly by email. The further correspondence with potential collaboration partners was by email, phone and on a few occasions in personal meetings to discuss the aims of the study and the details of the collaboration. The collaboration involved the distribution of the information material to the groups of interest. Supporting organisations and individuals were asked to share information documents, the link to the online survey and distribute digital flyers about the survey (including a QR-code) and interviews (Appendix 2) within their network. Interested care-experienced adults could access the survey and contact me if interested in partaking in an interview.

Convenience sampling was used due to the dependence on gatekeepers who supported the study. In the course of the recruitment process of collaboration partners, some organisations conducted snowball sampling by forwarding the information within their professional network. Due to the two types of sampling, the response rate of collaborating organisations and approached care-experienced adults cannot be estimated. Besides this, many approached organisations did not reply at all. However, a few of them might have shared the information within their networks without notification, which was the case for one interview participant.

In the course of the preparations and the total 12-month data collection period, several stages of the continuous recruitment process concerning the search for collaboration partners took place. The pandemic impacted the recruitment process and prolonged the data collection.

Pre-pandemic collaboration recruitment: November 2019–March 2020

After receiving ethical approval from the Royal Holloway Ethics Committee at the end of November 2019, several relevant organisations were contacted by email with an invitation to support the study. The first nine organisations from both countries were approached in 2019.

At the beginning of 2020, the correspondence was continued with those who replied positively, and further organisations in both countries were contacted.

By mid–March 2020, 50 organisations, with 28 in Germany and 22 in England, were contacted. These included relevant teams in local authorities, charities, care leaver networks, care leavers forums, and residential and foster care providers. A few organisations were umbrella organisations or networks which work together with local authorities providing leaving care services, fostering services or residential youth care placements. For example, one English organisation which provides a nation-wide network with local authorities providing support for care leavers shared my request for collaborations within their network. From those, representatives from three local authorities in England expressed interest in supporting the study. One of the 22 organisations from England and nine out of 28 organisations in Germany replied by rejecting the collaboration. Reasons for rejecting the collaborations were various if they explained their decision, for instance:

- They raised concerns about insufficient support for participants given the sensitive topic,
- they were not in touch with care leavers at that time,
- the organisation was not interested or not able to support, and
- they had already participated in other studies or had their own research projects.

A few representatives of organisations reacted to the topic of the study cautiously or defensively. For example, in addition to concerns about required aftercare for study participants, a few organisations mentioned the fear of triggering effects of addressing the topic with specific questions and the tiredness of the care-experienced community of being ‘research objects’, or they questioned how the organisation or care-experienced community would profit from the study. These concerns were discussed together.

By mid-March 2020, six organisations in England (including one umbrella organisation with no direct contact with care leavers) and eight in Germany (including three umbrella organisations) responded positively by offering to support the study. A few organisations replied by discussing the request with their managers or team members but never responded with a clear decision. Many did not respond at all despite several emails or voice messages.

The pandemic hit: Postponing the start of the study

The start of the data collection was scheduled for 1st April 2020. As of mid-March 2020, the COVID-19 pandemic hit England and Germany with the implementation of nation-wide lockdowns, social distancing measures and noticeable uncertainty and anxiety among the population (Eurofound, 2020). After consulting the supervisory team, the start of the study was postponed. All collaboration partners were informed.

The developments of the pandemic in both countries were observed for several weeks. The study design was adapted to the current situation. This adaption included conducting interviews online and incorporating an additional survey question about the impact of the pandemic on the three aspects: feeling of belongingness, feeling like a burden and attitude towards life. The Ethics Committee approved the amendment by the end of June.

Sampling stages during the pandemic

July 2020–September 2020: After postponing the start of the data collection by three months, on 1st July 2020, the amended online survey was published. All 14 organisations and representatives who expressed interest in collaboration by March 2020 were contacted by email, providing them with all information to share with care-experienced young adults. Only a few replied, and the rest were contacted by email and phone over several weeks. Some replied that they were going to distribute the information soon. Other contact partners were on annual leave. One organisation mentioned not being able to participate due to the negative impact of the pandemic on their service. Further organisations said that the contacted manager who agreed to the collaboration had changed organisation in the meantime. The latter also resulted in a shortfall of these collaborations.

To find more collaboration partners, more organisations were contacted. A few organisations showed interest and accepted collaboration by sharing the information with care-experienced young people or organisations within their professional network. The study was introduced at an online meeting of the 'Bundesnetzwerk Care Leaver Initiativen' (translated: the National Network of Care Leavers' Initiatives). However, no new collaborations resulted from this venture.

By September 2020, five people had fully completed the online survey. The first two interviews took place at the end of September.

October 2020–February 2021: Due to the low participation rate and feedback from two consulted collaboration partners who are part of the care-experienced community in England, the age range for participants was extended up to 40 years. This amendment would include care-experienced adults who would have been eligible to request leaving care support since the early 2000s in line with the Children (Leaving Care) Act 2000, which would also conform with the legal support for young adults introduced in Germany in the 1990s. The term ‘care leavers’ was changed to ‘care-experienced adults’ to address those who might not identify as care leavers anymore and use a more inclusive terminology. Besides this, a WhatsApp number was added to the interview leaflet to offer an alternative way with a presumably lower threshold for young adults to get in contact and express their interest in partaking in an interview. Information material was updated and submitted to the existing collaboration partners.

At the same time, a broadly geographic-structural recruitment strategy to contact more potential collaboration partners was conducted. In addition to some nation-wide organisations, 104 organisations from all 48 English ceremonial counties with, in total, 240 email addresses, and 265 organisations from all 16 German federal states covering 105 areas, in addition to a few nationwide organisations with 742 email addresses, were contacted by email. The different numbers of approached organisations per country resulted from the accessibility of online contact details. A few additional organisations or people were contacted due to recommendations, attended conferences and established contacts with the supervisory team.

Reminders were sent about three weeks after the initial email to an updated mailing list of 860 contact email addresses of those previously contacted organisations that did not respond. While 65 contacts responded with a rejection to support my study for various reasons, 22 confirmed their support. The reasons for rejecting collaboration were, among other aspects:

- no contact with young adults with care experience (21 replies, only from Germany),
- not enough capacity/limited resources or not in the position to participate (13 replies),
- the negative impact of the pandemic on service or lack of direct contact to inform young adults about the project due to COVID-19 restrictions (seven replies),
- already participated in several leaving care research studies recently and/or received too many research requests that may affect the self-perception of care leavers as being study objectives (four replies), and
- the information to participate/collaborate was insufficient, or there was not enough therapeutical support for aftercare due to the sensitive topic (three replies).

From this extensive approach, the sample sizes of the survey and interviews increased. In total, 24 sufficiently completed survey responses were collected, and four further interviews took place from November to January 2021. The recruitment of potential new collaboration partners was paused in January and February due to the deterioration of the pandemic and national wide lockdowns in both countries.

March–June 2021: As lockdowns were increasingly eased from March, infection rates decreased, and vaccination programmes continued, the next round to recruit more collaboration partners took place. Previously contacted organisations were approached, namely those which did not reply to the requests from October or November or requested to be contacted again in early 2021.

In addition to a national suicide prevention association in each country, 101 new organisations and relevant contacts were contacted. Among them were 22 contacts at universities from both countries as some, particularly English universities, have dedicated support services for care leavers. Student advisors for care leavers from three English universities shared the information with care-experienced students. Between March and June 2021, six contacts from Germany and eight from England offered support in recruiting participants.

As a striking example of the challenges in recruiting collaboration partners, one contact person from an English organisation that supports care leavers expressed interest and commitment to supporting this study. However, after discussing the study with her colleagues, the organisation declined the collaboration because they recently lost one young person who they supported due to suicide. This decision was reasonable as staff members might have been emotionally affected by their loss while highlighting the relevance of this topic under investigation.

On recommendation from one academic contact, a press release at local newspapers was prepared in collaboration with Dr Katrin Bain and sent to 13 local newspapers across England at the beginning of the Mental Health Awareness Week 2021. None of the approached editors responded. Local newspapers in Germany were approached as well. One local German newspaper published an article about the study at the end of May 2021.

With the request to share the information within their network again, reminders were sent to (previously) existing collaboration partners in March and June. The active recruitment process ended at the end of June 2021.

Closing the data collection

The deadline for the active recruitment of collaboration partners and participants was 30th June 2021, followed by the closing of the data collection. More than 60 organisations and contacts from both countries offered support in the sampling process of the study during the pandemic. How many eligible care-experienced adults received the information is unknown due to different sharing approaches and certain deficiencies in the correspondence. By the end of the extensive and, thus, successful 12-month data collection period, the survey collected 45 sufficiently completed responses, and 13 interviews were conducted.

A reflection on the impact of the pandemic

The COVID-19 pandemic, an unprecedented time, has caused many changes in our everyday lives across the world, including social and economic constraints. The current study was prepared and designed between 2017 and 2019 with planned in-person information meetings with relevant organisations and face-to-face interviews. However, as described earlier, the COVID-19 pandemic impacted the data collection since spring 2020. The unprecedented circumstances during the data collection would also need to be taken into account when interpreting the study's findings and valuing the success of the extensive recruitment strategy.

As accessing care-experienced adults who have already left care is considered to be difficult, the employment of the described broad, extensive recruitment process with various kinds of contacts and applied communication approaches seemed to be helpful in reaching more potential participations (Keller et al., 2016; McInroy, 2016). The scope of the impact of the pandemic on the sampling process, especially the accessibility of potential participants, was not predictable at the time of the start of the data collection. Meanwhile, further research was published on the impact of these unprecedented times on care leavers (see Feyer et al., 2020; Munro et al., 2021; Partnership for Young London et al., 2020; Roesch-Marsh et al., 2021) that would explain the challenges in the data collection process, the pandemic-related findings and the small but, according to the circumstances, reasonable sample sizes.

With the shift to an exclusively online approach of the data collection due to safety measures and travel restrictions, introductory meetings and interviews could not take place in person. Potential participants would be required to have access to relevant digital devices and an internet connection. Recent research from the UK and Germany indicated that some young people in care settings and care leavers lack digital access options. In England, before the

pandemic, most care leavers (91%) in England owned a smartphone, but 17% had no access to the internet at home (Briheim-Crookall et al., 2020a). In Germany, digital and online accessibility, both due to limited availability of devices and digital education, was found lacking for young people in residential care settings, including those who might be in supported semi-residential settings, compared to young people in the general population (Feyer et al., 2020). Feyer et al. (2020) highlighted that residential care settings were not prepared to quickly catch up with the digitalisation at the beginning of the pandemic. The lack of digitalisation covering digital education and the accessibility of devices and the internet in care settings and for care leavers became more prominent with its urgent indispensable need during the pandemic.

Roesch-Marsh et al. (2021) reported a digital divide affecting care-experienced people and care leavers in Scotland during the pandemic. The mixed-methods study found that care-experienced people, particularly care leavers, lacked access to the necessary technology, including devices, internet access, software and support. Access to such technology was easier for those care leavers with organisational links such as employment, education or training, or informal or formal networks. However, others without such connections faced ‘digital exclusion’. Besides this, care-experienced young people living in rural areas might also face unstable internet connections due to regional internet limitations, which is a known issue across the UK. Therefore, the pandemic highlighted that despite young people being considered ‘digital natives’, fewer young people with care experience have access to relevant technology (Roesch-Marsh et al., 2021).

Even more, the pandemic highlighted the extent to which care-experienced young people may face exclusion, risking an increase in loneliness. The discussed digital exclusion of many young adults with care experience would have restricted them from accessing and receiving information and, thus, participating in this study. Therefore, these circumstances not only further push people with care experience into a ‘hard-to-reach’ group for research purposes but exclude them from accessing essential resources and increase the risk for their mental well-being.

3.4 Quantitative method: Survey

As the quantitative approach of the study, the survey intended to investigate the sample's mental well-being, suicidal experiences, and related factors in the context of care experience on a larger scale. The first key question – ***What is the occurrence of suicidal ideation among care-experienced adults in England and Germany?*** – is addressed with a quantitative method by conducting a cross-sectional online survey in both countries (in English and German). The statistical analysis tested the following hypothesis to determine whether differences in the occurrence of suicidal ideation exist between the group from England and Germany:

(I) *H_0:* *The occurrences of reported suicidal ideation by care-experienced adults in England (C_{ENG}) and Germany (C_{DE}) are the same without a significant difference.*

H_1: *The occurrences of reported suicidal ideation by care-experienced adults in England (C_{ENG}) and Germany (C_{DE}) show a significant difference.*

For the second key research question – ***Which factors influence suicidal ideation in care-experienced young people?*** – and the underlying theoretical foundation consisting of the IPTS, the following hypothesis was tested:

(II) *H_0:* *There is no relationship between suicidal ideation reported by care-experienced young adults and their scores in thwarted belongingness (TB) and perceived burdensomeness (PB).*

H_1: *There is a positive relationship between suicidal ideation reported by care-experienced young adults and high scores in thwarted belongingness (TB) and perceived burdensomeness (PB).*

In addition, the survey explored relationships between suicidal ideation and demographic variables and further factors that participants perceive as influencing personally experienced suicidal ideation gathered in open-ended questions. In light of the COVID-19 pandemic, a further question was added to assess the experienced effects of the pandemic on the feeling of

belongingness, feeling of being a burden to others and the attitude towards life. The survey structure is outlined in detail below (see section 3.4.2).

The anonymous survey was accessible online with the link to the website shared via the mentioned collaboration partners. Online surveys have the advantages of being easy to conduct, low-priced, collecting anonymised data from large numbers of respondents, being geographically widespread and making it “easy for everyone to understand what the results represent” (Watson and Coombes, 2009, pp. 124). The remote approach was considered to offer broader access to the population and a lower threshold to answer sensitive questions. However, despite the advantages of online surveys, the circumstances during the data collection posed significant challenges to this study (see section 3.3).

3.4.1 The survey sample

As described above, the inclusion criteria for the research project were amended in the course of the data collection. This consisted of widening the age range from 18 to 26 years up to 40 years (in October 2020). Adults between 18 and 40 years who lived in residential or foster care at least on or after their 16th birthday in England or Germany were able to participate. The online survey applied inclusion criteria automatically to guarantee a description of the sample and to ensure the exclusion of especially younger respondents (children and adolescents) from the survey concerning ethical and legal restrictions.

The online survey used the software Qualtrics. Qualtrics offers dynamic routing abilities of an online survey by giving access only to respondents eligible to participate, for example, only those who click on age categories between 18 and 40. This software meets the privacy standards required for health care records (Schumacher et al., 2014).

To estimate the required sample size, the following formula was used (Tatherdoost, 2017):

$$n = \frac{p\,(100 - p)z^2}{E^2}$$

$$n_{(C)} = \frac{25\,(100 - 25)1.96^2}{5^2} \approx 288$$

n: *required sample size*; $n_{(C)}$: *total number of care leavers required*
p: *percentage occurence of a condition* (*e.g. suicidal ideation*)
E: *percentage maximimum error required*
z: *value corresponding to level of confidence*

The estimated sample size of $n_{(C)} = 288$ was oriented on 25% occurrence of suicidal ideation among the population based on the prediction of looked-after adolescents in foster care (Evans et al., 2017). However, the predicted estimation was only based on adolescents younger than 18 years and in foster care, which might not directly represent the population of interest. The lack of evidence on the occurrence of suicidal ideation among care-experienced adults led to the orientation of the previous knowledge to consider the minimum sample size.

Furthermore, the software G*Power was used to estimate the sample size for the hypotheses based on a minimum of 80% power value (a priori power calculations; see Appendix 3). Power is the probability that, due to unidentified differences (Type II error), the null hypothesis is falsely accepted as true, while it is false (Valliant et al., 2013). For testing the first hypothesis, 310 participants per group were recommended if the effect would be small ($d = 0.2$). For testing the bivariate correlation model of the second hypothesis with the parameters of two tails and estimated medium effect size ($r = 0.3$), the sample required a minimum of $n_{(C)} = 84$.

Despite the described recruitment effort, none of the calculated sample sizes were reached over the one-year data collection period. While 99 respondents gave full consent to participate (see Figure 3), 52 were either not eligible to participate – for example, because they did not answer Q1.5 (“Have you ever been in care?”) or stated that they were not in care on or after their 16th birthday ($n = 29$) – or did not reach the end of the survey as a signal of withdrawing from the study ($n = 23$). In total, 47 of the remaining respondents viewed the whole questionnaire. Two did not fill out a substantial part of the survey, as they did not answer any question of the main parts two to seven that would address the topic of the study. Therefore, those insufficiently completed cases were excluded from the analysis. In total, $n_{(C)} = 45$ completed survey responses were collected with $n_{(C_{DE})} = 29$ and $n_{(C_{ENG})} = 16$.

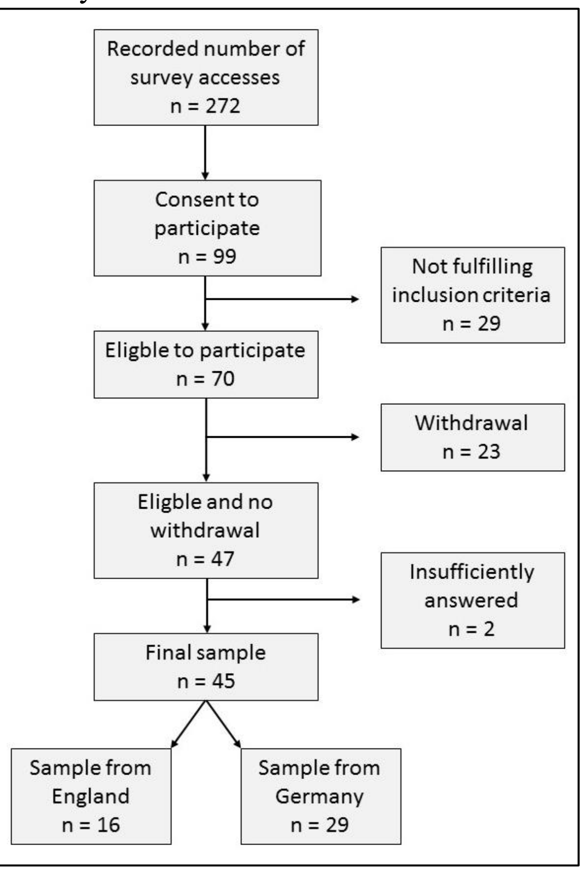

Figure 3: The process shows how the eligibility criteria formed the final survey sample of 45 respondents.

The calculations for preferred sample sizes might be unrealistic for this research project, as they do not consider the accessibility of the targeted group and time-specific circumstances

such as the pandemic. As Sydor (2013) stated in discussing the challenges of conducting research with hard-to-reach groups, in this case, care-experienced young adults during a pandemic, “well-evaluated but limited research data are preferable to no information from groups that are hidden or hard to reach” (2013, p. 33). Therefore, the statistical analysis was processed as the data provide important insights into the mental health, particularly experiences of suicidal ideation, among care-experienced young adults who have left care.

Demographic information

The overview of the demographic data aims to provide a better understanding of the sample and the results presented in section 4. Table 2 provides an overview of demographic information of the survey sample and the two subsamples from England and Germany.

The majority of survey participants were female (78%) compared to male (22%). Covering the age range from 18 to 40 years, the average age of the survey sample was 26 years. The majority (73%) were heterosexual, with 81% of the English sample and 69% of the German sample. Approximately half of the respondents (49%) stated they were single, 36% were in a relationship, 7% married and 9% others (including widowed). Eighty-four per cent of all participants reported having no children. About half of the participants (53%: 9 from England and 15 from Germany) stated they lived alone. Forty per cent of the sample (56% from England, 28% from Germany) classed themselves as having a disability. If specified, most of the disabilities were mental health disorders and autism spectrum disorders.

The average qualification level of the care-experienced sample was diverse. The majority of the English group had A-Level equivalent or higher, up to PhD level, of which about 30% had either a Bachelor’s or Master’s degree. 13% ($n = 2$) stated having GCSE-level qualification, and 19% ($n = 3$) had no qualification. The most common qualification level of the care-experienced sample from Germany (41%) was a *Realschulabschluss/Mittlere Reife* (GCSE equivalent). Seventeen per cent had a *Hauptschulabschluss* (lowest secondary school certificate). About a quarter had an *Abitur* (equivalent to A-Level), Bachelor’s or Master’s degree. Two people had completed professional training. About 10% ($n = 3$) were without qualification.

Concerning participants’ occupation status, one third were employed or self-employed, and 22% were students at the time of completing the survey, with similar distributions in both subsamples. Seven per cent were doing an apprenticeship. A further 7% mentioned being either

a homemaker or having several roles, such as being a student with part-time jobs. The remaining 29% stated they were either unemployed or unable to work.

Half of the English sample identified as White British ($n = 8$), about one third as White, British, British Irish or Scottish, and three participants classified themselves as either Black British African, Bengali or Middle Eastern. All participants from Germany stated being German, with two also having either a Kurdish migration background or an American ancestor.

The key characteristics of participants' care experience were diverse with a wide range of ages on entering care, duration in care and different types of placements. Table 2 shows basic data about their care experiences, and section 4 presents further data about care experience.

Table 2: Basic characteristics of sample's demographics and care experience

	Total		England		Germany	
	n = 45		n = 16		n = 29	
	N	%	N	%	N	%
Gender						
Female	35	77.8	13	81.3	22	75.9
Male	10	22.2	3	18.8	7	24.1
Age						
18–20	13	28.9	3	18.8	10	34.5
21–25	12	26.7	4	25.0	8	27.6
26–30	8	17.8	3	18.8	5	17.2
31–35	8	17.8	4	25.0	4	13.8
36–40	4	8.9	2	12.5	2	6.9
Mean age	25.7		27.3		24.8	
Sexuality						
Heterosexual	33	73.3	13	81.3	20	69.0
Homosexual	2	4.4	0	0.0	2	6.9
Bisexual	5	11.1	2	12.5	3	10.3
Other	4	8.9	1	6.3	3	10.3
N/A	1	2.2	0	0.0	1	3.4
Relationship status						
Single	22	48.9	8	50.0	14	48.3
In a relationship	16	35.6	5	31.3	11	37.9
Married	3	6.7	2	12.5	1	3.4
Widowed	1	2.2	0	0.0	1	3.4
Other	3	6.7	1	6.3	2	6.9

Living situation (multiple-response)						
Living alone	24	53.3	9	56.3	15	51.7
With partner	11	24.4	6	37.5	5	17.2
With own children	5	11.1	2	12.5	3	10.3
With parents	0	0.0	0	0.0	0	0.0
With (an)other family member(s)	1	2.2	0	0.0	1	3.4
With (a) foster parent(s)	0	0.0	0	0.0	0	0.0
With (a) friend(s)	1	2.2	0	0.0	1	3.4
Shared accommodation	4	8.9	1	6.3	3	10.3
Semi-independent living	1	2.2	0	0.0	1	3.4
Residential care placement	2	4.4	0	0.0	2	6.9
Student hall	0	0.0	0	0.0	0	0.0
Unstable housing situation	1	2.2	0	0.0	1	3.4
Other	3	6.7	1	6.3	2	6.9
Care placement types						
Foster care	10	22.2	8	50.0	2	6.9
Residential care	21	46.7	3	18.8	18	62.1
Both foster & residential care	11	24.4	3	18.8	8	27.6
Others	3	6.7	2	12.5	1	3.4
Age entering care						
≤ 1	2	4.4	1	6.3	1	3.4
2–5	3	6.7	1	6.3	2	6.9
6–9	9	20.0	4	25.0	5	17.2
10–13	11	24.4	2	12.5	9	31.0
14–17	17	37.8	7	43.8	10	34.5
≥18	2	4.4	0	0.0	2	6.9
Missing	1	2.2	1	6.3	0	0.0
Mean age	11.4		11.0		11.6	
Age leaving care						
16	4	8.9	3	18.8	1	3.4
17	7	15.6	1	6.3	6	20.7
18	18	40.0	9	56.3	9	31.0
19	3	6.7	1	6.3	2	6.9
20	3	6.7	0	0.0	3	10.3
21	4	8.9	2	12.5	2	6.9
22	1	2.2	0	0.0	1	3.4
Still in care (e.g. staying put)	2	4.4	0	0.0	2	6.9
Missing	3	6.7	0	0.0	3	10.3

3.4.2 Pilot test and structure of the survey

The predesigned survey was tested with a small sample prior to data collection. The pilot test aimed to test the content, phrasing and understandability of questions, the average duration for completing the online survey and to provide feedback on existing or missing questions and the structure. A small-scale pilot test ($n_{(test)} = 7$) of the online survey was conducted at the beginning of March 2020. The seven test participants were care-experienced young adults and professionals from relevant fields (social work, psychology and psychotherapy) with and without personal care experience. Participants of the pilot test completed the survey within 20–30 minutes. Their feedback helped shape the final version of the survey regarding clarity and completeness of questions, appropriate lengths and emotional responses considering the topic's sensitivity.

The survey 'Promoting Mental Wellbeing among Care-Experienced Adults' consists of seven parts with 72 items (Appendix 4). Depending on previous answers, the number of items displayed to a participant varied, as follow-up questions were displayed only if applicable. After an information and consent form, the survey was structured as follows:

General information part 1 (1)

The participant was asked about their demographical information. As several aspects are necessary concerning the topic of suicidal ideation, this part was split into two – one part at the beginning and one at the end of the survey – to keep the participant motivated and turn to the relevant topic quickly. Furthermore, the participant was asked about their care experience, including their age of entry into and leaving care and the number of placement changes.

Personal well-being (2)

This part introduced the participant to the theme of mental well-being and attitudes towards life. Five questions asked about feelings about their current life, well-being and future perspectives.

INQ (3)

The INQ-15 is a questionnaire based on Joiner's IPTS. It has 15 items on a 7-point-Likert scale from 1 ("not at all true for me") to 7 ("very true for me"). Two scales separate perceived burdensomeness (PB) and thwarted belongingness (TB). Six items, items 1–6, belong to the PB scale. The remaining nine items, items 7–15, belong to the TB scale (Van Orden et al., 2012). The sum of the items on each scale presents the score of PB and TB. Higher scores imply greater PB (range 6–42) and stronger TB (range: 7–63) (Brookings and Pederson, 2018). The English and German versions were used (Forkmann and Glaesmer, 2013a; Van Orden et al., 2012). The INQ-15, as a dominant part of the survey, was chosen due to its popularity in research about suicidal ideation and behaviour. Previous studies have proven the INQ as a valid and reliable tool (Hallensleben et al., 2016; Van Orden et al., 2012). It is a compact questionnaire with only 15 items that usually do not require more than five minutes (Forkmann and Glaesmer, 2013b). The English and German versions of the INQ are free to access online (https://psy.fsu.edu/~joinerlab/ and https://psychometrikon.de).

Attitudes towards life and death (4)

Following the INQ-15, four questions assessed suicidal thoughts with increasing severity based on interview questions by Paykel et al. (1974), also known as the Paykel Suicide Scale (PSS). The increasing severity measured by the four applied PSS questions (excluding the fifth question about suicide attempts) can be differentiated between low severity as passive suicidal ideation or thoughts about death (items 1–2) and high severity as active suicidal ideation (items 3–4) (Ashrafioun et al., 2016; Fonseca-Pedrero et al., 2019; Van Orden et al., 2015). These were distinguished between lifetime occurrence, last suicidal thoughts (within the previous month, previous 12 months or before the past year) informed by the study by Dennis et al. (2009), and a care-related occurrence as a point in time (only while in care, while in care and after leaving care, only after leaving care) oriented on the approach applied by Ayalon (2012). The PSS has been applied in international studies with various groups, including young people in the 'Saving and Empowering Young Lives in Europe' (SEYLE) study (Ashrafioun et al., 2016; Balázs et al., 2013). The German translation was thankfully received from Professor Dr Michael Kaess, who was involved in studies applying the PSS among young people in Germany and internationally, including the SEYLE study (see Kaess et al., 2014, 2011).

The next question asked, on a 5-point Likert scale, how the COVID-19 pandemic had impacted the person's feeling of belongingness, feeling of being a burden and attitude towards life. Next, questions about the time when the suicidal thoughts appeared first were posed. Open-ended, free-text questions asked about factors that participants consider to cause their personally experienced suicidal thoughts and that supported moving on. These were adopted in the in-depth interviews as well.

Reflection on care (5)

Two open-ended questions were asked about the respondents' opinions on the role of care regarding their attitude towards life and in suicide prevention. The first question asked whether and how their own care experience had influenced their attitude towards life. The second question asked about their wishes on how the care system could change to empower young people to have a satisfying early adulthood and prevent suicidal thoughts.

Empowerment and joy (6)

After the questions about suicidal ideation, open-ended questions were asked about the participant's experiences and resources, which are empowering for them. These questions were placed after the questions about suicidal ideation to turn the participant's focus on positive memories and resources, as answering the previous questions may have caused distress. Due to the focus of the research questions, this part was not included for analysis in this thesis.

General information part 2 (7)

The last part of the survey closed with further demographical questions. They focused on sexuality, relationship status, education and employment. Apart from getting more information about the participant, this part might also be helpful at the end of the survey to let the participant focus on specific aspects other than the previous sensitive questions about suicidal ideation. In the end, the survey thanked participants for their time and provided information on support services.

3.4.3 Practicability and psychometric properties

The survey underwent a pilot test to ensure its practicability for the planned study. As described above, a small group of young adults with care experience and professionals from relevant fields with and without care experience were consulted to assess the survey in a pilot test.

The incorporated INQ-15 is a questionnaire based on Joiner's IPTS to assess the two scales, TB and PB. This tool "was developed by the authors for use by researchers in the investigation of the etiology of suicidal desire/behaviour, as well as by clinicians as part of a risk assessment framework grounded in the theory" (Van Orden et al., 2012, p. 2). This instrument has been tested among diverse populations, for example, young people, elderly people, chronically ill women, and non-clinical and clinical samples (see Brookings and Pederson, 2018; Hallensleben et al., 2016; Ma et al., 2019; Van Orden et al., 2012). Several studies reported good psychometric properties of the INQ and considered it a reliable and valid instrument for evaluating proximal causes of suicidal ideation (see Forkmann and Glaesmer, 2013b; Hallensleben et al., 2016; Ma et al., 2019; Van Orden et al., 2012). The findings from a review and meta-analysis study by Chu et al. (2017) showed that the combination of TB and PB was significantly related to suicidal ideation. However, the authors highlighted the limitations of the INQ, as the results showed small to moderate relationships between IPTS factors and suicidal ideation and behaviour (Chu et al., 2017). Further limitations were mentioned regarding the lack of applied cut-off scores for the risk assessment, showing a concrete threshold when suicidal ideation is present (Brookings and Pederson, 2018; Forkmann and Glaesmer, 2013b).

Therefore, Forkmann and Glaesmer (2013b) recommended using additional tools to assess the risk of suicide in combination with the INQ. The four interview questions of the PSS are suitable as an additional assessment tool for suicidal ideation (Paykel et al., 1974). Other questionnaires for assessing suicidal ideation such as Beck's Hopelessness Scale or Beck's Suicide Intent Scale were rejected from being used in the survey because they consist of more items to be answered and are not openly accessible for free. Furthermore, the constructs of the IPTS focus on the individual social perceptions, which are especially interesting to investigate for a group such as care-experienced adults who have particular social experiences due to having been in and leaving care.

3.4.4 Analysis of the survey data

The survey data gathered with Qualtrics were downloaded in two file formats in Excel and Statistical Package for the Social Science (SPSS 25). While the analysis of open-ended questions was prepared with Excel and coded with NVivo 13, the computer-assisted software SPSS was used to analyse the further survey data.

Descriptive statistical analysis was used to present the sample's characteristics as a total sample and each country-specific subsample separately. First, the distribution of frequencies was analysed for demographic data, care experience, mental well-being, INQ factors and suicidal experience. Next, the means $\bar{x}$ including the range and standard deviation of numerical or ordinal variables were calculated: age (Q1.1); care experience characteristics such as age entering care (Q1.5.4–8); life satisfaction and mental well-being (Q2.1–2); future perspective (Q2.4); TB and PB score (Q3.1); PSS scores (Q4); the impact of the COVID-19 pandemic (Q4_Corona); and age of first suicidal thoughts (Q4.5).

The Shapiro–Wilk tests, with $p > 0.05$ indicating a normal distribution, and a visual inspection of their histograms suggested that most variables were not normally distributed (see Appendix 5). In contrast, only the variables of future perspective (Q2.4) and TB scores generally and the age entering care for each subsample were approximately normally distributed for both subsamples based on the Shapiro–Wilk test ($p > 0.05$). If the visual inspections of histograms showed unclear distribution results in addition to the normality test result, then the Shapiro–Wilk test's result was used as the final indicator for the distribution and following tests.

Mann–Whitney tests for non-parametric distributions were conducted to test the first hypothesis and to explore whether the differences between the two independent subsamples, in this case, mainly based on the two countries, were statistically significant. Kruskal–Wallis tests for more than two independent groups assessed differences in PSS scores across categorical variables of sexuality, relationship status and care types. If the Kruskal–Wallis test showed a significant difference between several groups, post hoc Mann–Whitney tests were conducted to assess which groups differ from each other.

Bivariate correlations between the responses of the PSS and relevant demographic (for example, age, gender and sexuality) and care-specific data were tested with Spearman's rank correlation coefficient (r_s) and Kendall's Tau (τ). For instance, based on previously identified risk factors for suicidal behaviour among young people leaving care in Northern Ireland by

Hamilton et al. (2015), correlations between suicidal thoughts and the age entering care, lengths of care experience and the number of care placement changes were tested.

To explore the relationship between recent suicidal thoughts (PSS of last month) and INQ scores considered in the second hypothesis, a scatter graph was created first. Correlation tests with Kendall's τ were carried out to test the second hypothesis to investigate a possible relationship between the variables. In addition, correlations between PSS scores and future perspectives were explored.

Generally, all percentage results are presented without decimal places to enhance legibility. Means and standard deviations are presented with one decimal place. Results of correlation tests such as p-values are presented with three decimal places, as required.

The data analysis of the open-ended questions aimed to identify reoccurring themes across the sample to explore influencing factors of suicidal ideation. While the two care-related open-ended questions (see Q5.1–2) were displayed to all participants, only those survey respondents who answered at least one of the general PSS questions with "Yes" saw the open-ended questions about experienced changes, perceived causes of suicidal ideation and coping strategies (see Q4.6–8).

As O'Cathain and Thomas (2004) described, open-ended questions offer respondents the opportunity to voice their views, particularly important for this study regarding the limited knowledge and presumed complexity about factors that influenced suicidal ideation among care-experienced young people. Open-ended questions about such issues were helpful, as it was impossible to provide an appropriate list of response options or anticipate possible answers and, therefore, were post-coded (Aldridge and Levine, 2001). Due to the limited free-text space, answers to open-ended survey questions are, unlike interview data, confined in their depth and may be assumed as neither qualitative nor solely quantitative data (O'Cathain and Thomas, 2004). The free-text answers were uploaded as an Excel file to NVivo 13 to assist in coding and sorting the data. As informed by content analysis, the following four steps were undertaken, as described by O'Cathain and Thomas (2004):

1. I familiarised myself with the responses to each open-ended question.
2. A coding frame for each issue was drafted based on the thematic content of the responses.
3. The coding frame was applied to the related texts and coded with NVivo.
4. The frequency of codes and themes were analysed.

The coding frames for questions 4.6–8 and 5.2 were informed by the thematic framework used to analyse the interview data and adapted. Question 5.1 “How do you think your experience of being in care influenced your attitude towards life?” was grouped into positive, negative, mixed, no impact and other as the coding frame. Matrix coding queries in NVivo 13 were conducted to show frequency distributions across the different themes and categories, and their ratios were further explored and graphically presented in Excel.

The data were analysed in its original language. A selection of quotes to support the findings is incorporated into the presentation of the results below (section 4). Quotes are displayed as they were written without any grammatical or spelling corrections. Selected German quotations were translated into English with translation software and manually checked for accuracy.

As Bryman (2012) mentioned that open-ended survey questions tend to be limited in length and detail and less likely to be answered by some respondents, the information gathered from semi-structured interviews conducted enabled to investigate this topic in greater depth. To link survey responses with in-depth interview data, these questions regarding content reoccurred in the interviews (see section 3.5.3 and Appendix 8).

The analysis of survey data would provide a broader perspective in understanding the experiences of suicidal ideation among care-experienced young adults. However, to supplement an in-depth understanding of the survey data, semi-structured interviews provided qualitative data to explore underlying mechanisms further.

3.5 Qualitative method: Interviews

To address the second key research question – ***Which factors influence suicidal ideation in care-experienced adults?*** – in-depth data from 13 semi-structured interviews were collected to investigate factors perceived to influence both the occurrence of and coping with suicidal ideation, including preventive factors. Based on the mixed-methods design, the qualitative interview data complement the survey data, particularly the responses to the open-ended questions, to address this research question by providing a more detailed, contextual understanding and possible explanations of the complexity of the lived experiences (Klassen et al., 2012). Focusing on factors and underlying mechanisms that influenced suicidal ideation among care-experienced adults may offer a better understanding of empowering young people in care and future care leavers. Furthermore, the qualitative approach aims to contribute to

preventive, empowering social work practices before looked-after young people leave the care system.

In both countries, care leavers often report the same difficult situation: when young adults have left the care system, various reports claim a rapid reduction of meetings with the social worker or a sudden drop of any contact with professionals or professional support (Sievers et al., 2014; Strahl et al., 2012; The Care Inquiry, 2013b). These circumstances might be related to limited financial or structural resources and austerity of the youth welfare systems in both countries (National Care Advisory Service, 2011, cited in Stein, 2012; Sievers, et al., 2016). Therefore, identifying factors to empower care-experienced young people even before leaving state care might enrich social work practice as part of the leaving care process. It might be even more realisable than suicide interventions after the public care has terminated.

The interviews collected the views of 13 care-experienced young adults who had experienced suicidal ideation in care or after leaving care and found coping strategies. The lived experience was important to better investigate contributing factors and mechanisms. The qualitative approach would help understand a young person's experience of suicidal ideation and care in depth.

3.5.1 Data collection and inclusion criteria

For the qualitative research part, interviews with voluntary participants with care experience from each of the two countries were conducted. Due to the pandemic, the interviews took place remotely only. Online meeting platforms such as Zoom, Microsoft Teams or Skype were predominantly used for the interviews. Telephone calls were only conducted alternatively in cases where the person would feel more comfortable, or difficulties with the internet connections occurred.

The sampling for the qualitative semi-structured interviews was selective and purposive. A selection of suitable interviewees was necessary for two reasons: first, the criteria ensured the fitting demographical characteristics of the research group. Second, most importantly, the criteria went along with the ethical considerations by selecting participants to ensure their ability to reflect on coping strategies and their well-being to limit the likelihood of emotional distress during the interview. Appendix 6 presents the inclusion and exclusion criteria for the interviews used for sampling.

The selective criteria were essential to ensure the participants' emotional well-being and reflectivity about influencing supportive factors such as coping strategies. Emotional stability had to be confirmed by the participants. To ensure the well-being and safety of the participants, participants needed to confirm that they had not experienced suicidal thoughts recently and were able and willing to talk about their experience of these thoughts. The criteria, particularly the emotional and reflective abilities, were discussed in advance with potential interviewees during an initial phone call. A checklist helped ensure potential participants' eligibility and collect some demographic information in advance (Appendix 7). To thank them for their time, a €15/£15 e-voucher or PayPal transaction was offered to each interview participant.

Various experts recommend different sample sizes for qualitative research, which balance between one and seventy or even more interviews depending on the purpose, time and availability (Baker and Edwards, 2012). The qualitative interviews aimed to investigate factors that influenced past suicidal ideation among care-experienced adults that are either considered causes or resources. In addition, the interviews sought to explore the role of the care experience and system and the transition to adulthood. Therefore, participants were required to have been in care at least on/after their 16th birthday and not have experienced suicidal ideation recently. As the inclusion criteria were relatively narrow, the sample size depended on the availability of participants and the achievement of a substantial in-depth view. In total, 13 interviews were conducted between September 2020 and June 2021. Five further people expressed interest in taking part in an interview but did not fit the inclusion criteria and, therefore, were not interviewed.

3.5.2 The interview sample

The following demographic information was collected from 13 interviews with care-experienced young adults, seven young adults from England and six from Germany. All of the participants were between 18 and 30 years old. The total sample consisted of nine females, including one transgender female, and four males. While the gender distribution in the German sample was even (three females and three males), the English sample had the majority of females (six females, including one transgender female, and one male). Participants from Germany were all German nationals, with one having double citizenship. The group from England showed a range of ethnicities, with four participants identifying as 'White' or 'White British' and three as 'Asian British', 'Mixed' or 'Iranian/Middle Eastern'. Overall, seven were

in full-time or part-time employment, were freelancers or had several jobs, three were in apprenticeship/vocational training, and three were unemployed or unable to work (one did unpaid volunteering work). Three of the seven in any employment were university students at the time of the interview.

The age of entering the care system ranged from 1 to 17, with nine participants entering care as teenagers between 13 and 15. Participants from Germany who had all solely lived in residential care, the most used type of care in Germany, entered the care system between 13 and 15 years. The age range when entering the care system in the English sample was more diverse, with three out of seven entering the care system under the age of six. The sample of interviewed participants spent different lengths in care ranging from 1 to 17 years. In addition, the care types were more diverse in the English sample, with the majority of them having lived with foster families either only or at least at some point during their time in care. One participant reported being in kinship care before living with a foster family, another one lived in multiple foster and residential care placements, and one who entered the care system at the age of 17 lived in supported temporary accommodations. Striking here is also that the number of changes of placements during their time in care was higher among the English sample, with 1–48 changes compared to 0–2 changes in the German sample.

While one participant from Germany reported being 'still in care' while living in supported accommodation at age 18, all others reported having left care between the ages of 16 and 20. Two young adults from England were living in semi-independent living at the time of the interviews, though they did not consider themselves still in care. Different legal definitions from both countries of when care officially ends may influence whether some young adults view themselves as 'still in care'. In England, young people officially leave care at the age of 18, and though they have the option of staying put or moving into semi-independent living, young people are not considered in care anymore after this age. Participants from England perceived the time when leaving their last foster or residential care placement as the point of leaving care. Therefore, the English sample reported leaving care between the ages of 16 and 19 (with one person including the time of staying put with her former foster carer). Care-experienced young adults in Germany still consider themselves in care when living in supported or semi-independent accommodation by a residential care provider. The age range of leaving the care system for German participants was between 17 and 20, with the latest time of ceasing support by the care provider.

All participants had experienced suicidal ideation at least at one point in their past. The last time they had suicidal thoughts was between three months and five years before the interview.

In conclusion, the sample presents a range of experiences and diversity. While the German group reflects residential care during adolescence, the English group shows a great variety in care types and age entering care. Each group shows a diverse distribution of regions in which they lived in care and at the time of participation. While qualitative research does not aim for a representative sample, the variety of experiences and backgrounds across all interviews contributes to a broad spectrum of perspectives.

3.5.3 The interview structure

The interviews aimed to explore factors influencing suicidal ideation among care-experienced young people in England and Germany. IPTS informed the semi-structured interviews as an initial theoretical foundation. The semi-structured interviews focused on lived experiences while addressing theoretical constructs (Bryman, 2012; Galletta, 2013).

Wengraf (2006) published a pyramid model for the construction of qualitative research. It shows the relationship and setting from the research purpose, the research question over theory questions to interview questions (Wengraf, 2006). This model was adopted in the interview guide (see Appendix 8). The interview guide had four broad parts: care experience, perceived causes of suicidal ideation, coping strategies, and wishes and recommendations on how the care system could contribute to preventing suicidal ideation. The questions on the topic guide served only as a thematic orientation and suggested prompts. Demographic data were collected before, at the beginning of or after the interview (see Appendix 9). All interviews were audio-recorded and took place in either English or German.

The interview was structured into three broad segments recommended by Galletta (2013): the opening, middle, and concluding segments. The opening segment covered preliminary steps to ensure the participant's informed consent and a comfortable atmosphere, and introduce the topic. The topic-related introduction is supposed "to be the most open-ended [segment] in [the] interview, focused on encouraging a generative narrative, a way into the phenomenon of study as determined by the participant" (Galletta, 2013, p. 48). The consent to participate was audio-recorded at the beginning of the interview.

The first theory question (TQ1) addressed the experience of (leaving) care and the occurrence of suicidal ideation (see interview guide). As an initial question to encourage a generative narrative, the participants were asked to talk about time in care, particularly when they left care. Questions about the occurrence of suicidal ideation followed.

The middle segment focused on influencing factors to this experience related to the specifications of the research questions II-a and II-b. The interview questions under the theory questions TQ2 and TQ3 formed the central part of this segment. TQ2 addressed perceived causes of suicidal ideation, including interpersonal factors based on the IPTS. By keeping the IPTS as the main component of the initial theoretical framework in mind but without using leading questions, the participants were asked to describe their social life and feelings when they were with other people when they had acute suicidal thoughts. To explore the influence of the care system in the context of suicidal ideation, questions about the role of their social workers, carers or PAs were asked. Similarly, by investigating TQ3 about resources and coping strategies, questions about interpersonal factors regarding their social life and the care system's role were asked.

The concluding segment offered the opportunity to turn back to points that were said before to explore and clarify them further, for example, contradictions. This segment is about meaning-making with the participant. The participant's wishes and recommendations (TQ4) on suicide prevention within the care system were explored. This part led to the end of the interview by asking the participant about their final thoughts and points, emphasising the participants' contribution and appreciating them for the interview (Galletta, 2013). The 13 interviews lasted, on average, about 73 minutes, including occasional breaks due to disrupted internet or telephone connections.

After finishing the interview by stopping the recording, the meeting continued with a debriefing. A follow-up call was scheduled on the following days to check for the participant's well-being in case of pondering or emotional distress as a further debriefing segment and provide the option to add additional ideas or clarifications to the interview. Five of the 13 interviews were supplemented during the follow-up call.

3.5.4 Preparation for analysis: Transcription and data management

The audio-recorded interviews were manually transcribed into Microsoft Word documents in their original language, English or German. The purpose of the transcription from the sound recordings of each interview was to capture the content of the spoken word of the interviewee in a textual form to be coded and analysed later (Poland, 2001). A verbatim transcription informed by Powers (2005) was used, including punctuation and selected non-verbal aspects that appear relevant to the meaning of the spoken word, such as pauses, laughter, and paraphrasing others. If words were unclear to understand, they were marked in the transcript. The interviewer's words were transcribed in a simplified way by leaving out non-verbal aspects based on recommendations from Powers (2005), as those would not contribute to the quality and purpose of the transcript.

A higher level of detail of non-verbal, phonetic aspects was not necessary for the goal of this piece of research, in addition to the technical limitations of capturing non-verbal clues in online- and telephone interviews. The transcription system (see Appendix 10) was informed by Powers (2005), and the "alternative abbreviated instructions for transcribers" by Poland (2001, p. 641), with some aspects simplified to fit the purpose of the transcript better.

While transcribing the interview recordings and familiarising with the data, Saldaña (2013) suggests handwritten preliminary jottings of codes and striking topics. They included reoccurring and new topics, and links between topics and contrasts to aspects identified in previous interviews.

The transcripts were analysed with the computer-assisted qualitative data analysis software NVivo 13. NVivo provides various features to manage and examine the meaning of the records with a specific focus (Bazeley and Jackson, 2013). Each transcript was assigned as a case in the category 'person'. Case classifications were added for every interview participant, including demographic information such as gender, age, country, ethnicity and type of care placement(s).

3.5.5 Framework analysis

Framework analysis, developed by Ritchie and Spencer, is an "analytic approach […] in the context of conducting applied qualitative research" (Ritchie and Spencer, 1994, p. 173). As initially used in applied policy research, the authors highlighted the role of qualitative research in understanding, explaining and theorising social behaviour relevant to policy makers.

Research objectives in line with the origin of this analytical approach would need to address at least one of the four categories:

- Contextual: identification of characteristics of phenomena (for example, people's experiences, attitudes, needs)
- Diagnostic: investigation of reasons or causes of phenomena
- Evaluative: assessment of the effectiveness
- Strategic: creating theories, plans or policies (Ritchie and Spencer, 1994).

Primarily contextual and diagnostic, but also strategic objectives have intertwined in this research. It aims to understand the needs of care-experienced people who had experienced suicidal ideation (contextual), and investigate the causes and developed coping strategies (diagnostic). In the end, the study seeks to provide recommendations for future research and social work or care practice on how the findings could help improve the support for young people in and leaving care in light of suicide prevention (strategic).

Framework analysis was used as a method for analysing the data systematically. It is a well-studied, transparent, systematic and structured approach to analysing the data, especially from semi-structured interviews in applied medical, health, social and policy research (Gale et al., 2013; Parkinson et al., 2016; Ritchie and Spencer, 1994). It provides a thematic analysis that orders and integrates data with a matrix-based method according to key themes, concepts and categories (Bryman, 2012; Ritchie et al., 2003). In line with the type of qualitative data gathered for this part of the research project, this approach is most suitable for analysing semi-structured interviews thematically where a comparison between cases is desired (Gale et al., 2013).

Framework analysis is an analytical method for qualitative data that appears suitable for CR-oriented research. It is flexible regarding its underlying epistemology to allow deductive and inductive analysis (Gale et al., 2013). Joiner's IPTS as part of the conceptual framework informed the construction of a priori codes. Furthermore, this approach offered to explore emerging themes and ideas. The examination of participants' causal attributions about the causes for developing suicidal ideation, the reasons for the decline of suicidal thoughts and ways that helped them cope with suicidal thoughts would be in line with the critical realist aim of emerging new ideas about the underlying mechanism that caused the events.

Framework analysis applies five constitutive steps: familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation (Gale et al., 2013; Parkinson et al., 2016; Ritchie and Spencer, 1994).

1) Familiarisation

The step of familiarising is to gain an overview of the material (Ritchie and Spencer, 1994). Transcripts were reread, also partly while relistening to the recordings simultaneously (Gale et al., 2013). All transcripts from one country underwent the familiarisation process first before proceeding with the second country to develop a country-specific insight of the data in comparison. Relevant aspects such as key ideas and recurrent themes were jotted down (Ritchie and Spencer, 1994). Overview tables per country were created in Excel with summaries about the main contents of each case distinguishing between the following aspects: care experience, leaving care experience, perceived causes of suicidal ideation, experiences of suicidal ideation, coping strategies and wishes or recommendations. Memos were reviewed, and a priori concepts were listed based on the conceptual framework, including interview topic guide, survey topics, and relevant suicide theories. This approach offered an inductive and deductive combination to test, for instance, the informing theoretical framework containing Joiner's IPTS.

After familiarising with each interview, the initial coding of three interviews was undertaken on paper. Transcripts were read and coded paragraph by paragraph to "divid[e] up [the] transcript […] into bite-size pieces for analysis" (Lacey and Luff, 2009, p. 31). For each section, either one code or several simultaneous codes were assigned. Codes were created in English. As the 13 interviews were lengthy, with up to 32 pages of a transcript to review, initial coding helped gain and retain an overview of the data. As Gale et al. (2013) described, the initial coding process takes place between the first stage of familiarisation and the second stage of identifying a thematic framework.

2) Identifying a thematic framework

Based on the previous familiarisation with the data, the next stage contained the identification of a thematic framework to sort the material. The thematic framework consists of three components: a priori issues informed by the research objectives and theoretical foundations, emergent topics, and analytical themes based on recurrence and detected patterns of perspectives and experiences within the material (Ritchie and Spencer, 1994).

Codes were sorted hierarchically to generate themes. The structure of the interview guide and the IPTS as a theoretical foundation informed the structure of codes and themes. Similar codes were grouped, and references from the data were collated. By applying the first version of the framework ('index') to a few transcripts, categories and major themes were further refined to represent the diverse experiences and views gathered from the data. As the sample consisted of

care-experienced young adults from England and Germany with the objective of a bi-national comparison, a joint index in English was used for both groups to help identify common and divergent themes (Ritchie and Spencer, 1994).

This process of identifying a suitable thematic framework was verified with the supervisory team, who read the initially coded transcripts, discussed striking topics and provided coding suggestions. The guidance by the supervisory team helped to revise the coding process to include a more inductive approach. Several options to structure codes and themes were tested to decide the most suitable framework. The final thematic framework consisted of 61 codes grouped into 10 themes (Appendix 11).

3) Indexing

Next, the thematic framework was applied to all interview transcripts using NVivo 13. NVivo 13 helped to organise the data into the thematic framework. Codes were managed into the identified themes and hierarchies based on a combined numerical system that included descriptive index headings (Ritchie and Spencer, 1994). Memos were written during the application of the thematic framework to help identify possible links between codes and themes.

4) Charting

The following step of charting enables "to build up a picture of the data as a whole, by considering the range of attitude and experience for each issue or theme" (Ritchie and Spencer, 1994, p. 182). The references were thematically arranged into a chart subdivided into headings and subheadings. The thematic approach provides separate charts for each major theme. Each row of the chart was assigned to a case, while the columns presented the codes that were considered to be a pattern of experience or view underlying the major theme (Ritchie and Spencer, 1994). Two charts were created for each of the 10 themes, one for England and the other for Germany, to facilitate a comparison between the two countries (Ritchie and Spencer, 1994).

The function called Framework Matrices offered by NVivo 13 was used to create charts. References were automatically assigned to a cell that linked a code (each in a new column) to a case row. The framework matrices were transferred to Excel for further processing, as it provides a more flexible use to view and summarise the cells of the charts (see Figure 4).

		Codes		
		A : 5.1-Control	B : 5.2-Psychological, emotional pressure	C : 5.3-Overwhelmed
Participants (England)	1 : E01-E1 Interview			
	2 : E07-E2 Interview			
	3 : E08-E3 Interview			
	4 : E09-E4 Interview			
	5 : E10-E5 Interview			
	6 : E11-E6 Interview			
	7 : E13-E7 Interview			

Figure 4: Example of the chart 'control' with codes (columns), cases (rows) and incomplete cells containing summaries.

The cells of references were summarised in English while maintaining the original meaning of the interview passage (Gale et al., 2013). Each chart was copied into a second Excel sheet to enhance the closeness to the original meaning. While one sheet contained the summaries of each case per code only, the other one contained additionally one central quote per case and code. Quotes were kept in the original language. To track all original quotes, each summary was referenced by the line numbers of the transcript (Ritchie and Spencer, 1994). Contrasting cases and simultaneous coding were noted.

5) Mapping and interpretation

After filling out the charts with the data, guided by the research questions and the study's objectives, the final step of the framework analysis described by Ritchie and Spencer (1994) is to review key attributes of the data and interpret the data set. The charts and additional notes were examined by comparing and seeking patterns of responses (Ritchie and Spencer, 1994). Analytical memos were written for each theme to prepare for the interpretation process. The memos included a definition of each theme, underlying codes, a summary of key points of each code in comparison between England and Germany, deviant cases and further ideas for the interpretation process, such as identified links to other themes. The themes were assigned to one of the three socio-ecological levels: individual, interpersonal and structural. In addition, simultaneous coding was reviewed to identify reoccurring links across themes and different socio-ecological levels.

Chapter five presents the findings of the interviews analysed with the framework analysis. The presentation of the findings was complemented with direct quotes, which were extracted from the transcripts without changes to the non-verbatim signs. Quotes in German were translated with software and checked for translation accuracy.

The data from the semi-structured interviews aimed to provide an in-depth understanding of suicidal ideation among care-experienced young people, particularly the role of the transition from care and potential implications for suicide prevention in the care system. Moreover, this was the first study that gathered qualitative data about this topic from young adults with care experience from two countries.

3.6 Ethical considerations

Ethical considerations were fundamental to the study, considering the sensitive topic and researched group. Every participant received information about the study, its purpose, anonymity, autonomy and voluntariness during participation, precautions and supporting information about support services. The six principles of ethical research from the Economic and Social Research Council (ESRC) informed the ethical framework for this research design: voluntariness, informed consent, anonymity and confidentiality, transparency, independence of research, well-being and value (ESRC, 2015). These are in line with the Market Research Society's (MRS) code of conduct principles in the *MRS Guidelines for Research with Children and Young People* (MRS, 2014). In addition, the ethical considerations in conducting research with care leavers by Mendes et al. (2014) and Keller et al. (2016) were taken into account. Ethical considerations included the following criteria:

- Participation was voluntary. Participants could skip questions during the survey and the interview. Furthermore, the participants could stop or withdraw from participation at any time, which would ensure their autonomy.
- Participants received details about the purpose, participant criteria, options and risks for participants and contact details of the research team before starting the survey or interview. Every participant was required to give their informed consent before participating in the study.
- Privacy and anonymity were ensured, including the online survey platform's privacy policy and data storage. No identifying details were collected during the survey to

ensure the anonymity of the participants. Names and other identifying information of interview participants were anonymised in the transcripts.

- There was no conflict of interest in conducting this study. This research was independent. This research project was funded by the Studienstiftung des deutschen Volkes [translated: German Academic Scholarship Foundation].

Special attention was paid to all participants' emotional well-being throughout the process, particularly as sensitive questions were asked that may cause distress as they might remember an unpleasant experience. The participants were informed about the topic, possible sensitive and distressing questions, and the opportunity to withdraw from the study at any time. Contact details for support services were provided in the survey and the interviews.

To address topic-related ethical considerations, an additional literature search was conducted in advance to find information about possible iatrogenic effects of screening for suicide. This knowledge was valuable in discussions with potential collaboration partners and in addressing their concerns about the safety of young care-experienced adults participating.

The online survey had limitations concerning the researcher's control for observing, intervening and identifying participants who were at acute risk. With the awareness of these limitations, the choice to conduct an anonymous online survey to investigate the occurrence of suicidal ideation and influencing factors also had advantages, mainly as it addressed a sensitive topic. Based on the reported experiences in the SharpTalk study, which conducted an online study about self-harm with young people, anonymity is considered highly important to report their experiences and feelings, which they might feel reluctant to disclose if they are identifiable by the researchers (Sharkey et al., 2011). This advantage of a digital study design was already supported in the late 1980s by a clinical study with 102 inpatients, which demonstrated that the use of a computer-delivered screening for the risk of suicide is widely accepted and further provides more information that patients may be unwilling to tell a professional face-to-face (Levine et al., 1989). Whitlock et al. (2013) confirmed that a "growing body of research suggests that web-based surveys increase honest disclosure of private behaviors, such as NSSI, suicidal thoughts or actions […] [which would have] never previously [been] revealed in off-line exchange" (Whitlock et al., 2013, p. 28). Based on the web-based study design, the autonomy and personal control of the participants in deciding whether they want to answer questions or even withdraw from the study would be easier in an anonymous online survey than in a face-to-face approach (Whitlock et al., 2013).

Furthermore, a non-face-to-face approach would reduce the possible pressure to answer to comply with social expectations or the fear of possible consequences of an honest but maybe worrying answer. Sharkey et al. (2011) reported that reviewers of ethics committees expressed concerns about the vulnerability of the potential participants as limitations due to safety were present. Concerns were, among other things, that the subject or the medium of the study could raise the vulnerability (Sharkey et al., 2011). These ethical considerations were addressed by Plener et al. (2012) and Whitlock et al. (2013), who referred to previous studies assessing these concerns. Those studies showed that the rate of suicidal behaviour stayed the same or even decreased after questioning about suicidal ideation and behaviour (Plener et al., 2012; Whitlock et al., 2013). One of the mentioned studies conducted a survey with adolescents about suicidal ideation and behaviour and reported that those young participants who disclosed depressed feelings and suicidal behaviour seemed less upset after participating and experienced the study about this topic as beneficial for their well-being (Gould et al., 2005). Other studies about suicide research have reported similar effects within the investigated samples (Gibson et al., 2014; Smith et al., 2010). The study by DeCou and Schumann (2018) presented that no significant pooled effect was found during assessments of the iatrogenic effect of suicidal screening among vulnerable groups, for example, adolescents with a history of depression and adults with a history of suicide attempts and suicidal ideation. The authors concluded that the assessment for suicidal ideation and behaviour is appropriate and does not cause any harm (DeCou and Schumann, 2018).

In summary, several researchers have inferred that research-based questioning about these experiences does not trigger suicidal ideation and behaviour and is safe to conduct (DeCou and Schumann, 2018; Gould et al., 2005; Law et al., 2015; Plener et al., 2012; Smith et al., 2010). During the literature review of the mentioned databases, no publication indicated that screening for the risk of suicide would trigger suicidal ideation or behaviour. This finding would support the statement that the risk of inducing suicidal thoughts and behaviour with questions about the topic, which ethical committees and gatekeepers are often worried about, is a myth (Bajaj et al., 2008).

Nevertheless, it was essential to be aware that some people might feel uncomfortable about being asked about suicide directly (Bajaj et al., 2008). In the Australian school-based study by Robinson et al. (2011) about the screening for the risk of suicide among students, the researchers reported that a minority of at-risk students perceived the questions as more distressing and less worthwhile than others not at risk. However, the general results of the study supported the previously mentioned evidence that screening for the risk of suicide did not cause

significant distress (Robinson et al., 2011). De Beurs et al. (2016) investigated the affective reactions of university students answering questions about suicidal ideation. The researchers found that answering questions about suicide did not affect the mood of the participating majority. A small group of more vulnerable participants reported distress, but none of the participants contacted the recommended psychologist during or after the study (de Beurs et al., 2016). This study was reviewed, among other aspects, concerning the iatrogenic effects of suicidal screening and included in a meta-analysis that presented that "the pooled effect of assessing suicidality was nonsignificant with regard to the increased psychological distress" (DeCou and Schumann, 2018, p. 535).

It must be considered, and participants were informed in advance, that the questions about suicidal ideation might provoke temporary pondering and short-term emotional distress, particularly for those who experienced life adversities, as Whitlock et al. (2013) mentioned. At the same time, the researchers highlighted that such questions could stimulate self-reflection, which might be related to the mentioned beneficial experiences of a possible reduction of the symptoms (Whitlock et al., 2013). Providing distressed participants with contact details of support services as resources mentioned by Law et al. (2015) and ensuring autonomy about answering the questions, in addition, took into account that a few participants might feel uncomfortable and upset. The following principles were applied:

- Participants were informed about the study and possible risks and asked about their informed consent.
- Participants could ask questions and contact the researcher and the supervisory team.
- Participants were informed about support services, including contact details to ensure their safety and access to support.
- Anonymous participation and confidentiality were ensured.
- Participants maintained control by choosing to answer, skip a question or withdraw from the study at any point.
- Participants could request a summary of the study results at the end.

These ethical principles were accordant with the ethical requirements in online surveys with vulnerable and hard-to-reach young groups (McInroy, 2016). The principles mentioned above were applied to both parts of the study.

Due to the direct contact, the interview process was arranged in three stages that enhanced the ethical realisation: a pre-interview call, interview and a follow-up call. The pre-interview call was set after a person expressed interest in participating in an interview. This relatively informal call aimed to discuss details of the interview participation, clarify questions, build rapport, and check on the interview participant's eligibility. Interview participants were informed in more detail about the study and the topic. One part of the information given to the participant in advance was the limitation of confidentiality in the best interest of the participant to keep them safe based on the ESRC's (2015) Framework for Research Ethics: "If for example an interview reveals that a participant or another person identified in the interview is in significant danger, the researcher will be obliged to take action in response to that disclosure" (p. 24). In case of disclosure of the severe risk of harm, measures to ensure their safety would have been discussed with the young adult, as Mendes et al. (2014) recommend when conducting research with care leavers.

In order to reduce this eventuality, interviewees were selected based on the inclusion criteria (see section 3.5.2), mainly whether they appeared and confirmed themselves to be comfortable and emotionally stable to share their experience. In addition, suitable participants were advised to identify a person they trusted to meet or talk to (considering lockdown measures) immediately after the interview. As previously (pre-pandemic) planned, participants could have invited a person who would accompany them to a face-to-face interview, as recommended by Keller et al. (2016). The option of a support person was discussed in advance at a pre-interview call. This option would ensure that participants who might get distressed would feel more comfortable and have direct support identified and in place. Contact details of support services were given to every participant in writing.

The pre-interview call allowed for building rapport by giving potential participants the option to ask questions about the project and the researcher, which would reduce the power imbalance between the researcher and the researched (Karnieli-Miller et al., 2009). With the initial contact before an interview, a longer relationship with the interviewees and a more comfortable, confident interview atmosphere were established (Keller et al., 2016). If the person was considered eligible and agreed to participate, a date for the interview was scheduled. The information sheet, including the consent form and contact details of support services (see Appendix 12), was sent to participants in advance.

The interview appointment started with casual chatting to continue building rapport and making the person feel more comfortable, then reminding the person about the interview topic, aim and

conditions before starting the recording with the participant's consent. During the interview, a focus was on the emotional reactions of the interviewee if the person might signal emotional distress. A few emotional reactions occurred during the interviews. For example, one person asked to have a break for a minute to take a deep breath. Generally, the interview atmosphere appeared to be positive and relaxed throughout and this was confirmed in the feedback from all participants afterwards. The interview ended by stopping the recording. However, the meeting continued with a debriefing consisting of a reflection on the interview and, as Keller et al. (2016) recommended, informal chatting for several minutes afterwards. The reimbursement options and confirmation of the day and time of the follow-up call were discussed.

As Mendes et al. (2014) discussed the ethical questions about financial reimbursements for participants in leaving care research, I considered a small financial reimbursement for their time and potentially uncomfortable situations due to possible distress as fair and ethical. Incentives as small financial reimbursements of €15/£15 were offered to each interviewee. All interviewees were ensured to receive this incentive even if they decided to withdraw from the interview.

During the follow-up call, usually the following day of the interview, the interviewees were asked about their well-being, pondering and further thoughts resulting from the interview. Keller et al. (2016) raised the question of professional boundaries within the role of a researcher and whether it is ethical to call an interviewee afterwards. However, I consider this follow-up contact part of my ethical responsibility as a researcher to ensure the emotional well-being of the participants after discussing sensitive topics, such as past suicidal ideation and care experience. Furthermore, this follow-up call offered the option to supplement the interview data that otherwise would have been missed.

As a qualified social worker with a specialisation in psychosocial counselling and mediation and work experience in the psychiatric field and youth and family services, I was confident in having the required skills to conduct this research safely. As part of my preparation for this study, I attended extra training in suicide prevention prior to the data collection. While I previously worked inter alia with young people who showed self-harming behaviour and expressed suicidal ideation, my experience and self-reflection skills would contribute to dealing with this sensitive topic myself. Furthermore, these skills enabled me to respond appropriately if a participant showed signs of distress during or after the interview. Therefore, with the preparations and ethical considerations, I was able to conduct this research in a safe manner.

The study received ethical approval from the University Research Ethics Committee of the Royal Holloway University in November 2019. An amendment regarding its adaption to the pandemic was approved in June 2020 (see Appendix 13).

3.7 Summary

This chapter presented the research questions, methodological foundation informed by critical realism and methods applied. The recruitment process during the pandemic was described in detail, and the additional challenges during these unprecedented times were highlighted. The study compared England and Germany with a mixed-methods approach containing an online survey and semi-structured interviews. The ethical considerations of conducting a study about suicidal ideation among a vulnerable group were addressed in thorough preparations to investigate this topic.

4. FINDINGS FROM THE SURVEY

This chapter presents the findings from the cross-national online survey in England and Germany. Survey data were collected from July 2020 to June 2021. In total, 45 completed questionnaires fulfilled the eligibility criteria. The total sample ($n = 45$) had 29 participants from Germany and 16 participants from England. The average age of the sample was 26 years ($SD = 6.8$), with a range from 18 to 40 years, and three-quarters were female.

Key findings of the survey 'Promoting Mental Wellbeing among Care-Experienced Adults' are presented, and relevant results in comparison between the two subsamples are highlighted. The survey seeks to explore the occurrence of suicidal ideation among people with care experience, how many participants experienced suicidal thoughts of various severity and the factors influencing this experience. This part closes with the participants' reflections on the influence of their care experience on their attitude towards life and their wishes on how the care system could contribute to suicide prevention among care-experienced young people.

Selected statistical findings are presented graphically. An applied colour code distinguishes between results from the total sample (grey), the sample from England (blue) and the sample from Germany (orange/red).

4.1 Care experience

A central inclusion criterion for participation was the experience of care on or after a young person's 16th birthday. This criterion was chosen as it is the basis for young people being eligible for leaving care support and experiencing the transition from care in early adulthood. The following descriptions aim to explore characteristics of care experiences that help contextualise the subsequent results about suicidal ideation among care-experienced adults. To explore similarities and differences between the two groups from England and Germany, comparisons of specific aspects of their care experiences were conducted.

As Table 2 shows (see section 3.4.1), the average age when participants came into care was 11 years, ranging from age one or younger up to 18 years. About half of the respondents entered care between 12 and 16.

Almost half of the survey participants (47%; $n = 21$) were in residential care, 22% ($n = 10$) in foster care, and about 24% ($n = 11$) lived in both foster and residential care (see Table 2, section 3.4). The rest, 7% ($n = 3$), lived in alternative care accommodations, which included temporary housing, hostels, therapeutic residential care, and supported or independent accommodation.

The distribution of care settings differs between the two subsamples, as presented by national statistics (see sections 2.2.1 and 2.2.2). Half of the participating care-experienced adults from England were only in foster care compared to 7% ($n = 2$) from Germany. A further 19% ($n = 3$) of participants from England were only in residential care compared to 62% ($n = 18$) of

participants from Germany. A combination of foster care and residential care placements was reported by 19% ($n = 3$) of respondents from England and 28% ($n = 8$) from Germany.

The average length of being in care was seven years ($SD = 4.9$), similar in both countries. Overall, participants reported changing care placements on average 4.6 times ($SD = 11.6$) while in care. Adults with care experience from England reported more changes in placements while in care than those from Germany. The English group had, on average, 10.5 changes, with 31% ($n = 5$) reporting five moves and 25% ($n = 4$) of participants stating having had six moves or more, while two participants both reported having moved 57 times (see section 4.6: ‘A possible double-response: Tests to validate results’). The German group reported an average of 1.5 moves within the care system with a maximum of six times. As displayed in Figure 5, most respondents from Germany had no or only one change of placements.

A Mann–Whitney test for non-normal distributions, and a t-test, if normally distributed, were conducted to determine whether there were statistically significant differences between the English and German samples. The result shows that the number of placement changes of the groups was significantly different statistically ($p = 0.001$), while the age entering care (t-test: $p = 0.674$) and lengths of care ($p = 0.961$) indicate similar distributions (Appendix 14.1).

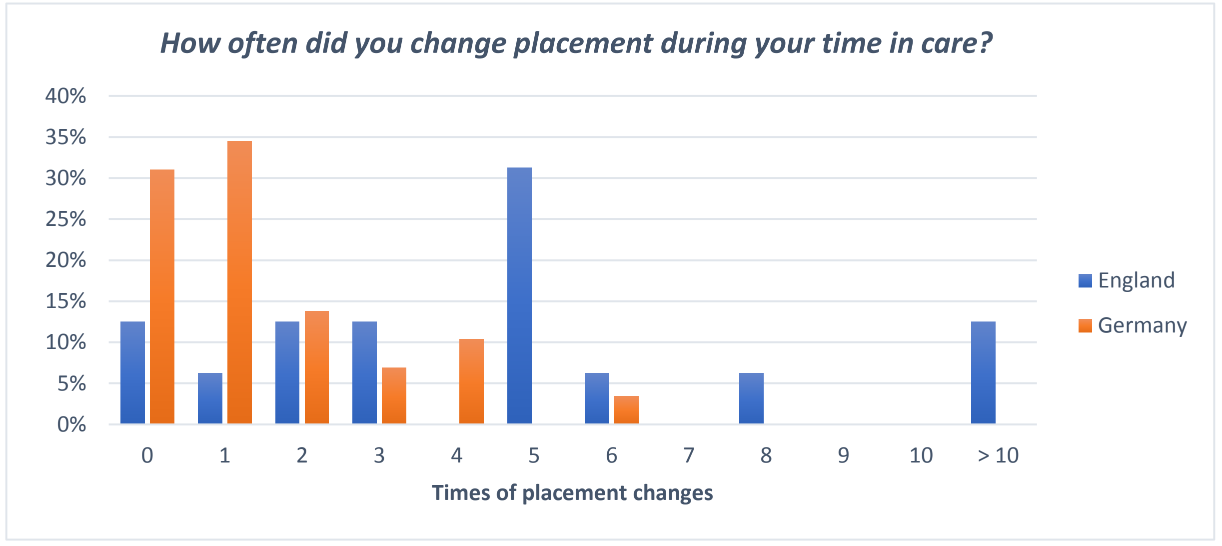

Figure 5: Frequency distribution of the number of placement changes while in care in comparison between the two samples from England and Germany.

Eighteen years is considered a crucial age for many care-experienced young people as this is usually the age at which they leave care. Participants were, on average, 18.3 years old when they left care. Forty per cent ($n = 18$) of the participants from both countries left care at the age of 18. One quarter ($n = 11$) left care between 16 and 17. Another quarter ($n = 11$) left their last care placement between 19 and 22, indicating a leaving care support by prolonged living in their care placement, such as staying put. About 4% ($n = 2$) were still in care at the

time of participation. One of these two respondents from Germany mentioned that he was living in residential care. The other reported living in semi-independent accommodation offered by a residential care provider.

As shown in Figure 6, there is a slight shift in the age distribution of leaving care between the two countries. A Mann–Whitney test indicated no significant difference between the distribution of both groups ($p = 0.557$, Appendix 14.2).

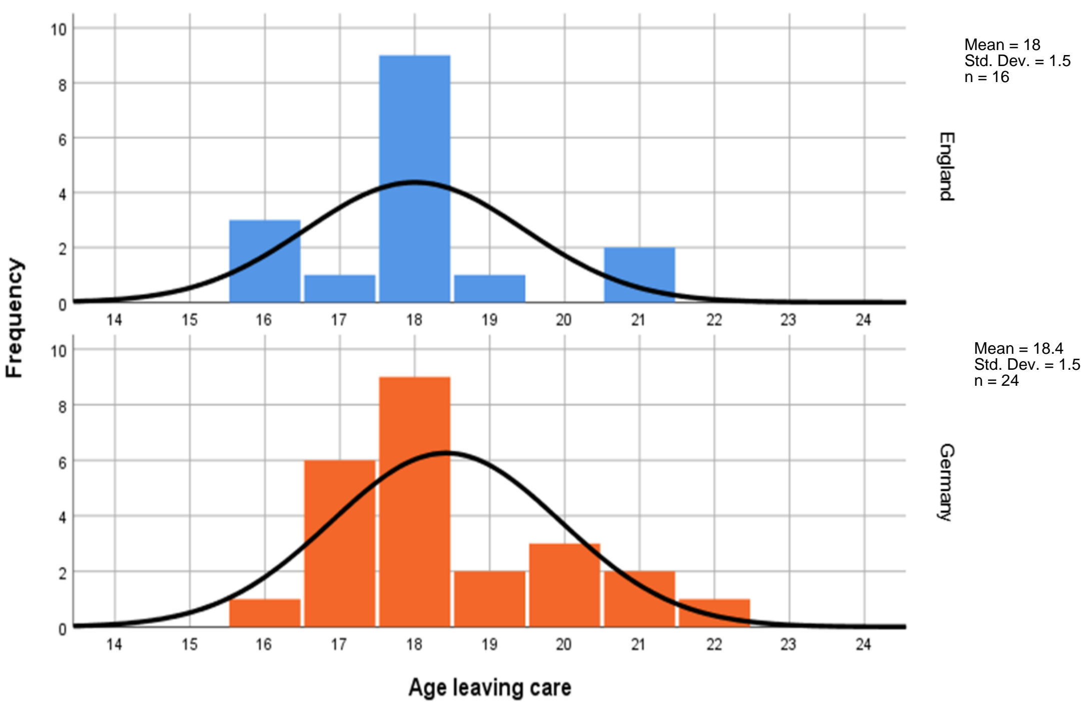

Figure 6: Country-specific distribution of the age when participants left care (not included are participants who stated they were still in care).

Two-thirds of respondents ($n = 30$) were in contact with professionals from the care system at the time of participation. Fifty per cent of the English group and 76% of the German group were still in touch with their social worker, PA or a former carer. The majority of adults with care experience from Germany mentioned that they were still in contact with their (former) carers, 13 mentioned carers from residential care and five mentioned foster carers, while participants from England named PAs. This result indicates that most participants kept in contact with professionals after the support ended, while ten participants were still supported. At the time of the survey, about 22% of the total sample with a similar number in each country (25% of the English sample and 21% of the German sample) stated that they were still receiving support for care leavers from the local authority or youth welfare office. On average, participants, excluding those who were still receiving support, were 19.5 years old when their support from the local authority terminated. In an overview, 9% mentioned that their support ceased at age 16 or 17,

27% at age 18, 18% at age 19 or 20, 13% at age 21 and a further 11% between age 23 and 25 (see Appendix 14.3).

Family relationships and contact with family members were explored in the context of care experience. Eighty-seven per cent of participants (75% from England, 93% from Germany) had contact with family members while they were in care and 76% after leaving care (63% from England, 83% from Germany). Care-experienced adults from both countries had most often regular contact with siblings ($n = 28$) and/or mothers ($n = 21$) after leaving care (see Appendix 14.4). Approximately 90% ($n = 41$) of the sample had siblings (94% from England, 90% from Germany). Forty-four per cent ($n = 20$) mentioned that their siblings lived with their family when they were in care, with an almost equal amount in each group (44% from England, 45% from Germany). Thirty-two per cent ($n = 13$) mentioned that either all or some of their siblings were in care at the same time as they were (47% from England, 23% from Germany). Of the 15 participants who reported that at least one of their siblings were in care concurrently, 67% ($n = 10$) mentioned that they lived at least partly together with their siblings in the same care home, while of the rest, 33% ($n = 5$), stated that they did not live together with their siblings.

4.2 Mental well-being

The general mental well-being of the sample was assessed. This section covers the current evaluation of life satisfaction, mental well-being, contact with mental health services and future perspectives.

Participants were asked to assess on a scale from 1 (not positive at all) to 10 (extremely positive) how they felt about their current life at the time of participation. Generally, participants showed an average life satisfaction of $\bar{x} = 5.6$ ($SD = 2.5$). The group from England had a mean life satisfaction of $\bar{x}_{ENG} = 5.8$ ($SD = 2.6$) compared to a mean of $\bar{x}_{DE} = 5.6$ ($SD = 2.5$) of life satisfaction among the group from Germany. To determine whether there is a difference in life satisfaction between the group from England and Germany, a Mann–Whitney test was conducted after a Shapiro–Wilk test, suggested a non-normal distribution. The results indicate no significant difference between both groups ($U = 223, p = 0.829$).

Both groups described, on average, their mental well-being as fair ($\bar{x} = 3.0$, $SD = 1.0$). Forty-four per cent ($n = 20$) of the total sample was in contact with a mental health service within

the last two months before participation, with more participants from Germany ($52\%, n = 15$) stating recent contact with a mental health service than from England ($31\%, n = 5$).

On a scale from 1 (not positive at all) to 10 (extremely positive), participants described how they felt about the future. The participants showed a slight trend to a positive future perspective with $\bar{x} = 6.3$ ($SD = 2.3$) as presented in Figure 7. With no statistically significant difference between the means of the subsamples indicated by an independent sample t-test ($t_{n=43} = -0.486, p = 0.630$), the English sample reached a mean of $\bar{x}_{ENG} = 6.1$ ($SD = 2.4$), and the German group showed a slightly higher mean of $\bar{x}_{DE} = 6.4$ ($SD = 2.3$).

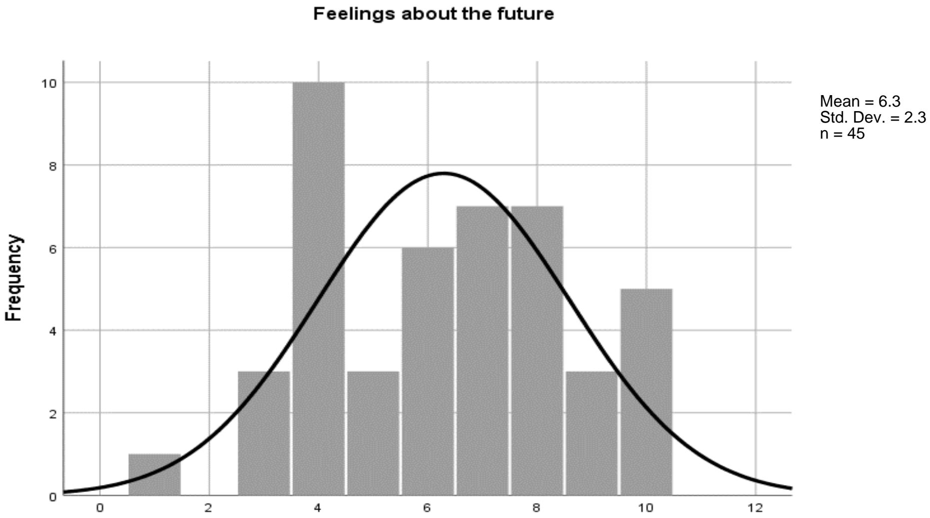

Figure 7: Distribution of scores about the feeling about the future (future perspective) of the total sample. The scale ranges from 0 as 'not positive at all' to 10 as 'extremely positive.'

4.3 The occurrence of suicidal ideation

To answer the first research question – ***What is the occurrence of suicidal ideation among care-experienced young adults in England and Germany?*** – the data set was analysed to determine the occurrence of suicidal ideation among care-experienced adults. Therefore, the answers to the four questions of the Paykel Suicide Scale (PSS) were assessed regarding the occurrence of suicidal ideation across a lifetime, the last year and last month, and at time points during or after leaving care. Furthermore, participants were asked to provide the age at which they experienced suicidal thoughts for the first time.

Forty-three participants answered at least one of the lifetime PSS questions with "Yes". With an average of $\bar{x} = 3.4$ ($SD = 1.1$), the majority of participants from both countries (84% of $n = 45$) had experienced active suicidal ideation (scoring 3–4 of PSS) at one point in

their lives, with 71% having reached the point where they seriously considered taking their life (scoring 4 on the PSS). In comparison, the sample from England scored on average $\bar{x}_{ENG} = 3.9$ ($SD = 0.3$), and the sample from Germany showed, on average, a slightly lower lifetime score of $\bar{x}_{DE} = 3.1$ ($SD = 1.3$).

Looking at the more recent occurrence of suicidal ideation, the total sample's average PSS score was $\bar{x} = 2.0$ ($SD = 1.7$) for the past year and a further $\bar{x} = 1.1$ ($SD = 1.4$) for the past month of participation ($n = 34$). About half ($n = 16$) of the 34 responding participants reported active suicidal thoughts within the last year, of which nine participants (27% of 34) had seriously considered taking their lives. In the previous month, about one-fifth ($n = 7$) of the respondents reported active suicidal thoughts, with three (9%) answering all PSS questions with "Yes" (including the fourth question: "Have you reached the point where you seriously considered taking your life?"). Figure 8 presents the distribution of PSS scores across different time scales.

Decreasing trends between the two time points can be seen across both country-specific subsamples, with fewer people reporting active suicidal thoughts within the last month. The group from England ($n = 12$) showed $\bar{x}_{ENG} = 1.9$ ($SD = 1.7$) within the last year of participation and $\bar{x}_{ENG} = 0.8$ ($SD = 1.5$) within the last month. The results from the group from Germany ($n = 22$) showed $\bar{x}_{De} = 2.0$ ($SD = 1.7$) within the last year and $\bar{x}_{De} = 1.3$ ($SD = 1.3$) in the last month.

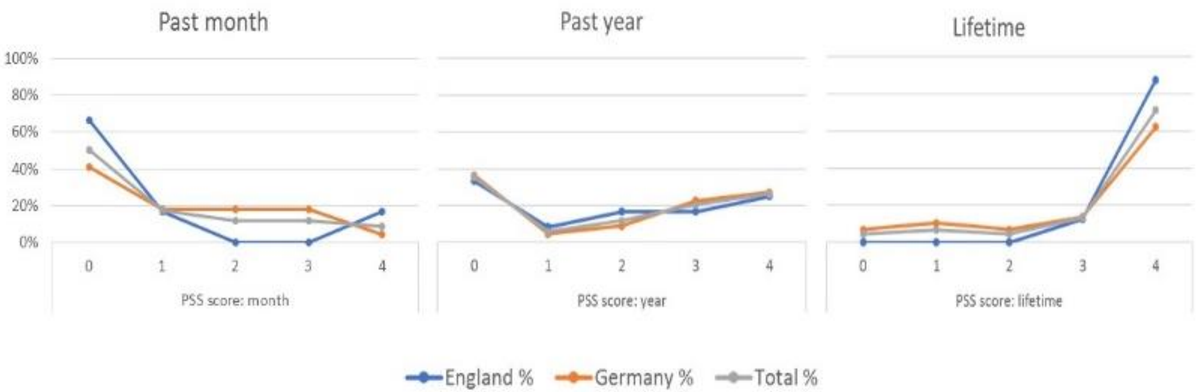

Figure 8: Percental distribution of Paykel Suicide Scale (PSS) scores of the last month, year and lifetime occurrence across the total sample and subsamples from England and Germany.

A Mann–Whitney test shows that the lifetime scale of the PSS was at the edge of the significance level at $p = 0.050$. Overall, the results suggest that the means of the PSS data of a lifetime occurrence, last year ($p = 0.901$) and previous month ($p = 0.276$) do not differ significantly between both groups from England and Germany (see Appendix 14.5). Therefore, the null hypothesis is likely to be retained, that is, there is no significant difference in the

occurrence of suicidal ideation between the two groups from England and Germany. Furthermore, these results show that with a more recent, smaller time scale, fewer people experience suicidal thoughts. In contrast, larger time scales show more people reporting the experience of suicidal ideation with increased severity.

In addition, a Mann–Whitney test was computed to assess gender differences in the PSS scores. The PSS scores across different times do not show any significant difference between genders ($U_{month} = 3.775, p = 0.896, U_{year} = 95.9, p = 0.752;\ U_{lifetime} = 170, p = 0.864$; see Appendix 15.6).

Overall, the average age of first suicidal ideation was $\bar{x} = 13.6$ years ($SD = 3.8$), with about half of respondents ($n = 19$) reporting having been 12 years or younger. About one quarter ($n = 10$) of all 39 respondents to this question who had experienced suicidal ideation reported having been ten years or younger. Five participants reported having first experienced suicidal thoughts as adults when they were 18 years or older (three were 18 or 19, one was 24, and another was 26 or older). A similar mean age was shown between people with care experience from England $\bar{x}_{ENG} = 13.7$ ($SD = 4.1$) and Germany $\bar{x}_{DE} = 13.5$ ($SD = 3.6$). The Mann–Whitney test indicated no significant age difference in first suicidal ideation between the two groups ($p = 0.966$, see Appendix 14.7).

As presented in Figure 9, most participants (40–60%) stated that they experienced suicidal ideation of different severity assessed with the PSS both during and after leaving care. More people reported having experienced active suicidal thoughts only after leaving care (11–16%) than only in care (7–9%).

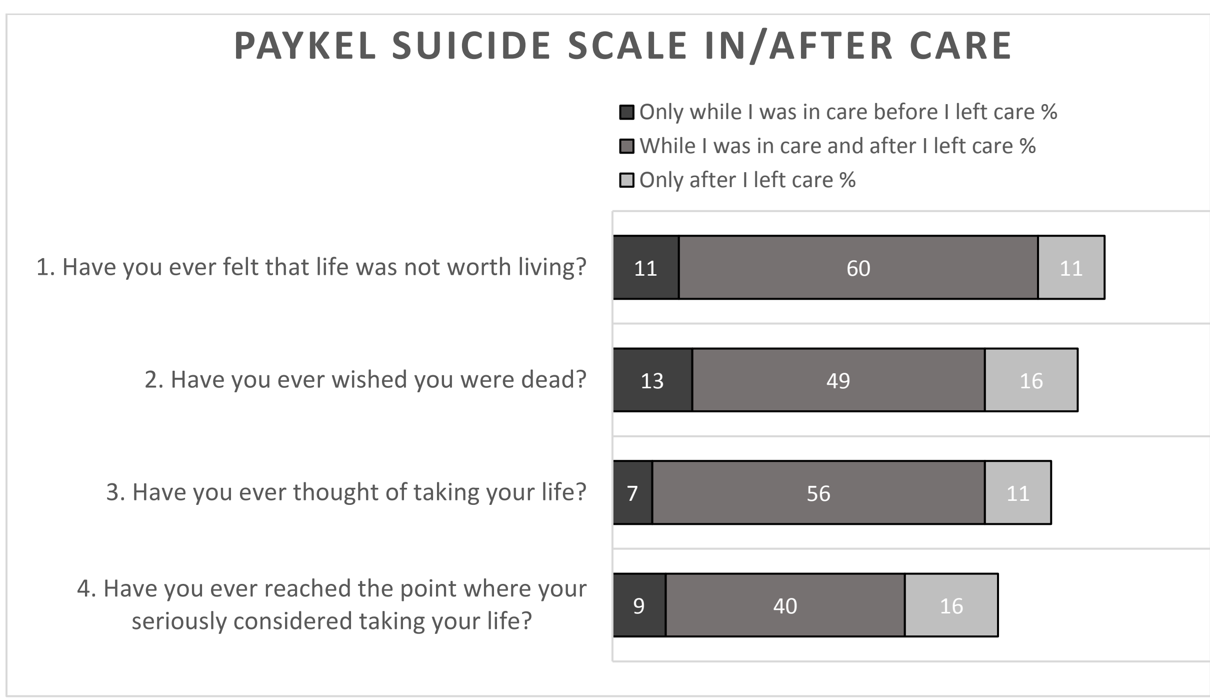

Figure 9: The distribution of Paykel Suicide Scale (PSS) responses (n=45) presenting the occurrence of suicidal ideation only in care (black), in and after leaving care (dark grey), and only after leaving care (bright grey).

4.4 Exploration of factors influencing suicidal ideation

To explore the second research question, the survey data were analysed to explore factors influencing suicidal ideation. This analysis included testing the second hypothesis to determine whether a relationship exists between recent suicidal ideation among care-experienced young adults, assessed with the PSS, and the Interpersonal Needs Questionnaire (INQ) factors, perceived burdensomeness (PB) and thwarted belongingness (TB). Correlations between the INQ factors and suicidal ideation were explored across groups of different countries and gender. In addition, various variables such as data about care experience, age and future perspectives were analysed to investigate whether a relationship with suicidal ideation exists. The impact of the pandemic on PB, TB and the general attitude towards life was investigated. The categorised answers to the open-ended, free-text questions about what participants considered as factors influencing the occurrence of suicidal thoughts and coping with suicidal ideation are presented in their frequencies.

IPTS factors: Perceived Burdensomeness and Thwarted Belongingness

Based on the theoretical foundation of this research, the INQ factors assessed on a scale of 1–7 showed an average score of $\bar{x}_{PB} = 2.8$ ($SD = 1.7$) for PB ($n = 45$) and $\bar{x}_{TB} = 3.7$ ($SD = 1.2$) for TB ($n = 43$). The histograms in Figure 10 show the distribution of both factors.

Recent suicidal ideation within the last month was correlated positively with PB ($\tau = 0.426, p = 0.002;\ n = 34$) but not with TB ($\tau = 0.078, p = 0.575;\ n = 32$). Similar results were found between suicidal ideation within the past year and the two INQ factors with PB positively correlated ($\tau = 0.421, p = 0.002;\ n = 34$), while there was no correlation shown for TB ($\tau = 0.155, p = 0.262;\ n = 32$).

The scatter plots of Figure 11 present a positive relationship between PB and PSS scores of the last month and the last year compared to TB. Therefore, the second key hypothesis, "there is a positive relationship between suicidal ideation reported by care-experienced young adults and high scores in thwarted belongingness (TB) and perceived burdensomeness (PB)", can only partly be confirmed for PB and suicidal ideation, as no significant correlation was found with TB (see Appendix 14.8).

The relationship between INQ and PSS scores was further explored in comparison between the two groups from England and Germany. The sample from England showed a positive correlation between recent PSS scores and PB (last month: $\tau = 0.542, p = 0.030$; last year: $\tau = 0.775, p = 0.001; n = 12$) but not for TB. The sample from Germany showed a significant positive correlation between last month's PSS scores and PB scores ($\tau = 0.432, p = 0.011$) but not of the past year or TB. The results show that recent PB is correlated with a higher PSS score of the last month in both countries.

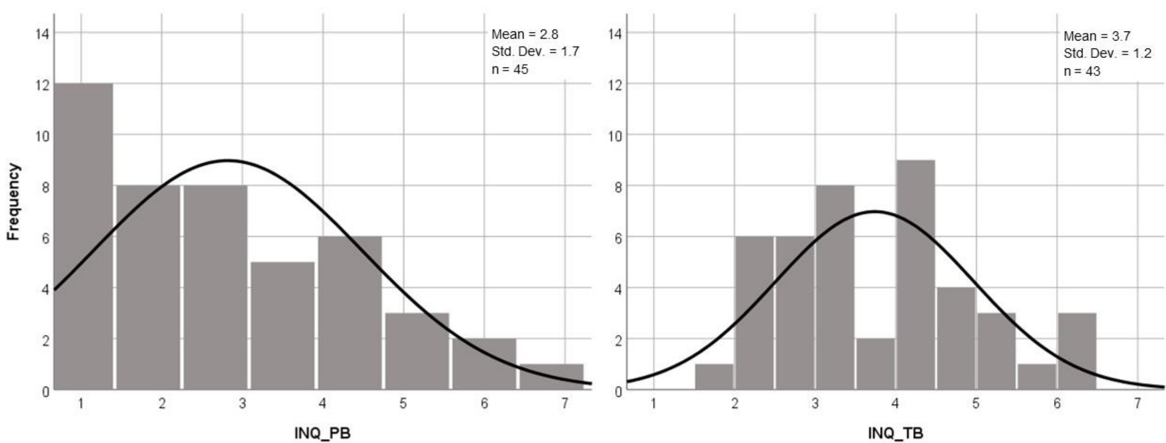

Figure 10: Frequency distribution of Interpersonal Needs Questionnaire (INQ) scores of perceived burdensomeness (PB) and thwarted belongingness (TB) based on the total sample (n = 45).

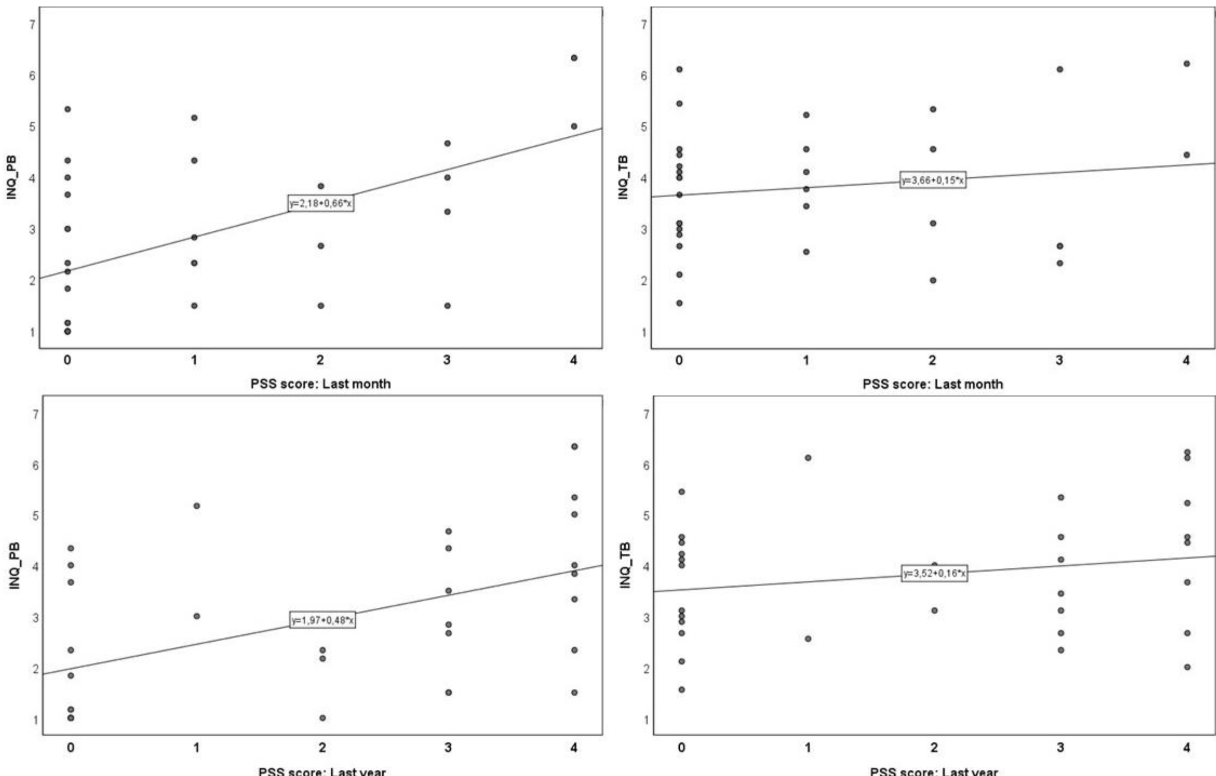

Figure 11: Scatter plots presenting the relationship between Paykel Suicide Scale (PSS) scores and the Interpersonal Needs Questionnaire (INQ) factors; left: positive correlations between perceived burdensomeness (PB) and PSS; right: no significant correlations between thwarted belongingness (TB) and PSS.

Future perspective

To explore further relationships between several factors and suicidal ideation, correlations were tested on various ordinal or continuous variables. First, Kendall's τ, as well as a Spearman's rank correlation test, were conducted to assess the relationship between future perspective and suicidal ideation (PSS score) in the past month, year and across lifetime. There was a significant negative correlation between future perspective and PSS score of the past month, $\tau = -0.388, p = 0.006$; $r_s = -0.463, p = 0.006; n = 34$), and past year, ($\tau = 0.406, p = 0.003$; $r_s = 0.512, p = 0.002; n = 34$). There was no significant correlation found between the variable and PSS score in a lifetime; $\tau = -0.036, p = 0.775$; $r_s = -0.037, p = 0.808; n = 45$. These results indicate that a more positive future perspective correlates with a lower PSS score within the last month and the past year and vice versa (see Figure 12). By repeating Kendall's τ test with a comparison between the subsamples from England and Germany, these results were only reflected by the group from England ($n = 12$), last month: $\tau = -0.579, p = 0.027$; last year: $\tau = -0.739, p = 0.003$. There was no significant correlation found for the group from Germany ($n = 22$), last month: $\tau = -0.302, p = 0.082$; last year: $\tau = -0.240, p = 0.170$. Therefore, a negative future perspective correlates with higher PSS scores, but the relationship was only evident in the English sample.

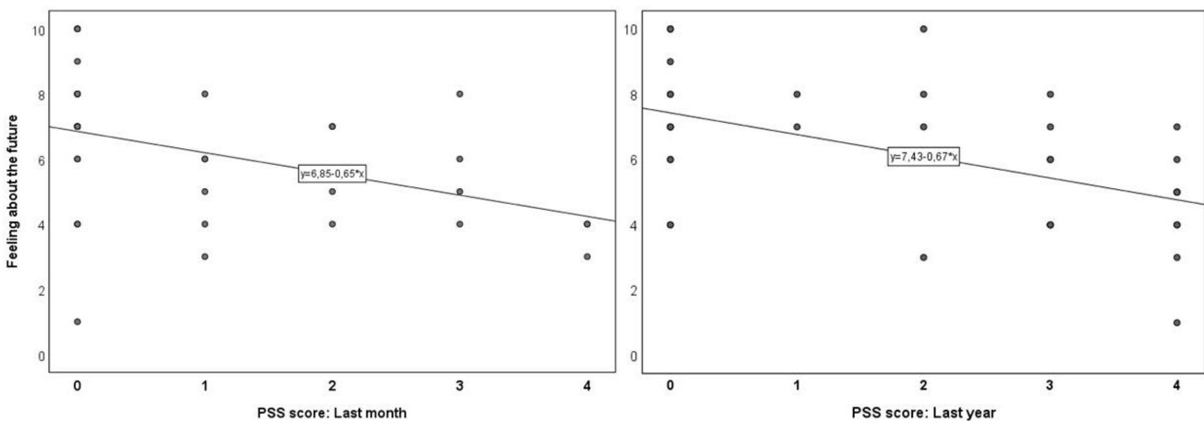

Figure 12: Negative correlation between a positive feeling about the future and higher Paykel Suicide Scale (PSS) scores of the past month and year.

Age, relationship status and sexuality

In the next step, demographic characteristics were tested regarding a relationship with suicidal ideation based on PSS scores. This demographic information was age, relationship status and sexuality.

First, correlation tests with Kendall's τ and Spearman's rank correlations coefficient were used to explore whether a relationship between the age of a person and the recent PSS scores exist. There was no significant correlation found between age and PSS score of the last month ($\tau = -0.037, p = 0.785;\ r_s = -0.046, p = 0.784; n = 34$) and past year ($\tau = 0.107, p = 0.429;\ r_s = 0.131, p = 0.461; n = 34$).

Second, the distribution of PSS scores was compared between different relationship statuses and sexuality across the whole sample (see Appendix 14.9). Kruskal–Wallis tests were conducted to assess whether significant differences between the groups exist. The results show no significant difference across different groups in terms of their relationship status: $H(3) = 2.08, p = 0.556$ for last month's PSS scores; $H(3) = 3.76, p = 0.289$ for the past year's PSS scores; and $H(3) = 0.61, p = 0.0895$ for lifetime PSS scores. Similarly, the Kruskal–Wallis test indicated no significant difference in PSS scores between different sexual orientations: $H(3) = 5.59, p = 0.133$ for last month's PSS scores; $H(3) = 5.58, p = 0.134$ for last year's PSS scores; and $H(3) = 0.95, p = 0.813$ for lifetime PSS scores.

Continuous care-specific variables

Next, the non-parametric correlation tests were used to assess the relationship between suicidal ideation (month, year and lifetime) and care-related continuous variables covering age entering care, duration in care, number of placement changes and age ceasing support from social services. There was no significant correlation between PSS scores and any of the variables (see Appendix 14.10).

Kendall's τ correlation tests were computed to explore whether a relationship between these care-related variables and INQ factors exists. Again, no significant correlation was found between the variables (Appendix 14.11).

Care placement types

Based on PSS scores, different groups of care-related categorical variables were compared regarding their suicidal ideation. First, different care placement types were assessed regarding their distributions of frequencies of PSS scores, as presented in Figure 13. The following Kruskal–Wallis test indicated that differences across groups are not statistically significant: $H(3) = 5.59, p = 0.133$ for last month's PSS scores; $H(3) = 5.58, p = 0.134$ for last year's PSS scores; and $H(3) = 0.95, p = 0.813$ for lifetime PSS scores. Due to visual different distributed frequencies between the groups who only lived in foster or residential care, a Mann–Whitney test was conducted to compare these two groups separately. Results indicated no significant difference between foster care and residential care: $U_{month} = 44, p = 0.130$; $U_{year} = 48.5, p = 0.235$; and $U_{lifetime} = 102, p = 0.874$.

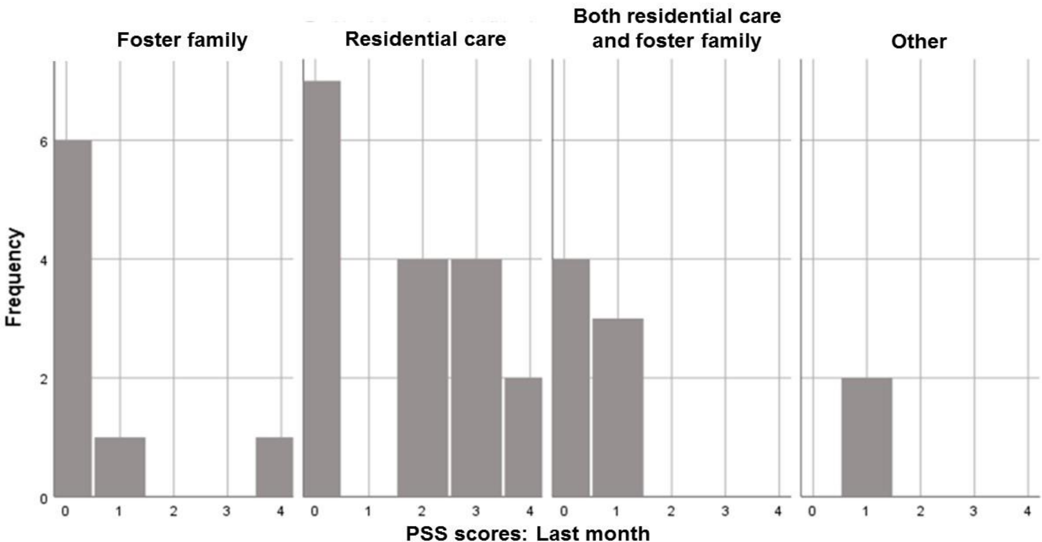

Figure 13: The frequency distribution of Paykel Suicide Scale (PSS) scores (month) across different care placement types.

Siblings in care

Second, another care-related categorical variable of whether participants' siblings lived in care simultaneously as the participants' did was tested on differences in the distribution of PSS scores. Figure 14 presents the distributions of PSS scores for last month, year and lifetime occurrence across the different groups. Those answering "No, my sibling(s) lived with our family while I was in care" show the highest and more distributed PSS scores compared to other groups.

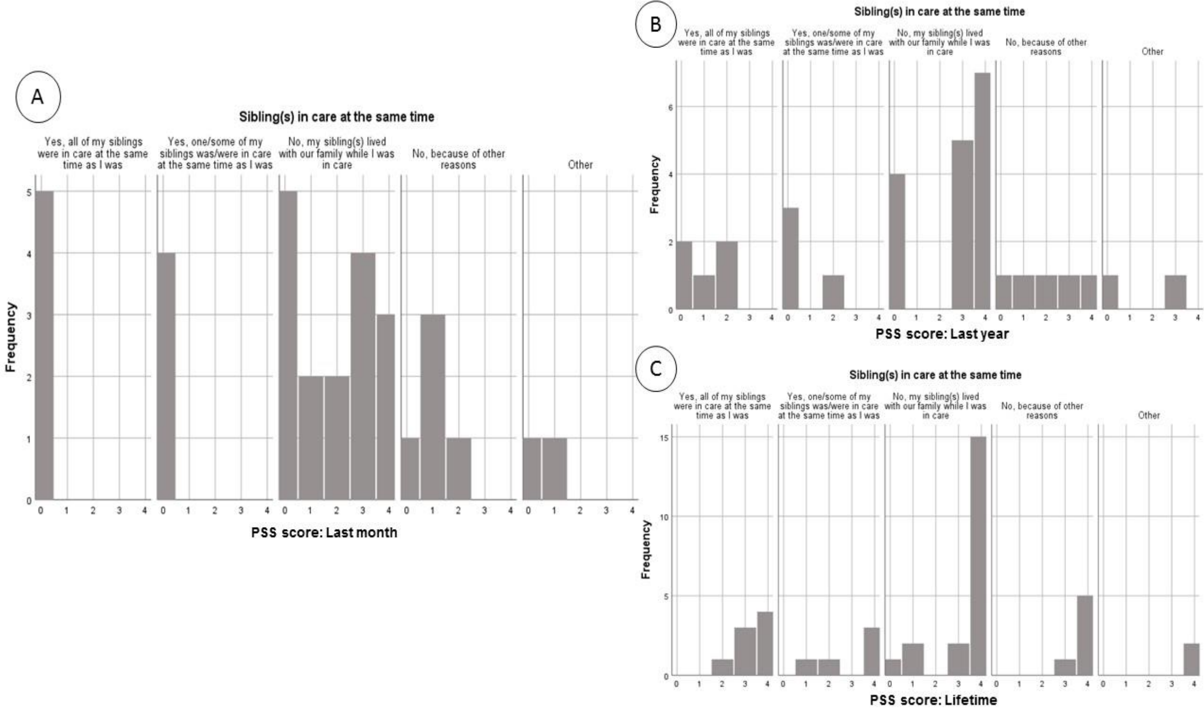

Figure 14: Frequency distribution of Paykel Suicide Scale (PSS) scores of last month (A), last year (B) and lifetime occurrence (C) across different groups of whether siblings of participants were in care at the same time as themselves.

A Kruskal–Wallis test showed a significant difference in the distribution of PSS scores within a month, $H(3) = 11.766, p = 0.008$, between groups of adults whose siblings were or were not in care at the same time as themselves. Participants whose siblings were not in care at the same time showed higher PSS scores. There was no significant difference for the PSS of the past year: $H(3) = 8.39, p = 0.061$; and lifetime: $H(3) = 2.00, p = 0.596$.

To determine which groups differ significantly, post hoc Mann–Whitney tests were conducted for pairwise comparisons (see Appendix 14.12). The Mann–Whitney tests indicated significant differences in the PSS scores of the last month ($U_{month} = 12.5, p = 0.020$) and the past year ($U_{year} = 16, p = 0.039$) between those whose all siblings were in care at the same time as they were and those whose siblings were not in care at the same time as they lived with their family and due to other reasons (for instance, because the siblings were already adults at that

time or lived with another parent who was not the participant's parent). Those whose siblings were in care at the same time had lower PSS scores. Similarly, the PSS results varied between the group that mentioned some (but not all) of their siblings were in care at the same time as themselves and the group whose siblings lived with their family: $U_{month(some)} = 10,\ p = 0.044;\ U_{year(some)} = 10,\ p = 0.022$. For those who stated that their siblings were not in care at the same time because of other reasons (than siblings living with the family), the test results indicated significant differences for only last month's PSS scores, with the groups stating that all or some of their siblings were in care at the same time as themselves: $U_{month(all)} = 2.5$, $p = 0.048$; $U_{month(some)} = 2,\ p = 0.048$. The results did not show any significant difference between the group 'other' and any other groups.

Third, following these results, the frequency distributions were assessed by distinguishing the responses of those whose siblings were in care at the same time as themselves into three groups of having lived together, partly living together or not living in the same care placement. A Kruskal–Wallis test was computed to assess whether significant differences in the PSS scores (month: $n = 6$; year: $n = 6$; lifetime: $n = 10$) exist between the groups. The results do not show any significant differences between the three groups: $H_{month} = 0, p = 1.000$; $H_{year} = 0.480, p = 1.000$; and $H_{lifetime} = 1.97, p = 0.333$.

In summary, the results indicate higher rates of suicidal ideation in adults whose siblings lived with their family while they were in care. The separation of siblings between different care placements did not show significant differences in suicidal ideation in adulthood. Therefore, the results indicate better outcomes with less severe suicidal thoughts in adulthood for those whose siblings were in care at the same time as they were, independently of whether they lived in the same care placement.

Influence of the COVID-19 pandemic

The survey data were tested on how far the pandemic influenced INQ factors and the attitude towards life. Survey respondents were asked to report on a 5-point Likert scale (from 1 = positively to 5 = negatively) how the COVID-19 pandemic affected their feeling of belongingness, perception of being a burden to others and attitude towards life. On average, the sample reported a mean of $\bar{x}_{Belongingness} = 3.6$ ($SD = 1.2$), $\bar{x}_{Burden} = 3.1$ ($SD = 1.2$) and $\bar{x}_{Life\ attitude} = 3.1$ ($SD = 1.2$), as presented in Figure 15. These results show that participants tended to assess the impact of the pandemic slightly negatively on the factor of their feeling of

belongingness. To compare, the English group reported a mean of $\bar{x}_{Belongingness} = 3.9$ ($SD = 0.9$), $\bar{x}_{Burden} = 3.6$ ($SD = 1.2$) and $\bar{x}_{Life\ attitude} = 3.5$ ($SD = 1.1$), and the German group reported a mean of $\bar{x}_{Belongingness} = 3.5$ ($SD = 1.2$), $\bar{x}_{Burden} = 2.9$ ($SD = 1.2$) and $\bar{x}_{Life\ attitude} = 2.9$ ($SD = 1.2$) (see Appendix 14.13). The group from England seemed to rate the impact of the pandemic on all factors slightly more negatively than the group from Germany.

As a Shapiro–Wilk test showed a non-parametric distribution, a Mann–Whitney test was computed to assess whether the two samples' distributions of the pandemic-related variables differ significantly. The Mann–Whitney test showed no significant difference between the distribution of the impact of the pandemic on the feeling of belongingness ($p = 0.260$), the feeling of being a burden ($p = 0.095$) and attitude towards life ($p = 0.094$) between the two groups (see Appendix 14.14). These results indicate that both groups showed a similar distribution of the impact of the pandemic on all three factors.

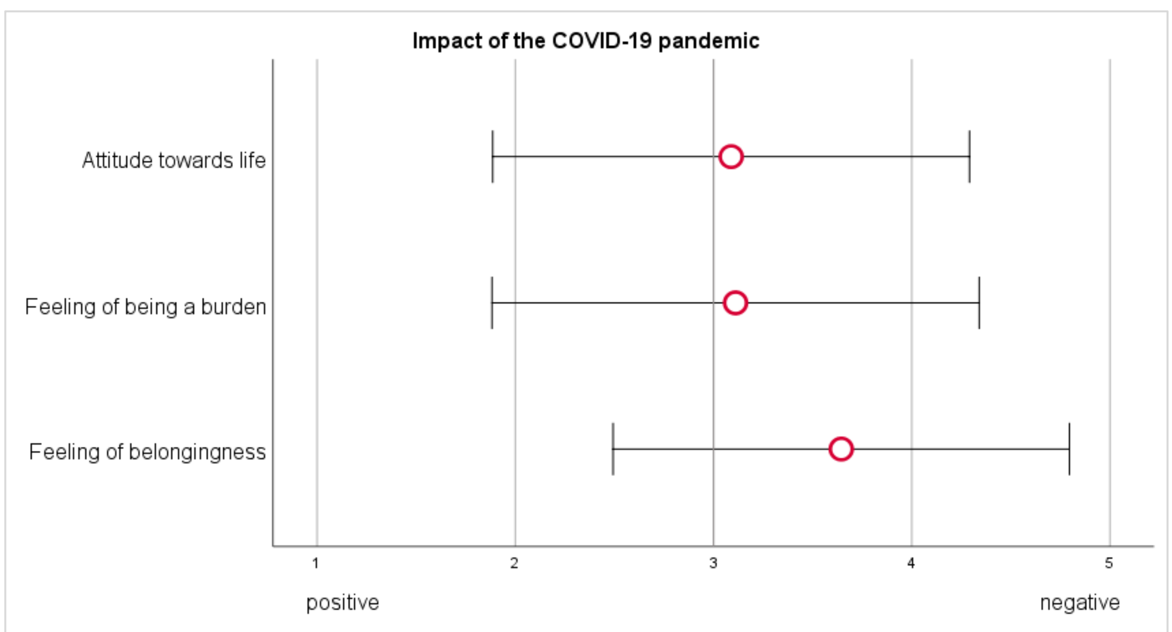

Figure 15: Impact of the COVID-19 pandemic. Mean and standard deviation of how the pandemic affected the three factors of the feeling of belongingness, the feeling of being a burden and attitude towards life; ranging from (1) positively to (5) negatively (n = 45).

Perceptions of links to suicidal ideation

The 43 participants who had a lifetime PSS score of 1 or higher were asked three open-ended questions about changes at the time of their first suicidal thoughts, their perceptions of causes and what helped to cope with suicidal ideation. The coding framework identified from the analysis of the interview data was adopted. The coded answers were grouped into themes,

including simultaneous coding if the person mentioned several aspects (multiple responses). Frequency analyses were conducted to assess how many participants mentioned a specific theme or code. The most common themes are presented in more detail.

Participants were asked whether they experienced changes at the time of their first suicidal thoughts. The 31 participants, who confirmed experiencing changes at that time, were further asked what changed when they experienced suicidal ideation for the first time. Figure 16 presents the frequencies of their categorised responses.

Thirty participants answered the open-ended question about changes at the times they experienced suicidal ideation for the first time. One third each ($n = 10$) of all 30 respondents to this question mentioned aspects grouped into the themes 'transition & places' and 'social connection' and, hence, the categories appeared most often.

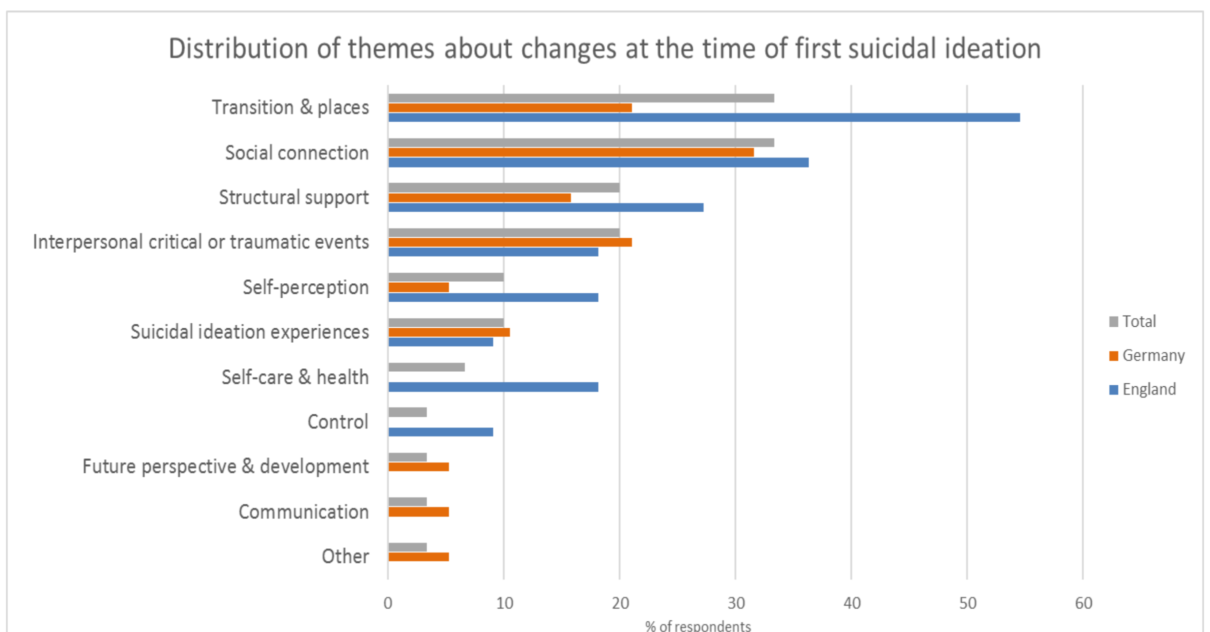

Figure 16: Frequency distribution (in %) of themes developed from coded open-ended answers on what participants perceived of changes at the time they experienced suicidal thoughts for the first time.

'Transition & places' contain most often responses about transitions into, within or from the care system, including placement breakdowns, education or employment changes or changes of accommodation. In the following, a few written responses about changes at the time of first suicidal thoughts are presented that were categorised as 'Transition & places':

> *Change of school and move.* (26-year-old man from Germany, first suicidal thoughts at the age of 13)

> *Foster placement breakdown.* (21-year-old woman from England, first suicidal thoughts at the age of 17)

> *I came into care at the age of 13 and have received psychological help.* (18-year-old woman from Germany, first suicidal thoughts at the age of 11)

The quotes indicate that transitions do not necessarily mean a transition from one foster home to another or from care to independent living during early adulthood. They instead show that general changes in a young person's life – such as places, social environment, relationships or support – occurred around the same time as several participants developed suicidal ideation for the first time.

The theme 'social connection' often includes reports about lacking or thwarted belongingness, such as feeling rejected resulting from losing friendships, relationship breakups and reduced or ceased contact with family members. For instance, the following written responses were assigned to this theme of 'social connection':

> *Family contact became less, felt rejected more.* (32-year-old woman from England, first suicidal thoughts at the age of 14)

> *My brother went into care and I was not allowed to see him.* (20-year-old man from England, first suicidal thoughts at the age of 15)

> *I fell in love for the first time with a boy who didn't want to know anything about me.* (27-year-old woman from Germany, first suicidal thoughts at the age of 12)

Many responses assigned to the theme 'social connection' referred to family relationships and the care system's impact on these. These findings indicate a possible negative impact of the care system on relevant, especially intra-familial relationships that can affect a young person's mental well-being and further contribute to the development of suicidal ideation. However, thwarted belongingness, including the experiences of exclusion or rejection, was not only mentioned in light of family relationships and care experience but also identified in peer and romantic relationships, as indicated by the last quote above.

A further 20% ($n = 6$) of participants each mentioned aspects of 'structural support' and 'interpersonal critical or traumatic events' as changes at the time they first experienced suicidal ideation. 'Structural support' mainly covers reports about access to support that was either restricted or received to help deal with suicidal ideation. Some participants stated restricted or disappointing access to support as follows:

> *And no support from pathways.* (21-year-old woman from England, first suicidal thoughts at the age of 17)

Police were useless rapist was never convicted. (40-year-old woman from England, first suicidal thoughts at the age of 26 or older)

Others, in comparison, stated positive changes to access support such as:

And I was able to come to terms with the events through therapy. (19-year-old man from Germany, first suicidal thoughts at the age of 14)

Help has changed my perspective on life in a positive way. (39-year-old man from Germany, first suicidal thoughts at the age of 14)

'Interpersonal critical or traumatic events' were also mentioned by 20% of participants ($n = 6$) as a change at times of their first suicidal ideation. Reports of this theme cover bullying, sexual assault, parental mental health issues or a loss of a close person, including miscarriages. Quotes are presented below:

And was bullied at school (.) At that time, my mother became even more depressed than before. (27-year-old woman from Germany, first suicidal thoughts at the age of 12)

Got raped [...] got a new job where I was bullied new relationship was violent. (40-year-old woman from England, first suicidal thoughts at the age of 26 or older)

Met a man, got married, had children, suffered several miscarriages, 1 abortion. That's when you learn to appreciate and love life. (35-year-old woman from Germany, first suicidal thoughts at age 19).

Traumatic events at the time of the first experienced suicidal ideation were diverse. While intra-familial abuse or neglect is a common reason many children come into care, those were not directly mentioned in the participants' answers about the time when their suicidal thoughts appeared for the first time. However, the following two quotes may imply negative intra-familial experiences and living situations while providing no details or further explanation:

Familial circumstances. (20-year-old woman from Germany, first suicidal thoughts at the age of 10 or younger)

I think I was aware of my surroundings when I started to grow up. (26-year-old woman from England, first suicidal thoughts at the age of 12)

One person who had a lifetime PSS score of 1 with answering "Yes" on the question "Have you ever thought of taking your life, even if you would not really do it?" stated the following as an

interpersonal traumatic event that may indicate the cautious interpretation of suicidal ideation of the PSS:

> *Basically, I didn't have suicidal thoughts, I said I was going to kill myself because I was being bullied, and I thought if I said that, they would leave me alone.* (29-year-old woman from Germany)

This case highlights how bullying at school can affect a young person. Even if the person stated that she did not have suicidal thoughts, her answers indicate bullying can cause desperation and a search for an escape from the situation. However, as shown in the further findings, others attributed bullying as a cause of their suicidal ideation.

Other less commonly mentioned themes with only two or three reports were 'self-perception,' reflecting on self-esteem and guilt; 'suicidal ideation experiences' such as self-harming practices and changes of attitude towards life; and 'self-care and health' containing personal mental health issues or stress. One-response topics followed, including 'control', regarding loss of control; 'future perspective & development', regarding growing older; and 'communication', such as having friends to talk to.

The responses reflect changes at the time the respondents experienced suicidal thoughts for the first time. While some of the responses may be understood as possible triggers of suicidal thoughts, such as foster placement breakdowns or feeling rejected, others, such as entering the care system and receiving mental health support, may positively affect expressed suicidal thoughts. Therefore, these reports reflect changes at the time of first suicidal ideation and may not be directly understood as causes or triggers solely.

Perceived causes of suicidal ideation

With the next open-ended question, participants were asked what they perceived as causes of personally experienced suicidal ideation. Figure 17 presents the frequencies of the categorised responses about the perceived causes of 41 respondents, with 15 participants from England and 26 from Germany. The most common themes above 20% of the total sample are described below.

'Interpersonal critical or traumatic events' were perceived as the most often mentioned cause of participants' suicidal thoughts (63%), with 12 (47%) participants from England and 23 (73%) participants from Germany mentioning aspects grouped under this theme. This theme

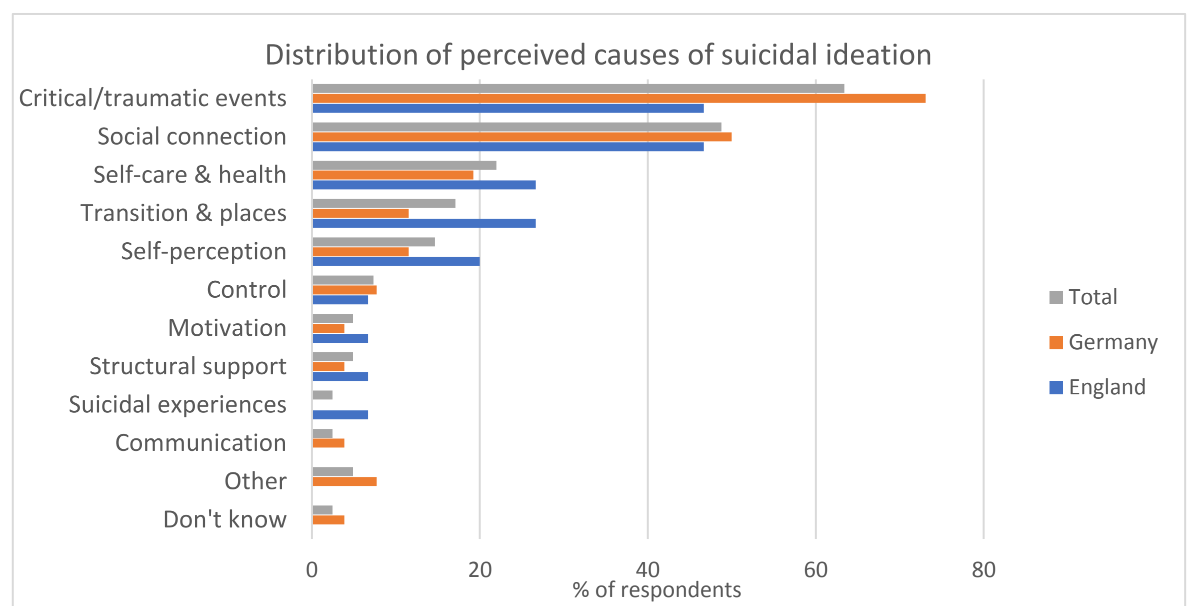

Figure 17: Percentual frequency distributions of themes about perceived causes of suicidal ideation, distinguished between the total sample (grey), the subsamples from England (blue) and Germany (orange).

consists of a variety of codes reflecting the perceived causes: intra-familial abuse ($11\%, n = 5$), violence and abuse (general) ($24\%, n = 10$), loss of a beloved person ($13\%, n = 6$), parental mental health issues ($13\%, n = 6$) and harassment and bullying ($29\%, n = 12$). Figure 18 A shows the percentual distributions across the codes of the themes. A selection of quotes assigned to different codes is presented below.

Intra-familial or general abuse and violence:

> *Mistreated by foster parents […] Abused by parents and step parents.* (31-year-old woman from England)

> *Years of emotional abuse from my mother.* (23-year-old woman from England)

> *Wanting to escape abuse.* (18-year-old woman from England)

Loss of a beloved person:

> *My mother took her own life.* (21-year-old woman from Germany)

> *Death of carer.* (26-year-old woman from England)

Parental mental health issues:

> *Was becoming aware of my mum's ill […] mental health and alcohol addiction. I've been told I found my mum unconscious after an overdose.* (35-year-old woman from England)

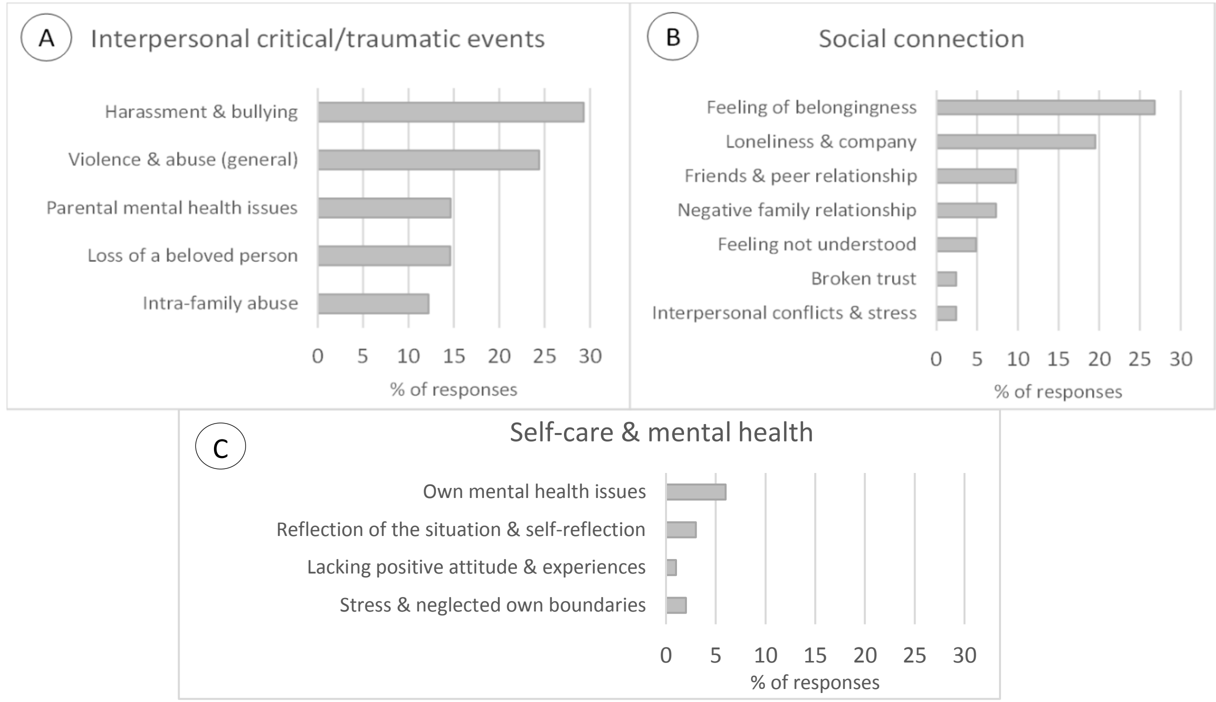

Figure 18: Distribution (in % of n = 41 respondents) of codes of the three most common themes about what participants perceived as causes of their suicidal ideation: 'interpersonal critical or traumatic events' (A), 'social connection' (B) and 'self-care & mental health' (C).

> *Parents who would rather drink alcohol than call their child.* (35-year-old woman from Germany)

Harassment and bullying:

> *I had the feeling that no one understood my feelings because I was laughed at at school.* (27-year-old woman from Germany)

> *I was bullied and threatened at school.* (18-year-old woman from Germany)

The findings highlight the impact of harassment and bullying and generally the experience of any violence and abuse, both intra- and extra-familial, on the development of suicidal ideation. While multiple factors may contribute to the development of suicidal ideation, as several answers were assigned to multiple codes or themes, the experience of traumatic events appears to be a relevant risk factor for suicidal ideation.

The second-most mentioned theme in the context of perceived causes of suicidal ideation was 'social connection' ($49\%, n = 20$). As presented in Figure 18 B, most responses were often assigned to theme-internal codes of 'feeling of belongingness' such as social exclusion, rejection, loss of friends, impacted family relationships, and 'loneliness & social company', including feeling alone and social isolation. The quotes below are examples of the responses that were assigned to the codes 'feeling of belongingness' such as aspects of thwarted

belongingness and ‘loneliness & social company’:

> *Social exclusion for more than three months.* (26-year-old man from Germany)

> *Rejection was more apparent the older I got, family became less interested, all my siblings were still at home [...] lack of socialisation in 2–1 staffed placements.* (32-year-old woman from England)

> *I missed my brother and knew I was unable to go home and see him.* (40-year-old woman from England)

> *The feeling of being completely alone, having no one.* (35-year-old woman from Germany)

The quotes above show that thwarted belongingness is diverse and includes a lack of social contacts, exclusion, and physical and social distance from family members. Loneliness seems to be closely connected to the feeling of belongingness. It can be experienced both by being alone physically and socially as having no one to reach out to for company and support. Furthermore, the findings also indicate links between thwarted belongingness and the care system.

The third most common topic with 22% ($n = 9$) of participants was ‘self-care and health’ as causes of suicidal ideation. Most of the responses grouped under this theme referred to the mental health issues of the participants themselves. The quote below by a young man from England is an example of how participants attributed their mental health issues, such as depression, as a cause of their suicidal ideation:

> *Being very depressed and sadden about where I lived and what had happened in my life.* (20-year-old man from England)

Further but less frequent themes mentioned by six or more participants as causes of suicidal ideation included ‘transition & places’ such as changes of accommodation. The theme included care placement changes and uncovering or processing their past, which appeared to be related to transitions described in chapter five in more detail. In addition, the theme ‘self-perception’ was identified, covering low self-esteem and guilt of letting others down.

Some quotes presented above were extracted from a longer answer. As mentioned before, several participants reported multiple causes assigned to various codes and themes. The following quote from a young man from Germany shows that he perceived multiple causes of

his suicidal ideation:

> *Father died, family broke up, mother became mentally ill, was bullied, had almost no friends, was cheated on... I have become a part of an addiction (computer games).* (19-year-old man from Germany)

To summarise, interpersonal traumatic events such as bullying and abuse and social factors regarding the lacking or thwarted feeling of belongingness or social isolation were identified as the most often mentioned factors perceived as influencing their suicidal ideation. Several participants mentioned multiple factors. The frequencies of themes showed a similar order in both groups from England and Germany.

Coping with suicidal ideation

Next, participants were asked what they perceived as helpful in coping with and resolving suicidal ideation. Figure 19 presents the frequencies of their categorised responses to coping strategies and resources. In contrast to the previous question about causes of suicidal ideation that showed a similar order of frequencies of themes in both groups from England and Germany, the prominence of themes differs between the two subsamples. Therefore, the five most often mentioned themes across the whole sample of respondents ($n = 40$) are presented in more detail, as these also cover the most common themes in both countries.

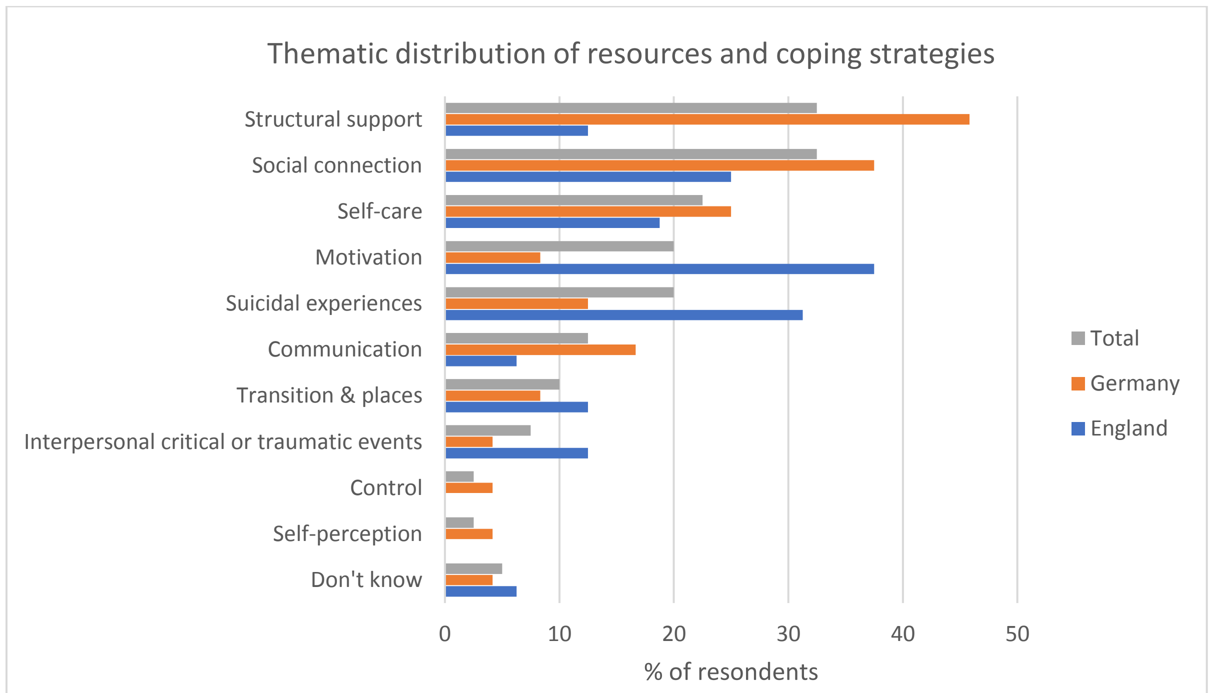

Figure 19: Percentual distribution of themes identified as resources and coping strategies.

Both the themes of ‘structural support’ and ‘social connection’ received the most counts across the whole sample (33%). They were the most common themes from the group of Germany (46%, 38%) but not from England (13%, 25%).

As shown in Figure 20 B, participants, mainly from Germany, mentioned that professional mental health support such as psychotherapy or inpatient psychiatric treatment was helpful for them in coping with suicidal ideation. Mental health support was also the only topic of this theme mentioned by the two participants from England. However, apart from the stated positive impact of professional mental health support, some also reported the discharge from (psychiatric) hospitals due to negative experiences in hospitals.

The quotes below were assigned to the theme ‘structural support’. They reflect positive and negative experiences of mental health support when answering the questions about what participants consider contributing to reducing and coping with suicidal thoughts.

> *An inpatient stay at the child and adolescent psychiatry [name of city].* (18-year-old woman from Germany)

> *One of the other children who was abuse[d] alongside me took his own life when I was 24 I was so upset and did not want the person to ruin anyone else life so with therapy dealt with some of the trauma.* (40-year-old woman from England)

> *Transfer to another hospital + discharge day.* (39-year-old man from Germany)

> *I was hospitalised given medication and electronic shock treatment it was terrible in hospital I was an adult and most staff treated me like a child and spoke to others about me including my parents rather than to me some staff were abusive and treated me like a criminal but after about three months I was discharged.* (40-year-old woman from England)

Furthermore, referring to social resources (England: $25\%, n = 4$; Germany: $38\%, n = 9$), respondents reflected most often on the positive role of their partners in the coping process, as shown in the quotes below (see also Figure 20 A). Those were mentioned by 25% of participants from England ($n = 4$) and 13% from Germany ($n = 3$). Family ($8\%, n = 2$), friends ($4\%, n = 1$) or professionals ($4\%, n = 1$), mentioned only by a few participants from Germany, seemed to have a minor role compared to romantic relationships.

> *Now I have a boyfriend for many years and he is my salvation from this hole.* (22-year-old woman from Germany)

These thoughts still come back from time to time. But lately less because I get a lot of support from my partner. (19-year-old man from Germany)

My boyfriend being the only consistent thing in my entire life. (21-year-old woman from England)

'Self-care' was mentioned by 23% ($n = 9$) of participants, including 25% ($n = 6$) from Germany and 19% ($n = 3$) from England. This theme contained mainly distractions and activities as coping with suicidal ideation (see Figure 20 C). Some mentioned self-management skills such as developing a routine, showing emotions and having a choice. Furthermore, one person noted that having positive experiences contributed to coping with suicidal thoughts.

Participants from England ($38\%, n = 6$) most often reflected on their personal motivation to cope with suicidal thoughts (see Figure 20 D), with 20% of the total sample ($n = 8$). This theme contains personal development, the reflection on their achievements, a positive future perspective and hope, a purpose in life such as caring about others by not leaving a person due to suicide, and their intrinsic motivation to change.

I moved to a new city and got a job I'm good at and rewarded for. (30-year-old woman from England)

I have always been passionate about my education and the career plans I had for myself - so I would just put all my energy into planning my future etc. Also, as I was the only person my mother really had in her life, what often was the only reason I didn't commit suicide was the thought of leaving her to her own devices, the guilt was too much. Moving out of toxic environments and being nurtured. (23-year-old woman from England)

The other theme that received 20% ($n = 8$) of responses was 'suicidal experiences' as a reflection on coping strategies (see Figure 20 E). Apart from one person who mentioned self-harm as a coping strategy, most of the respondents to this theme indicated that they view their suicidal ideation as a chronic or reoccurring experience which they would never completely get rid of. The reoccurring or chronic suicidal experience was mentioned by more participants from England than from Germany. While many participants who had experienced suicidal ideation in the past showed that they found a way to cope with suicidal ideation, as shown above, some might have long-term suicidal experiences.

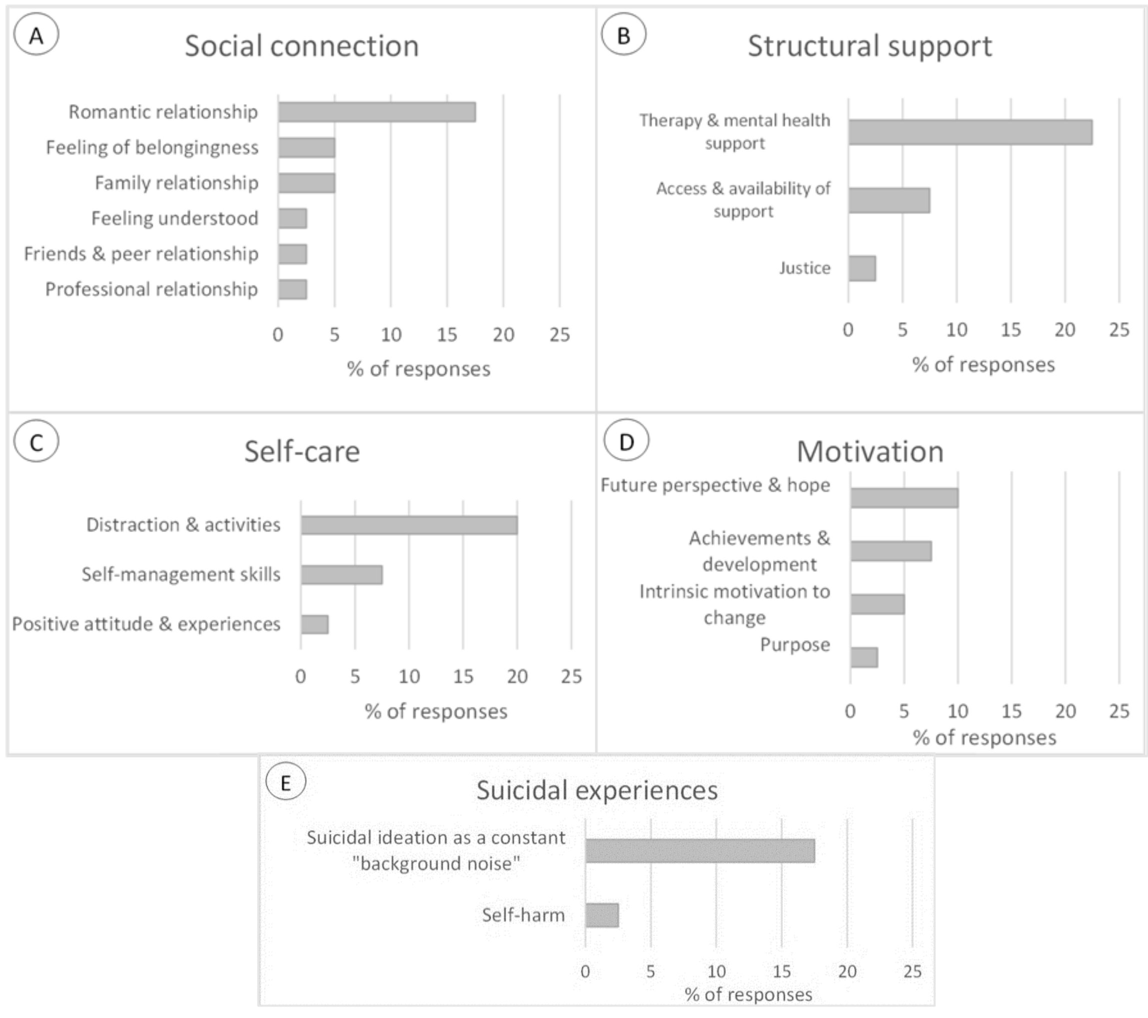

Figure 20: Distribution of codes assigned to the five most common themes about resources and coping strategies (n = 40): 'social connection' (A), 'structural support' (B), 'self-care' (C), 'motivation' (D) and 'suicidal experiences' (E).

The quotes below were assigned to the code 'suicidal ideation as a constant background noise.' The two quoted participants describe their experiences of chronic suicidal ideation.

> *I live with them... suicidal ideation is a part of my life now- though far less powerful. I think ageing, employment, time and independence has helped me forge a different perspective.* (35-year-old woman from England)

> *They [suicidal thoughts] never left because my youth had a big impact on me and there was never any psychological help from the youth welfare services. Since I was not a drug addict or violent, I fell through the cracks and received no support. Unfortunately, the youth welfare services also only focused on "functioning" (eating, going to school and not attracting negative attention).* (33-year-old man from Germany)

The last quote highlights a chronic experience of suicidal ideation concerning the care system. The young man from Germany explains that a lack of formal support from youth welfare services and, thus, access to mental health support influenced his chronic experience of suicidal

ideation. He reflects on the focus of "functioning" by the youth welfare services and may imply a deficit-based orientation within the care system that restricted him from accessing necessary support.

In summary, the samples from both countries differ in the frequencies and dominance of factors their participants experienced and considered helpful in coping with suicidal ideation. On the one hand, the group from Germany most often mentioned professional mental health support and help from romantic partners. On the other hand, participants from England more often mentioned their personal motivation as a coping strategy or reflected on the experience of continuous or reoccurring suicidal ideation. While the latter highlights that people might experience suicidal ideation over various time ranges, the results show diverse resources and coping strategies.

4.5 Reflection on the influence of care

This part presents respondents' reflections on how their experience of being in care influenced their attitudes towards life. Furthermore, their wishes are presented on how the care system could change to ensure that care-experienced young people have satisfying early adulthood and to prevent the experience of suicidal ideation. Forty-two participants (14 from England, 29 from Germany) answered this part of the survey.

Participants from both countries showed different tendencies in assessing how their care experience influenced their attitude towards life (Figure 21). While the vast majority of respondents from Germany, 76% ($n = 22$), reported a positive impact of having been in care, only 14% ($n = 2$) of the group from England reported a solely positive impact.

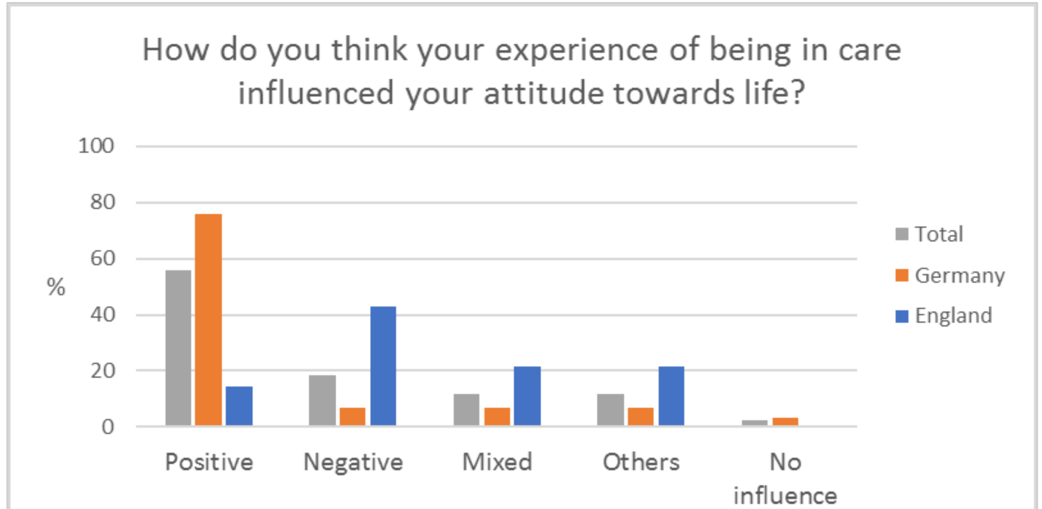

Figure 21: Percentual distribution of participants' evaluation of the relationship between their care experience and attitude towards life.

I was shown that it is also possible to live differently. Therapies helped me during this time. Carers were able to convince me that my parents were not quite right. They gave me trust and security, which every child desires. I learned discipline and personal responsibility to be the way I am today. To be a role model for my children. (35-year-old woman from Germany)

I think I wouldn't have as good a life as I have today without my time there. I feel like I can do everything and have a good structure. (25-year-old woman from Germany)

I go through life more positively because I have people around me who share their experiences with me and I can benefit from that. (18-year-old woman from Germany)

The whole experience gave me a lot of healing to work on it gave me resilience independence strength and the motivation to succeed my attitude towards life after leaving care is only you can make what you want of your life [.] That's now I am older and wiser but many of my younger years I had an attitude of being alone without any of the above in sight. (31-year-old woman from England)

However, 21% ($n = 3$) of respondents from England described the mixed influence of their care experience on their attitude towards life that combined both positive and negative effects. From Germany, only 7% ($n = 2$) reported a mixed impact. Almost half of participants from England ($43\%, n = 6$) described that their experience of being in care influenced their attitude towards life negatively, compared to 7% ($n = 2$) from Germany. The quote below by a young woman from England indicated a negative influence, as her care experience contributed to a sort of alienation and implied perceived burdensomeness and thwarted belongingness.

I will always feel different. Christmases, mothers day and fathers day are very touchy subjects for me and I have mental health issues now as I feel like everyone would be better off without me. I have rejection and attachment issues. (21-year-old woman from England)

One person from Germany described that the experience of being in care did not influence the person's attitude towards life. The category 'others' covers answers that did not directly answer the influence of care experience on the person's attitude towards life. For example, respondents described other experiences such as abuse or their general attitude towards life without linking it to their care experience. One person reported how her negative experience of being in care influenced the fact that she now supports care-experienced young people, while her statements did not reflect on her attitude towards life.

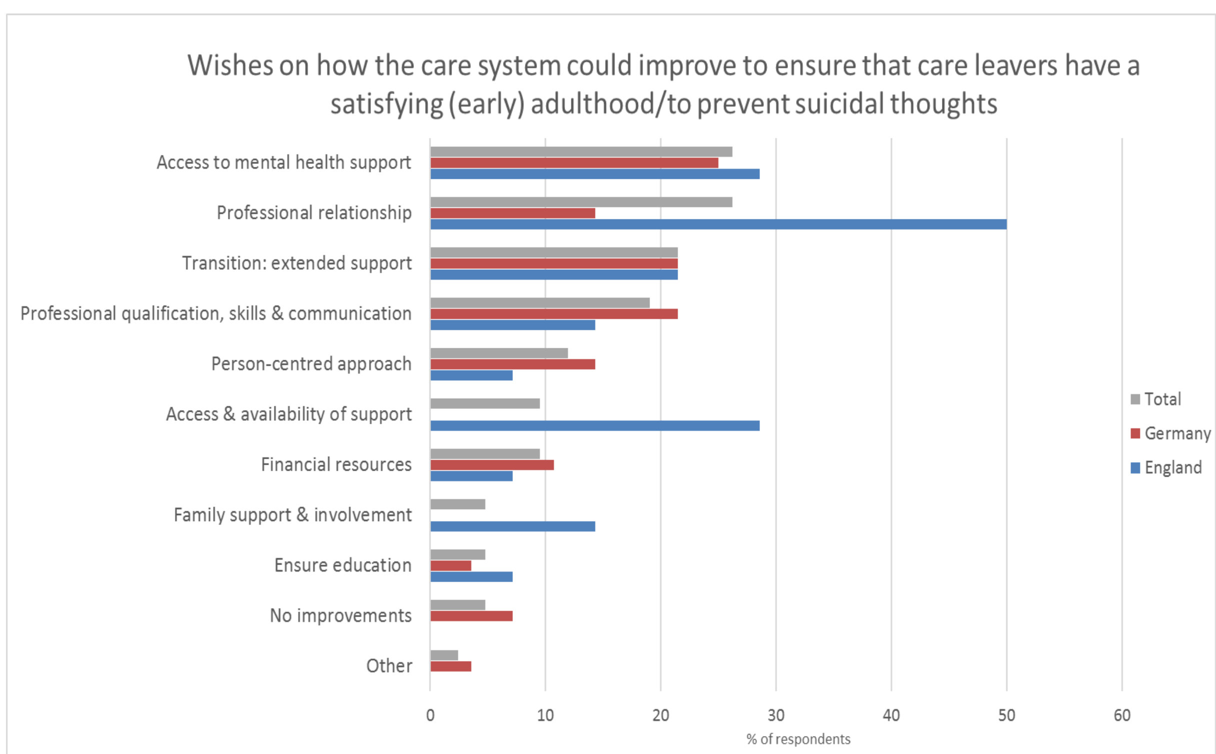

Figure 22: Percentual distribution of topics identified as wishes for improvement and changes in the care system.

Next, participants were asked about their wishes for changes in the care system to ensure that care-experienced young people have a satisfying (early) adulthood and to prevent suicidal ideation. As Figure 22 presents, the two groups differed partly in the order of frequencies of themes. The three most prominent themes of each country are presented in the following section.

Both groups mentioned that access to mental health support would be essential to ensure high life satisfaction and prevent suicidal ideation. Access to mental health support was the theme most often mentioned by participants from Germany, while it was also among the three most frequently mentioned themes among participants from England. Some respondents wrote the following concerning access to mental health support:

> *I would like to see more cooperation between youth welfare and (child and youth) psychiatry.* (32-year-old man from Germany)

> *That you have the possibility to talk to a psychologist who belongs to the youth welfare service. Otherwise, you have to spend months or even years looking for one and hoping to get on the waiting list. There are far too few psychologists and far too many need them.* (22-year-old woman from Germany)

> *Access to talking therapy to help resolve childhood trauma help to develop friendships and to have higher expectations of you and make you aware of opportunities.* (40-year-old woman from England)

Participants from England (50%) most often mentioned the wish that the relationship with professionals would need to change as a means to prevent suicidal ideation. Participants reflected, inter alia, on the permanence of professionals, emotional support from professionals, careful selection of foster carers and possibilities to stay in touch with professionals after leaving care. A woman from England described her wish as follows:

> *Provide more support and understanding when in and leaving care [.] Correctly place children and young people also correctly match them with social workers and PA[s] they think they will actually form a beneficial relationship with [.] Cut out the amount of social workers and PA[s] the young person has so it is a personal service they receive rather than a numbers game.* (31-year-old woman from England)

Another aspect, equally often mentioned among both groups, was the wish for extended support in the transition from care. Often, people wished that leaving care would be based on their development and readiness rather than on age. The following two quotes from participants reflect such wishes:

> *To set young people up for the future, more semi[-]independence living arrangements with ongoing support, an involved after care support service and more mentoring services to set people up for real life and for longer than the ages currently stand, most care leavers need longer to adjust.* (32-year-old woman from England)

> *Youth welfare services should stop forcing young people to move out when they reach the age of majority and deprive them of financial security. Not the age, but the respective development of each person in care must be taken into account.* (22-year-old woman from Germany)

Especially for participants from Germany, the qualification and skills of professionals, including the way and options to talk, was also a common theme. They raised the wishes that foster parents should be suitable for their role and carers. Both foster parents and residential care workers need to be well-educated on addressing young people's psychological needs and issues appropriately. The wish was raised that carers develop greater awareness of the young people's mental health. Furthermore, participants wrote that they wished that the communication between young people and adults involved in their care would improve. In

addition, professionals need to take young people's expressed suicidal thoughts and mental health issues seriously. The following quotes were assigned to the code 'professional qualification, skills and communication':

> *More training on how to help young people (with mental health problems). Many group homes are unprepared and overwhelmed by some of the 'abnormal' comments of teenagers etc.* (18-year-old woman from Germany)

> *In any case, the suicidal thoughts should be taken seriously and no stupid sayings should be made. The carers should talk to the young person to see what actually triggered it and, if necessary, draw up a skills box (together with the young person).* (18-year-old woman from Germany)

> *Change essentially everything. Children who go through have a significantly lower chance of becoming successful and mentally, financially stable. It starts with how the social workers neglect the minors trying to come into care, as it'll cost them money and time, not to mention the racial injustice. To the foster parents not looking after the child for the right reasons and right way.* (18-year-old woman from England)

As already referred to in the last quote from the 18-year-old woman from England, another theme was the access and availability of support, which participants from England most often mentioned. Participants wrote wishes about more support and understanding, more interaction between professionals and young people and better availability and accessibility of professionals without the young person needing to become active to approach them for support. A woman from England wrote the following:

> *I would want them [social workers etc.] to interact with children and young people more, to let them know what the services are really about and how they support children and young people, as I feel that isn't properly recognised and we try and run away from it not knowing this is the support we actually need.* (26-year-old woman from England)

In summary, the two groups from England and Germany evaluated their experience of being in care very differently. While the participants from Germany most often described a positive impact of their care experience, respondents from England more often described that their care experience negatively influenced their attitude towards life.

The views on how the care system could contribute to preventing suicidal ideation and ensuring satisfying early adulthood of care leavers were diverse, though prominent themes across both groups were access to mental health support and extended support in the transition phase from

care. In addition, participants from England most often described wishes for an improved relationship with professionals in the care system.

4.6 A possible double-response: Tests to validate results

After completing the tests and reviewing the results, two completed questionnaires attracted attention due to the same very specific, unusually high number of placement changes during care (57 times). I reviewed the responses of both completed questionnaires. One was completed in December 2020, and the other one in May 2021. While some key data were different, such as age entering and leaving care, others like age, gender, country and placement types were the same. Due to some similar phrases used in open-ended questions, the suspicion substantiated that both questionnaires were completed by the same person at different times, about six months apart.

Therefore, to check whether the significant results presented above would change if either one or both questionnaires were excluded from the analysis, the most central tests, primarily focusing on those indicating significant results before, such as significant differences of distributions between different groups or correlations, were conducted again. The following tests were conducted again with only the first questionnaire excluded ($n = 44$), only the second questionnaire excluded ($n = 44$) and both excluded ($n = 43$), and compared to the results of the initial total sample ($n = 45$):

- Mann–Whitney test
    - Number of placement changes: England and Germany
    - PSS lifetime: England and Germany
    - PSS year: England and Germany
    - PSS month: England and Germany
    - Age of first suicidal thoughts: England and Germany
    - Coronavirus pandemic impact: England and Germany
- Kruskal–Wallis test
    - PSS scores (month, year, lifetime) and groups regarding siblings in care
- Post hoc Mann–Whitney test following Kruskal–Wallis test
    - PSS scores: siblings in care at the same time and not in care
- Kendall's τ test
    - PSS (month, year) and INQ factors

- PSS (month, year) and INQ factors: country
- PSS (month, year) and future perspective: country

If one of the two responses was excluded ($n = 44$), the average number of care placement changes decreased to 3.4, from previously 4.6 (see section 4.1), and for the English sample ($n = 15$), from 10.5 to 7.1 changes on average. While only two tests showed a change from a previous significant ($n = 45$) to a non-significant result, all other tests showed a similar significant result, as previously presented (see Appendix 15).

First, one significant difference between the samples appeared when the most recent, possibly double-completed questionnaire was included but not the one from December, as the otherwise significant correlation between PSS of last month and PB is no longer significant. This change is related to a very time-sensitive question that is highly likely to vary within one case over a specific time, even if a person completed the questionnaire twice. It is significant again when both responses are deleted. Therefore, a significant correlation is rather likely between PB and PSS scores of the last month.

Second, the p-value of the Mann–Whitney tests for the past year's PSS between those whose siblings were in care at the same time as themselves and those whose siblings lived with their family while they were in care was slightly over the significant level ($p_{(n = 44)} = 0.053, p_{(n = 43)} = 0.086$) compared to the total samples of $n = 45$ ($p = 0.039$). While the year's PSS then no longer showed a significant difference between these two groups, all other group comparisons of the PSS of the last month and year still indicated the same result as with the total samples of $n = 45$.

Due to some similarities but also variations and differences in the responses from these two completed questionnaires, even differences in time-independent variables such as different ages mentioned when the respondent(s) left care, it can be neither disproven nor confirmed whether it was the same person, and hints of specific responses made this check indispensable. Due to the verification of significant tests, the presented results above can be still counted as valid for this study. Therefore, the following discussion refers to the initial total sample of $n = 45$.

4.7 Summary

The results from the survey indicate a variety of experiences of suicidal ideation among adults with care experience. The occurrence of suicidal ideation across the sample varied dependent

on the time scale. While most participants reported having had active suicidal thoughts at least at one time in their life, fewer people described suicidal ideation more recently. First suicidal ideation was reported on average in early adolescence. Also, the impact of the pandemic on the attitude towards life and IPTS factors was explored.

While some differences were found between the group from England and Germany, such as the number of placement changes, several similar trends were found between the two samples. For instance, there was no significant difference found in the occurrence of suicidal ideation, indicating a similar distribution of reported suicidal thoughts.

The hypothesis that a positive relationship between recent suicidal ideation and IPTS factors would exist was partly confirmed. Other factors such as gender, sexuality, placement changes or length of care did not show a significant correlation with suicidal ideation despite the indication of previous research. However, other factors indicated significant differences, for instance, whether a young person's siblings were in care at the same time as they were or not. If siblings were in care simultaneously to the respondents, they showed significantly less severe suicidal ideation in adulthood than those whose siblings lived with their families.

In addition, participants reported on changes at the time of their first suicidal thoughts, including reports of transitions, negatively experienced social relationships or traumatic experiences. They perceived interpersonal critical or traumatic events and impacted social connection as the most common causes of their suicidal ideation. Furthermore, the participants described factors contributing to coping with suicidal thoughts, including access to structural support such as mental health support and social resources. Moreover, the results indicate that while many reported coping strategies and helpful resources, some might experience suicidal ideation rather chronically or reoccurring. Finally, the participants reflected on the influence of their care experience on their attitude towards life and how the care system could contribute to preventing suicidal ideation for care-experienced young people.

Taken together, the results present a multi-faceted picture of the experience of suicidal ideation among adults with care experience from England and Germany. The findings reflect the complexity of this topic that would not allow a general, simple answer to the research questions on the occurrence of and factors influencing suicidal ideation.

5. FINDINGS FROM THE INTERVIEWS

This chapter presents the findings from the semi-structured qualitative interviews with 13 care-experienced young adults. From the interviews, 61 codes were created, grouped into 10 themes using the framework analysis to answer the research questions and explore factors influencing suicidal ideation among care-experienced young adults in England and Germany. Each theme is firstly defined before presenting the related central findings. Deviant cases, as well as similarities and differences between each country-specific group, are highlighted. Since the themes consist of multiple codes grouped, some of which appeared more dominant than others, the length of the themes varies. At the end of this section, the interpretation of the findings across themes and thematic interconnections within a socio-ecological framework are discussed to provide a more comprehensive answer to the research questions about the occurrence and influencing factors of suicidal ideation among people with care experience.

The 10 themes identified across the interview data are categorised into three socio-ecological levels: individual, interpersonal and structural (see Figure 23). The individual level comprises five themes focusing on internal emotional and cognitive experiences: suicidal ideation experiences, self-perception, control, self-care and motivation. On the interpersonal level, three themes cover relational factors separated into interpersonal critical or traumatic events, social connection and communication. The structural level covers transitions between placements, places, services and from care, and structural support reflecting on the accessibility and organisational conditions of formal support.

Themes and levels overlap in multiple ways. At the end of this chapter, an example presents the interconnections of themes across different levels as part of the further interpretation of the findings from the interview data discussed in chapter 6. The current chapter aims to provide insight into each theme and guide towards the further interpretation using a socio-ecological perspective.

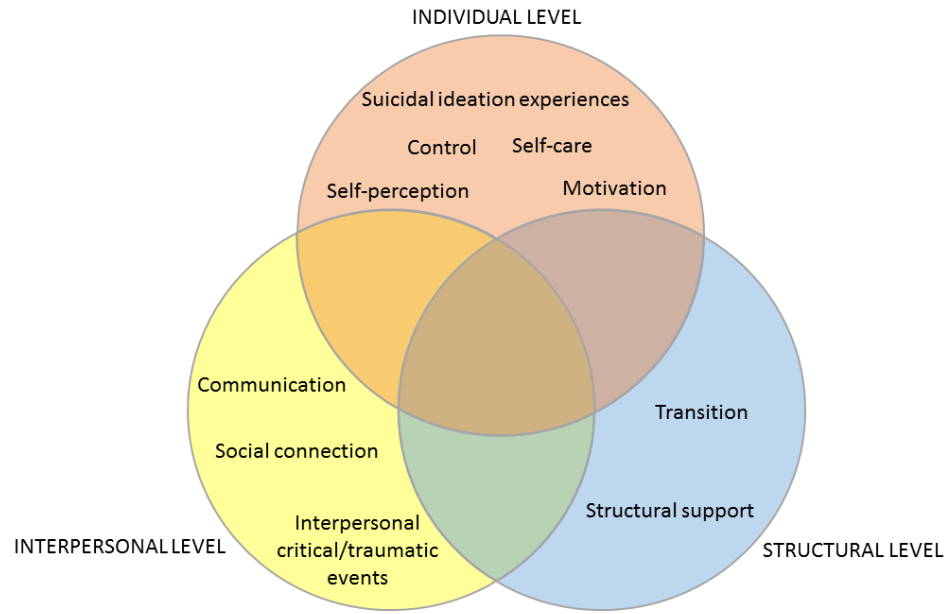

Figure 23: Themes categorised into three overlapping socio-ecological levels: individual, interpersonal and structural.

5.1 Individual level

The individual level covers mainly person-focused cognitive and emotional experiences in the context of suicidal ideation. This category includes aspects of the experience of suicidal ideation itself and intrapersonal factors contributing to the development of and coping with suicidal thoughts, including self-perception, control, motivation and self-care. While the focus is mainly on the individual, some aspects have links to interpersonal and structural levels, which are further discussed at the end of the chapter.

5.1.1 Suicidal ideation experiences

As a starting point in presenting the findings from the interview data, this chapter provides an overview of experienced suicidal ideation and other related experiences gathered from the interviews. This overview should help to better understand the range of experiences of suicidal ideation reported by the participants. This theme consists of six identified codes:

- first suicidal ideation,
- active suicidal ideation,
- passive suicidal ideation,
- ambivalent attitude towards life and death,

- self-harm, and
- suicidal ideation as continuous background noise.

The age at which the interview sample had **first experienced suicidal thoughts** ranged from 8 to 18. Seven out of 13 participants had their first suicidal thoughts between the ages of 11 and 13. As described below, these thoughts were not clinically assessed but individually reported by each participant. One young woman from Germany mentioned developmental impacts on mental health in relation to puberty as a triggering stage for developing suicidal ideation. In both groups, from England and Germany, the time of initial suicidal thoughts varied, occurring before entering the care system, during the time in the care system or after leaving care. Note, however, that some of the participants from England entered the care system before the age of eight.

Furthermore, the interviews clarified the difference between **active and passive suicidal ideation**. In this context, it is essential to highlight the range of suicidal thoughts that were reported. For instance, a young woman from England described her passive suicidal thoughts:

> *And I was having um like, like suicidal ideation, like kind of 'Oh, it would be great if I could just disappear' [...]. It was on my mind a lot.* (E1)

A young man from Germany described his experience of passive suicidal thoughts first experienced while he was in residential care:

> '*For me it's easier when I'm not here.' So not here from [the residential home], but here, eh, on earth and [not?] underground [six feet under]. These (-) these thoughts then came up at some point. They also started to creep up on me, um, and then (-) first (-) I started to self-harm. Um, and only then did it develop, um, with the suicidal thoughts too (-) but it was also very, very gradual. It didn't happen all of a sudden, it went on for weeks, maybe even a few months, until it manifested itself.* (D4)

One participant from England described suicidal thoughts as two different types of thoughts. One type of thought was described as an intrusive thought like a voice in her head, and the other was called a "glide state" (E5), like a state of uncertainty, with blankness and feeling of loss of control with the depression taking control. While she did not describe these two kinds as passive or active suicidal thoughts, the various severity of these cognitions becomes apparent.

A distinction between passive and active suicidal thoughts is between feeling that life is not worth living and having concrete plans to die by suicide, as described by the young woman

(E4) in the following extract below. Just as she reported, several other participants reported experiencing their first passive suicidal thoughts from a young age as the first suicidal experience that developed further into active suicidal thoughts in later life.

> *Somewhere around 11 or 12, I started internalising everything […] That was probably at a time I was 11 or 12. I was like have thoughts like 'Oh, it must be my fault. Then it must be my problem. [inaudible] must be terrible. I should just die.' Um, so I think, 11 or 12, probably 12. (.) Yeah. I think the first ones. (.) So, they were, I think (-) they weren't that serious to begin with […] there were a lot of thoughts going through my head […] And then got to self-blame and lots of kind of 'Maybe I should just (.) not be here then.' […] And I think the older I got up more and more I stopped thinking it was other people and more it was me. So, at the time I (-) I think, probably the first time I had a serious blank I would have made a plan and I might do this, um, I was (-) probably my first year at uni actually. It got just worse and whether the first time I had a plan wouldn't have been until I was (.) yeah, at uni.* (E4)

She reflected on her experienced trajectory from passive to active suicidal thoughts over several years. She mentioned particularly the time of transition from care to university and having several problems coming up at once as triggering the change from previously passive to active suicidal thoughts marked by starting to make suicidal plans at this point in time.

A young man from Germany reported one exceptional case about the distinction between active and passive suicidal thoughts. He described that a drug overdose triggered his first severe active suicidal thoughts in the year of leaving the care system, which continued to last beyond the consumption of drugs. He reported having had less severe suicidal thoughts when he was younger when he experienced some loss, such as breaking up with a partner. In addition, he described the ambivalence between active suicidal thoughts as an escape from painful problems and fear of taking this action.

> *Suicidal thoughts, you don't look forward to it, it's a reaction. Something that at least caused me a lot of fear. I was (-) afraid of taking this way out. […] it's a way out, because if you're no longer alive, you no longer have any problems. So if you look at it soberly. But then I'm very (-) you want to live, and you're very afraid of no longer (-) being there, and then you lose what you have.* (D3)

Several participants reported an **ambivalence between suicidal and life-affirming thoughts** and behaviour. Concerning contact with professionals and professional assessments, the

reported experience of ambivalence between life and death is essential to take into account. This ambivalence includes the fear of death or planning one's own future while simultaneously having the wish to die by putting oneself into life-threatening situations. A young woman from England described the challenge for professionals to deal with such ambivalent suicidal behaviour as follows:

> *It was confusing because I've always had two sides to me. So, on one hand, I've always been very kind of enthusiastic and very determined in terms of like my career and my education and all those things I wanna do. But on the other hand, like I'm looking at university courses I wanna do but I'm doing it whilst I've (-) I've not taken my insulin and I'm really high and I know I'm going to, you know, end up in hospital in (-) in like this evening or something. So, it's just like I'm on my way to hospital looking at university courses, but like if I'm going to hospital 'cause I didn't take my insulin. So, I had this like whole destructive side and like suicidal side that I was planning my future at the same time. So, it was just (.) a really weird kinda dynamic that I had in my head, which was really confusing to the professionals as well because I'd be in hospital talking to them about the courses I have applied to and the work experience I want to do but, you know, I'm sitting there because I did that to myself and I'm putting myself in danger, and I'm jeopardising all the things that I'm planning by not, you know, taking my insulin or putting myself into dangerous situations.* (E7)

As part of the suicidal experience or as a coping strategy, several participants from both countries reported **self-harm**, varying from cutting to misuse of medication, as described above. Some young adults from Germany reported starting with self-harming practices before having had suicidal thoughts. For instance, one young woman from Germany described that residential care workers ignored her self-harming practices while she was in care. She did not have suicidal ideation at that time. However, suicidal thoughts occurred first when she moved out to live alone in a supported flat by the same care provider, where she then attempted suicide.

> *I also remember exactly when I hurt myself for the first time. It was on [date]. It was because I couldn't cope with this emotional inner pressure, and I had to relieve it somehow [...] And not deep or anything, but it was (-) it just hurt and it was good for me in that moment. [...] I hid it all the time, somehow for a month, but I did it over and over again. And at some point it came out and the care workers said that I was only doing it to get attention. So. At that time I thought, 'Well, no. Are you just stupid?' and today I think that of course it was a cry for help, but you just didn't react the way I*

> *wanted. [...] I don't think I'll ever forget that [...] and then this 'Yeah, you're just looking for attention. [...] you're not really feeling that bad. You just want to get noticed.' [...] I had a really bad low and hurt my leg at some point. [...] And then I really got down with my freshly injured leg and of course I saw the care workers looking at me, and they just didn't react at all. They just sat in their seats and let me do my thing.* (D6)

Her reflection on this situation shows disappointment in the care workers' ignorance of her self-harming behaviour and mental well-being. She reflected that her self-harming behaviour had two functions: one was a coping strategy, and the other was a cry for help, help that she did not receive from the residential care workers.

Some young people might have developed a cognitive protection mechanism restricting their ability to discuss their suicidal ideation and underlying causes. One interviewed person described having experienced depression since being a small child. However, she also mentioned that it was difficult to recall the triggers and causes of her first suicidal thoughts as her brain would try to protect her from those memories.

It also appeared that some experienced suicidal ideation as something chronic as a so-called **'constant "background noise"'** (E5) with active suicidal thoughts "pop [up]" (E5) occasionally, as described by a young woman from England. Additionally, further participants reported having such thoughts regularly or being always there hidden in the background until the people received psychotherapeutic treatment and finally coped with the triggering experiences they had undergone. One young woman from Germany described her acceptance of chronic depressive and suicidal experiences as follows:

> *Of course, there are still dark days when, for example, I harm myself or something, which hasn't been the case for a long time (knocks on the table). Um. But it's just (-) it's really been reduced. And I think it also has a lot to do with acceptance, simply understanding that this will accompany me throughout my life and that there will always be one or two dark days a year.* (D6)

There are many similarities between the reports from both countries that covered both self-harm experiences, continuous suicidal ideation as background noise, and the difference between passive and active suicidal thoughts. In addition, the ambivalent attitudes between the wish to die and to live were discussed in both groups, which participants considered as posing challenges for professionals to deal with the young person's suicidal state. Both groups reported

a range of ages when participants experienced suicidal thoughts for the first time. To summarize, the experience of suicidal ideation is diverse, with overall similarities between reports from the two countries.

5.1.2 Self-perception

Another theme that emerged from the interview data was ‘self-perception’. Participants reported that they considered their perception of themselves to influence either the development of suicidal ideation or coping with it. This theme consists of one deductively informed theoretical construct of the interpersonal-psychological theory of suicide (IPTS) ‘perceived burdensomeness’ and the following further identified related codes:

- letting others down,
- self-worth and self-esteem,
- self-blame and reproaches, and
- identity and self-image.

Based on the theoretical origin of IPTS, perceived burdensomeness connects the individual to the interpersonal level. However, the code was grouped within this theme because perceived burdensomeness appeared to be more strongly linked to self-blame and self-esteem, as described below.

The IPTS construct of **perceived burdensomeness** was inter alia found in a report by one young adult from England who described the impact of this factor as the crucial point at which suicidal ideation becomes life-threatening. She explained from her experience that active suicidal thoughts become most dangerous when a person starts believing that their death would be better for anybody else.

> *That’s the (.) one that causes the people to attempt suicide because (.) it’s (-) it’s (breathing out) it’s impregnably (pause) destructive would be my best description. It basically just removes all reason, all love, it (-) it makes you believe what you’re doing is the right thing, what you’re doing is better for anybody else.* (E5)

A self-perception of being a burden links both the intra- and interpersonal levels. Several participants from the German group reported further links to this factor. Some described that they did not want to become a burden to others by causing them to worry, so they distanced

themselves and would not talk about their situation. A young woman from Germany discussed the link between the feeling of being a burden and suicidal thoughts as follows:

> D6: *It's a very long process, it's also connected to my childhood, because I quickly get this feeling that I'm a burden to others. [...] And then I interpret too much into it. [...]*
>
> Interviewer: *You just said that you had this feeling early on that you could be a burden to others. How (-) does this thought play a role, if it is somehow connected to your suicidal thoughts, is there any connection that you see?*
>
> D6: *Yes, such elements are of course very conducive to such thoughts. Yes. (..) So, it was also back then when I had this (-) Well, there were a total of 3 suicide attempts, and the last one was just the most blatant. [...] And it was also this: I can't confide in anyone because I'm a burden, no one understands me and I'm actually just a big burden for everyone and they would all be much better off if they didn't have me.*

Others mentioned this feeling of being a burden when getting rejected by others. One person described a vicious circle of suicidal ideation, as such thoughts were triggered by the feeling of being a burden to his parents by causing worries because he needed psychiatric inpatient treatment due to being suicidal.

> *Then I didn't really want to go there [psychiatry] again, only at the insistence of my parents did I go there again and I definitely had a lot of suicidal thoughts because I was there and had the feeling that my parents felt very bad and that I felt very bad*. (D5)

Related to this was the report of a young adult who developed suicidal thoughts when he felt like a failure and **let others down**, particularly beloved people such as family and friends, which also linked to low self-worth that contributed to suicidal ideation. The perception of letting others down appears closely related to perceived burdensomeness and self-blame and affecting or possibly mirroring a person's self-worth.

Topics such as low **self-esteem**, self-hatred, feeling of being unwanted, the unfulfilled longing for unconditional love and self-doubts linked to suicidal ideation were mentioned across the whole English sample and several from their German counterpart. One person mentioned that the many changes in foster carers (as she lived with eight foster families) made her question whether she was not loveable or worth the love:

> *And [in] terms of like the suicidal ideation and stuff, I think, you know, the fact that (.) I had lots of different social workers and I was going from one, you know, even before*

turning 18 going from one foster carer to another foster carer to another foster carer it's just like (.) especially when I had to go back home because the foster carers weren't very nice to me. It just felt like 'OK, well, my mum can't look after me because she has mental health issues but like you're being paid to look after me. You're being paid to try and support me or try and provide me with some sort of love but you're not able to do it' either so if this is just continuously happening at some point you're going to be like, OK, maybe I'm just not worth the love. Or maybe I'm just not lovable in any sort of sense. (E7)

Contrary to this, the opposite strategies of actively practising self-love, strengthening self-esteem, and feeling that others appreciate and believe in this person were examples of resources and coping strategies to deal with suicidal ideation. Examples from two young women from England stated their positive self-perception as relevant resources to cope with suicidal ideation as follows:

I felt like, um-m-m, when I started to feel better, I felt like I was someone that people could want to be around. Again. I felt like I lost that for a long time and I by that I never had that. (E1)

I wanted to feel unconditionally loved. Um. And now that's actually a funny one [...] because I at the time I didn't realise I wanted unconditional love but actually now later in life I've realised I find that unconditional love within myself. I don't need someone to love me unconditionally when I do that myself. And I think that's just part of like mindset change and stuff like that as well. (E6)

One young adult from England reported that a buffer protecting her mental health from deterioration was praising and appreciating behaviour by her foster carer that contributed to her self-perception as a contrast to the emotional abuse she had experienced previously. However, when this support went away with the transition to university, and she struggled to connect with people to find new friends, active suicidal thoughts were triggered.

My mental health got worse and worse and worse until I was 15, 16. And then I moved into my new placement and she [foster carer] was just (-) I mean there were lots of things wrong with that placement, there were lots of things really, really good about it. And one thing that was really good about [name of carer] which is the woman who was taking care of me (-) um, she was just showering me in compliments all the time. [...] She was just nice to me. She gave me a boost all the time. She told me that I was a nice

> *person and that I was pretty and just said nice things to me. And I suppose that was so contrary to everything that I've been exposed to before that that (-) I mean, it didn't always go in and it probably didn't change the way I thought about myself but it was a buffer (.) that made me kind of feel better in a day-to-day.* (E4)

Another identified factor contributing to the development of suicidal ideation was **self-blame**. Particularly, those who had experienced abuse blamed themselves for the abuse or for not talking about it. As one young adult from England reported, self-blame for being in care may be common across the care-experienced population. The person highlighted a need to actively tackle this self-blame experience among care-experienced people. Here, the person called for active engagement with foster children, telling them that they were not to blame and that it was not their fault for being in care.

> *This abandonment from being taken from their primary caregiver from an early age it causes them to make a connection of it's their fault, and then they carry that into adulthood because nobody has told [them?] that it's not their fault because nobody assumes that this child is blaming themselves for the issue because there was no […] way their fault*. (E5)

Another aspect influencing suicidal ideation seemed to be **identity and self-image**. For instance, one young adult who had been abused sexually reported experiencing a negative self-image and body image after the abuse contributing to the development of depression and further suicidal ideation. Participants who entered higher education reported an identity only based on academic success. They reported that the difficulties experienced in their academic education when their expectations of academic success were not met shook up their self-image, which further affected their mental health and triggered suicidal episodes. One participant from England recommended actively implementing identity-building activities for children in care by helping them identify hobbies, widening their interests and contributing to positive experiences. She hoped that this would prevent young people in care from only identifying with their academic success.

> *The biggest thing was, um, growing up in care, it was so much pressure like because my school knew I was clever, like I mean I worked hard, I could perform well academically. […] So, I got to university. It was like (-) it was like working your whole life for something and then it happened. And it's just there. And it was like, now what? […] Or (-) kind of [course subject] wasn't working out and it was just like all those expectations had been absolutely crushed and I was like 'Oh, my gosh, what am I*

> *doing?' It was, yeah (-) I didn't really know myself. I feel like that is a lot of the issue with my mental health and with support with foster children is that in schools and with the support, they could have done a lot more identity-building.* (E1)

Another participant reported a similar experience of how academic expectations shaped her self-image. She highlighted that not fulfilling her self-image and expectations on how she viewed herself triggered active suicidal thoughts with a concrete suicide plan during her time at university:

> *Somewhere in there, my identity flipped, and I got really obsessed with, um, not being the thing that I ever [...] really thought I was and instead being this person who was brilliant at academia and really, really good at [art form]. [...] I got already really obsessed with this image of being very, very brilliant [...] Because, in the end, I just fell down and couldn't cope. Um. And then, that was the point that probably when it [got] worst and that was the first time that I (.) probably really seriously making plans like I had a proper (-) I knew where I was going to do it.* (E4)

A further aspect of identity that contributed to the development of suicidal ideation for one person was the reflection of gender identity during adolescence. The person indicated the challenge of accepting her transgender female identity in addition to previously experienced events.

> *That's probably because, on a certain level, I always hated myself. Um, and as said was the, um, the events that trying to describe transpired even to cause the (pause) suicide attempt even where also in direct correlation with me, my ability to accept who I was.* (E5)

The young woman reflected on how her self-image and identity were linked to her suicidal experiences. As described above, the disruption of a care-experienced young person's identity was identified as a reoccurring link to suicidal experiences across some of the participants' reports.

Overall, similarities between the English and German samples were mainly found in the reports of self-blame concerning their experienced abuse contributing to the development of suicidal ideation. Furthermore, the importance of self-love and self-acceptance as coping strategies against suicidal ideation appeared in reports from both countries, which was the counterpart to negatively impacted self-esteem and self-worth, contributing to the development of suicidal experiences.

Perceived burdensomeness was more often but not solely a topic in the German sample, while ‘identity and self-image’, particularly a care identity, for example, related to academic pressure but also self-blame, were mainly mentioned by English participants. As one participant reflected, the care experience may trigger self-blame among children in care, which further contributes to low mental health and poses a risk of developing suicidal ideation. Two participants with a background in higher education from England described having an identity focused heavily on academic success, sometimes attempting to tackle a negative stigma of care experience. As discussed further in the next section, in cases where their educational expectations and, thus, self-image were not fulfilled, their risk for suicidal episodes seemed to increase.

5.1.3 Control

Another theme that emerged from the data was ‘control’. This theme included the following three codes:

- (loss of) control,
- being overwhelmed, and
- emotional and psychological pressure.

For some participants, control or loss of control due to psychological pressure or overwhelming experiences contributed to the occurrence of suicidal thoughts. Hence, these three codes are closely linked with one another.

Some participants mentioned the feeling of **lost control** when being suicidal. One participant from England described active suicidal thoughts as follows:

> *All I really know about the situation (.) is this (-) is just blankness and a feeling of loss of control that and [inaudible] fear that’s whilst at place, um, I assume that’s how I (-) how I (-) how my brain felt when it was being in this view glide state, but (.) I don’t actually remember any of that.* (E5)

Some reported attempts to gain control over a situation or emotions linked to low mental health or suicidal thoughts. For instance, one participant from England reported the ambivalence between fear of death and her wish to die, which was also reported by other young adults (see section 5.1.1). She described that the fear of death was so consuming that, at one point, she tried to tackle this fear by taking control over the time when she would die.

It was a paradox because I was scared of death, but I didn't really want to be alive. But then my brain was almost like I can take control of this by choosing when I die. Um, amid the circumstances I was in. So, very strange. (E1)

Some care-experienced young adults from Germany reported similar experiences related to this theme. One young man described his suicidal thoughts as taking control by escaping painful situations, mainly caused by pressuring himself to hide problems from his family:

These suicidal thoughts as a way out of a stupid situation, um, or when a stupid situation kept coming up. (D3)

However, some from England also referred to their care experience itself, as they mentioned that young people in care or care leavers often do not feel that they have control over their support and decisions about their lives. For example, as discussed further in sections 5.2.2 and 5.3.1-2, care leavers are often not involved in decisions about when their support ceases. As a woman from England reported, very abruptly closing of cases that happened may result in the young person feeling a loss of control and could increase the risk of suicide if a young person already felt suicidal beforehand.

Many reported that suicidal thoughts were caused not only by one factor or experience but also by multiple problems mounting up, resulting in feeling **overwhelmed**. A young man from Germany described the influence of multiple factors contributing to psychological pressure due to self-doubts that pushed the desire to become better and resulted in his suicidal thoughts:

Because I often got into these problems or thought cycles: 'Nobody wants me. I'm just not good enough. I have to be better.' And then I built up pressure on myself and this pressure became too much for me. And then came these thoughts of suicide. But I could never pinpoint the crux of the matter, it didn't really exist for me. There were many, many factors, but they all hit me in a very short period of time. (D4)

Further aspects of control were related to **psychological pressure**, particularly mentioned by those who entered higher education. This pressure was related to academic pressure to tackle a negative stereotype of care or hide their care background in their new environment. As described in the previous section about 'identity and self-image,' one young woman from England reported too much pressure to succeed academically and in her career, leading to an emotional breakdown and active suicidal ideation.

So, when I got to third year [at university] I basically I just went too far like I took on too much work. I (-) I had to (-) I was doing far too much, and I put a load of pressure

on myself. […] I was going to run a business. I started running a business whilst doing my degree. And I was just (-) I was just doing far too much. […] I got already really obsessed with this image of being very, very brilliant. To my detriment because in the end, I just fell down and couldn't cope. (E4)

In comparison, contrasts between the two groups appeared to be mainly concerning academic pressure experienced by care-experienced young adults in England, which may also be related to the characteristics of the samples. However, hiding problems or their care background causing psychological pressure and further contributing the suicidal ideation were reported from a few participants from both groups. Based on reports from both groups, suicidal thoughts might also be understood as regaining control over an apparently problematic, hopeless situation as a sort of escape.

In conclusion, loss of control and feeling overwhelmed are relevant aspects influencing suicidal ideation. As described above, multiple factors may accumulate, contributing to psychological pressure and limited control and further the risk of developing suicidal ideations.

5.1.4 Motivation

The theme 'motivation' plays an important role in examining factors influencing suicidal ideation among care-experienced young people. It covers all aspects related to internal motivational factors triggering suicidal ideation and contributing to starting coping and 'healing'. This theme contains the following codes:

- future perspective and hope,
- achievements and development,
- goals and actions for reaching goals,
- rewards and purpose,
- intrinsic motivation, and
- mentors and role models.

Interviewed care-experienced adults reported multiple aspects influencing their motivation to cope with suicidal thoughts. **Hopelessness and a lack of positive future perspective** with no hope for getting better were identified as elements of suicidal ideation. In contrast, one woman also spoke of fears about the future and actively avoided thinking about the future as a coping strategy by only focusing on her present. However, this delayed future planning until her mid-

20s as thoughts about the future negatively affected her mental health. In comparison, hope and optimism for getting better in the future, for example, based on religious faith and actively reassuring yourself that the current mental health state is only temporary, were seen as important factors influencing coping. As the following quote by a young woman from England shows, the perception of time as a constant or changing state influences suicidal ideation.

> *And, I hope for the future. I think, hope for the future makes an enormous difference even if you're struggling at the time to know that you can put a lot of work and it will be hard but eventually you get to a point where things are OK because you have done that work. That (-) That makes an enormous difference. It's just knowing that it will get better. And I think when you're in the depth of feeling suicidal one of the hardest things is being able to see the woods through the trees. Like you, you know, you can cope with being suicidal today if you know that in five years time your mental health with probably been improved and your life will be better. But at the time you just feel like ev(-) there's no way anything will ever get any better and the only way out is this.* (E4)

As she referred to suicidal thoughts as "not being able to see the woods through the trees", she indicated that suicidal people struggle to see or develop a future perspective. In contrast, a positive future perspective, including the assurance that the emotional pain would be temporary, was identified as a relevant resource to counteract suicidal thoughts.

Participants from Germany reported similar impressions on the role of future perspectives. While one young woman also mentioned that a positive future perspective was an essential resource of motivation for her to cope nurtured from positive memories and experiences in the past, she highlighted that it needs to be realistic. The realism in the future perspective was critical for her motivation to know that times of low mental health and suicidal thoughts might also occur in the future. However, with her effort to cope, she hoped to be rewarded with more positive than negative experiences in the future.

In addition, the active reflection on one's **achievements**, such as academic and positive developments, helped several young adults to be able to see further positive developments and reach their goals in the future. Appreciating one's achievements contributes to higher life satisfaction. Hence, reaching one's goals and collecting accomplishments in life were considered a major coping strategy, as the following quotes indicate:

> *Gratitude plays a big part of my life. Just a pre-shading how far I've already come, um, and all the things I've achieved, everything I have now is everything I actually dreamed*

of 5, 6 years ago when I was feeling really suicidal. And I used to cry myself to sleep because my life was actually that bad. These are all the amazing things that I (-) I wished and hoped for and I managed to get them now. Of course, I still want to go a lot further and a lot higher and, you know, keep striving (.) but always take a moment to sit back and appreciate everything I've been able to achieve. (E6)

So, I think the social circle that I have now has impacted me very, very positively just because if I have a really bad day [...] they are able to sit me down and remind me that actually you've come all this way and the work you're doing now, this is the sort of impact I have on the young people, the next generation, etc. (E7)

Achieving the strengths to cope with trauma and suicidal ideation and realising positive development despite negative past experiences was mentioned as a personal resource for coping by participants from Germany as well. Even small achievements in daily life, such as taking care of bills and appointments, were seen as a success and positively influenced young people's mental health. Purposeful tasks such as taking care of a pet could be identified as a resource for life satisfaction. One young woman reflected on how her keyworker in residential care helped her see her achievements and coping with suicidal thoughts:

[My keyworker] was able to strengthen me in that way. She also showed me the positive side of life. She just brings up the good things. What I did well and everything. What I've already achieved in my life and that it would be too bad to just throw it all away. (D1)

In addition, the importance of professionals in the care system being confident in dealing with problems and contributing to developing the self-confidence that a young person can achieve positive outcomes even in challenging situations was reflected by one young man from Germany:

And I think it's much less likely to happen again in the future, whether it's suicidal thoughts and so on and so forth, if you, um, know that you're somehow protected through this crisis situation as a young person and that there's, um, a plan B for that as well. (D5)

Developing **goals** to motivate oneself can also contribute to successful care outcomes and coping with suicidal thoughts. Important are realistic, reachable goals for a young person. This resource would require the young person to have the motivation to work on reaching their goals and take active steps to achieve better outcomes. Implementing active changes and taking even

small steps were important when developing the **intrinsic motivation** to cope with suicidal ideation. Participants reported having developed a reflection on their individual state and the wish to change for the better at one point. This development often related to the understanding that it is about their actions to implement changes, as shown in the quotes below:

> *I was (-) didn't want to end my life, myself. I kept thinking about it. But then I thought like 'na' like, um, one day (.) one day I look myself in the mirror and kind of tweaked in my head that I didn't want to be like that anymore. That's what I brought myself out. [...] But I kind of looked myself in the mirror and just decided there and then I don't want to be like this anymore. And I started to get better. [...] So, I started doing little things that would make my mood a little bit better but ultimately it was kind of just looking at myself in the mirror. I am just going like 'Na. This isn't for me anymore.'* (E2)

> *When I kind of got myself into a calmer place mentally where I didn't actively want to kill myself that's when I started to think logically and that's when I decided to make the decision I felt like if anyone is gonna fix this it's would be me.* (E6)

This intrinsic motivation to change their current mental state appeared to be a crucial turning point to start coping with suicidal ideation. As described in the quotes above, the time point of when a suicidal young person may develop this motivation may not be possible to predict nor directly influenced by other factors.

However, for some, realising that they were not alone with their problems – as others experienced similar issues – motivated them to improve their situation actively. Their actions following the developed intrinsic motivation included introducing changes to their current life, such as getting out of their room, meeting with others, changing a course at university that the person struggled with, and actively seeking professional help.

The motivation to act against suicidal thoughts appeared to fluctuate and was difficult if active suicidal thoughts occurred again. Some reported having developed an internal cognitive conversation to motivate themselves to stay alive for a bit longer, even just another day (discussed further in section 5.1.5). When having this inner motivational talk, some reminded themselves of their achievements. Coping for those other than for yourself was also mentioned as a helpful thought to motivate yourself against suicidal ideation.

> *Every time [...] I would get stuck in some kind of suicidal thought cycle, I would just kind of tell myself over and over again that like, you know, just because maybe things*

aren't that bad as they seem right now which are probably not because your mind is doing weird things but let's say they are like it won't be as bad forever and if you leave now you won't know what it might be later. It might be really good. You might just have to hang around and walk through some stuff to get there. But like you should stay. (E4)

F*or example, just having little things like saying 'OK, well, you know, my therapist wants me to live, so I'm gonna try and stay. Or, you know, my mum needs me here, so I'll try and stay. Or now I've got a cat in the house it's just like let me stay until I have to feed her tomorrow. Let me stay until my shampoo bottle runs out.' And just finding little things like that rather than it needing to be 'I love myself and I love life and it's worth staying and that's why stay.' I think it's just doing it for other reasons, external reasons, until you get to a point where you feel like 'OK, I want to stay for me and I don't want to engage in those behaviours for me.'*(E7)

One participant also highlighted that sometimes a person would need a meaningful reason of why their life is important to them and others to convince themselves against suicide as a solution, hence, motivating oneself to cope in the moment:

You just find a way to remind yourself that your life is important to something, whether it's to you, to somebody else. (E5)

A purpose in life, such as having a meaningful, satisfying job, was mentioned as an important resource for life satisfaction and motivation for coping. In addition, responsibilities in daily life, such as looking after a pet, could contribute to life satisfaction. Several participants mentioned that they actively used their care experience to help others, for instance, by choosing a specific type of work, and realised that their voices matter to improve (leaving) care practice. For example, one interviewed young woman was involved in participation programmes to help develop and improve the service provision for young people in care and care leavers in their local authority. The following quotes by two participants reflect the positive impact their commitment to their work can have on their attitudes towards life and career perspectives:

I think mostly because even before my job, I've been doing a lot of volunteering for social services then, um, trying to help kinda all the other kinda care leavers. And, um, I think being able to go to trainings for social workers and going to trainings to train foster carers and being able to go to those things and speak about my experiences […] And you know, seeing people starting to understand what these things mean […]. So, I

feel quite lucky that I've been able to turn things around in that sort of sense, and that's really (.) changed my attitude towards life. (E7)

And the career path I chose, that I want to become an educator, is also because I can help other young people in this situation. […] Be it with suicidal thoughts or feeling overwhelmed. […] I think that if I hadn't experienced all that, um, I wouldn't be able to live out my career aspirations the way I do now. (D3)

As mentioned by one person, in some cases, a suicidal young person may not be at that stage to motivate themselves to start coping. She said that only a trusting person could help develop this motivation to start coping, as trust would be an essential factor that the suicidal young person needed to start listening and reflecting on their situation:

If somebody said something that (-) that meant to be helped, if you don't trust them or if you don't believe them, they'll do nothing. There will be no change. There will be no, […] basically like an understanding thing because the [suicidal] person would hear your voice said but they won't actually listen to it and process it […] So, you have to have trust in the person. (E5)

While a trusting relationship mentioned here as a resource to help develop a motivation to start coping, the topic is further discussed in section 5.2.2. In the context of influencing a person's motivation to start coping with suicidal thoughts, **role models and mentors** were identified as relevant external resources. Role models as valued social contacts could contribute to motivating a suicidal young person to make changes and start coping by learning from them and, as described by a young woman below, even becoming more alike:

Trying to find people that are different to you and maybe don't have the same experiences as you or have had them but have actually healed. Um, I think one really good thing to have in mind is that there's one (-) this one quite quote that goes like you are the average of your friends. So, like you become the sort of person that you're friends are and the sort of people that you have around you. So (.) Bring people into your life that you want to be like. Bring people into your life where you (-) you all can kind of grow together and, um, they're the sort of people that, you know, you (-) yeah, you want to be like yourself. (E7)

Social resources such as role models could motivate a young person to set goals, such as settling in life, having a better lifestyle and contributing to higher life satisfaction. Similarly, shared experiences by someone with similar experiences of care and suicidal ideation were considered

to help strengthen a young person's motivation for coping. In addition, mentors, especially peer mentors with backgrounds in the care system, were considered by several participants as highly valuable for care leavers and an option for suicide prevention. The mentors could become engaged in suicide prevention and any other area where care leavers would need support. They would also increase the availability of a young person's support system, as some participants from England mentioned. One young woman from England described the following characteristics of mentors for care leavers:

> *I think another good thing would be to have someone additional on top of the social worker, maybe more so like a buddy or a mentor. […] I think that a range of characteristics would be suitable for a mentor because obviously there would different mentors to see different care leavers. […] the kind of standard should be someone of maybe key working or youth work level. So, had experience with young people […] someone who genuinely cares, maybe some people from similar background, so maybe, ex-care leavers would be suitable for this type of role because, you know, they might have been in the care system 30 years ago, 20 years ago, even 5 years ago, um, but they have that own personal experience […] someone with personal experience that would be quite good.* (E6)

As mentioned by several participants, peer mentors would also need to be secure in themselves and perhaps also supported by professionals in the form of supervision. Due to similar experiences, peer mentors may be able to establish a positive relationship more quickly, promoting talking about suicidal ideation and seeking support. Another young woman from England reflected on her view on the role of peer mentoring among care-experienced young people:

> *So, like older care-experienced people who are mentoring but I think there's (-) there's an enormous amount of value in just getting care-experienced people together to talk and people who are older and have some ways in coping can help the young ones figure that out farther than a new PA whom they have for six months and, you know, until we put a lot of unreasonable expectation on the system and we're not making use of the resource that we have that's probably better.* (E4)

A young man from Germany suggested involving such peer mentors, for example, in prevention programmes in school and care settings. He also proposed that peer mentors could become "emotional translators" (D3) of the young person's needs in communication with professionals. Furthermore, as identified in some reports, mentors with shared experiences may help a young

person to not feel alone with suicidal thoughts and may be able to show ways to cope with such ideation. For instance, a young man from Germany reflected on the role of one of his peer residents in a children's home in helping him develop the motivation to cope with suicidal thoughts:

> *First of all, [a peer resident in the children's home] just showed me that I'm not alone with this [suicidal thoughts]. And on the other hand, he also talked a lot about his time when he was confronted with these thoughts himself. That was also helpful because he somehow found his way out of it, even with psychological help, because he then went to a psychiatric ward, but, um, he also managed to deal with these thoughts. He no longer has any problems [today]. And the fact that he also told [me?] a bit about himself was good.* (D4)

However, it would be important not to force someone in such a position as a peer mentor or role model, as this may overburden the young person and neglect their own needs. The same young man from Germany reported his experience of being pushed into a role-model position for peer residents while being in residential care, contributing to his suicidal ideation. As shown in the quote below, he reported being given too much pressure and responsibility for others in the children's home while putting his needs aside:

> *I couldn't talk about my problems with the care workers in the facility because they often said or I often heard that if someone else had problems, they should stick to me, the young people, because '[D4] is fine. He can do everything.' Although that wasn't true, but at that moment I couldn't say 'No, that's not true, I can't cope with it.' Because then I would have practically forbidden the other young people to help. Although I would have had the right to say 'No. I can't do it. I don't want to. The care workers have to do it.' I just didn't do it.* (D4)

His report shows that adverse effects could emerge if a young person is involuntarily pushed into a 'helping' role, such as being a peer mentor for other young people with care experience. In contrast, as described as purpose in life above, participants who have voluntarily chosen their commitment to supporting others reported positive impacts on their attitude towards life and aspirations. Therefore, people with care experience should only take on such roles voluntarily.

In summary, developing a motivation to get better and learn to cope with suicidal ideation or underlying trauma and seek help appeared to be crucial based on a young person's own decision. Realising their low mental state and that others may face similar issues are considered

helpful resources to develop a motivation to start coping. Furthermore, tackling the stigma against therapy by engaging with mentors with similar experiences could strengthen a young person's motivation to take care of their own needs.

Generally, motivational factors in coping with suicidal ideation showed many similarities between the English and German samples. An optimistic future perspective and goals and gathering more positive experiences contributed to taking action to cope with suicidal thoughts actively. Reflection on their positive development and achievements could contribute positively and strengthen a future perspective. Having someone for support and inspiration – role models or mentors, particularly peer mentors with shared experiences – were considered relevant interpersonal resources that could improve intrinsic motivation. The use of one's own care experiences to help others was identified to give a purpose in life and a resource for life satisfaction.

However, slight differences were found in the reflection on peer mentoring options. While both groups generally reflected positively on peers as mentors and a resource to develop intrinsic motivation and coping with suicidal thoughts, participants from England highlighted that mentors need to be emotionally stable and secure. As reported by a young man from Germany, while being a peer mentor would be beneficial for others, being involuntarily pushed into this role as a mentor may result in young people overburdening themselves and neglecting personal mental health needs, and contributing to the developing of suicidal thoughts. Another minor difference was found in the reflection on how several young people from England developed an internal motivational conversation to cope in small steps against acute suicidal intentions. Such reflections were rather limited in the German interviews, but one young woman reported a similar intrinsic talk by using positive memories and messages to strengthen her future perspective.

Overall, developing an internal motivation to deal with suicidal ideation appears to be the crucial turning point between suicidal ideation and starting to cope. As described, interpersonal factors such as role models and mentors can contribute to this motivation to cope, for instance, by feeling understood and creating hope with shared experiences and showing ways to cope.

5.1.5 Self-care

The topic of self-care practices reflects a young person's ability to cope with suicidal ideation. This theme included the following codes:

- self-management skills,
- reflection of the situation and self-reflection,
- positive attitude and experiences,
- living in the moment,
- healthy relationships and boundaries, and
- distraction and activities.

Care-experienced young adults from both countries described having developed different strategies to manage their emotions and help cope with and prevent suicidal ideation. Participants from England described daily **self-management strategies**. To those strategies belong taking small steps in becoming active in everyday life again after suicidal and depressive periods, such as going out for food shopping and keeping their place clean or distracting themselves from their worries. In addition, identified self-management skills contained managing stressful interpersonal contacts by staying calm, writing down their thoughts, and educating themselves on specific coping strategies that help deal with overwhelming emotions. It was mentioned that the transition from care appeared to be difficult for some due to the lack of self-management skills in how to live independently.

Part of the mentioned skills included the ability to show **self-awareness and reflection on a situation** objectively. The reflection also includes how suicidal behaviour would affect others and what a person was reacting to as a rationale for the suicidal thoughts. Participants considered it helpful to think that a situation can change for the better to deal with active suicidal ideation. Furthermore, the thought of 'not being alone with my problems' by learning that others have similar experiences helped the participants to cope and calm down. Therefore, a young woman from England recommended that professionals could support a suicidal young person by helping to create a distance from their suicidal thoughts.

> *If I would be the professional [...] I would also help them understand that pain is temporary, um, and that's OK. And to try and help them, um, see their thoughts as not, well (-) I supposed, this is where my religious life that I'm living which I would identify with as a professional, but kinda seeing these thoughts as not your own thoughts and just acknowledge them and see them, creating a bit of a distance (-) so acknowledge that they are there, but don't see them as yours, don't try and fight them.* (E1)

Care leavers from Germany reported similar experiences regarding self-management skills and self-reflection. They developed specific self-management skills, including the use of so-called

therapeutic ‘skill boxes’ that contained physical resources to deal with stress, self-harming desires and suicidal intentions at the moment. In addition, self-education for self-management and a clear daily structure helped avoid accumulating problems and get tasks done. For example, taking care of bills and other bureaucratic tasks was part of the self-management of a care leaver who lived in privately rented flats. One person from Germany highlighted that the most helpful therapeutic advice to deal with his suicidal ideation was to focus on himself and take care of his own needs:

> *And in the end, what helped me the most was that she [psychotherapist] simply said ‘[D4], you just have to think selfishly. If you get into these thought cycles again, and you can’t get out of them, then you have to talk to someone somehow. And then it doesn’t matter whether the person you want to talk to at that moment has time, wants to or whatever. Then you have to be selfish and just say, eh, ‘No, you have to talk to me now!’ Then you talk to them.’ Just be selfish. And that was actually what helped me the most. It might sound a bit stupid, but that ‘[D4], think selfish!’ helped me the most.* (D4)

Taking care of one’s own needs is part of self-awareness, as are the ability to reflect on a stressful situation and the reaction to it in an objective way to cope with problems and act quickly to stop depleting one’s mental health. A young woman from Germany described her self-management skills to prevent and cope with suicidal ideation as follows:

> *So, when I notice that (-) OK, things are slowly going downhill, I look for a contact person, a psychologist.* (D1)

As reported by several participants, **positive memories, experiences and attitudes**, including humour, would contribute to coping and preventing suicidal ideation. Some interviewed people used photos and letters to help them remind of positive experiences, as they might find it difficult to remember those when feeling actively suicidal. Those could or should also be actively taken together with professional support, as some professionals in the care system play major roles in a young person’s life. Such memories, such as photos and art projects, could be particularly important when the person leaves care or the service. A young woman from England described the role physical sources to remember positive experiences with key workers can play for a young person after having left care or the service:

> *They’re usually very worried about being professionals and professional boundaries. So, like you don’t really get to take a lot of like selfies or just pictures in general that you can hold on to. So, often like when the case does come to (-) to an end like you’re*

left with nothing. So, the personal advisor leaves. You have no pictures. You have no physical things that you can hold on to. So, it's just (-) it all disappears. And it's if like, you know, it never happens. So, to be really confusing for a lot of people, especially because memories are so much impacted by the emotions that you experience. […] I was just […] trying to get them to […] take more pictures with the young people. (E7)

One woman from England explained that she learnt to focus on positive experiences, which helped her cope and maintain good mental health.

So, at times where I wanna feel good and I (-) I wanna, um (.) improve my situation I simply adjust my thoughts to more positive things. You know, I don't put negative things out in the open and I only talk about past experience when I talk about negative things. [...] And it might not be immediately but, um, words are very powerful (.) 'cause I think there might be of mental health and stuff just by someone saying the wrong things to me that could instant trigger me to feel suicidal or, you know, um, feel bad with myself. […] Just staying positive! […] don't label the negatives! Find the positives! And I feel like that's really, really helps me. (E6)

Furthermore, of particular importance was the forming and maintaining **healthy boundaries**, particularly for those who experienced abuse or other experiences crossing their boundaries. Being able to say "no" and distance oneself from negative, abusive relationships helped to cope with suicidal ideation, as one woman from England described:

Even compared to sort of three years ago I have much, much healthier relationships now. I've got much healthier boundaries. I think, I've just been through enough stuff that when somebody start treat me badly I go 'No, I have that stuff. Go away!' I cannot just (-) I'm just not wanting to tolerate this anymore 'Go away!' Um. Which makes obviously makes enormous difference if you're not tolerating somebody being (.) abusive towards you, you're just going to be healthier and better for it. (E4)

In addition, actively using **distraction** to cope with suicidal ideation in the moment was something several participants highlighted as a way of managing lonely situations in which suicidal thoughts become more prominent. One woman described "**living in the moment**" (E3) as a distraction from her suicidal thoughts while avoiding thinking about the future. Focusing on the present, if not having a positive future perspective, may be a helpful resource for some young people to distract themselves from and cope with suicidal ideation in the moment. Furthermore, being active and staying busy with pursuits such as sports, work or hobbies were

considered valuable resources for coping. Therefore, one young man from England called for staff in semi-independent accommodation and social workers to motivate each care leaver to get out and do some activities together. Participants from Germany also reflected that living in group-based residential care helped structure a young person's day and strengthened a community feeling within the children's home that further was related to a positive sense of belongingness (see section 5.2.2). The community feeling and daily structure in residential care were considered helpful resources contributing to the care-experienced young people's mental health and distracting them from suicidal thoughts.

In summary, self-management skills, self-care of their own needs and positive attitudes were described as essential resources to deal with suicidal ideation and contribute to positive mental health. Links to the role of the care setting, for instance, residential care or professionals contributing to developing or offering such resources, were reflected. Many overlaps and similarities were found in both groups and all young adults. There were no significant differences or deviant cases found across both groups. Therefore, such resources and management skills are relevant across borders.

5.1.6 Summary

The experiences of suicidal ideation were diverse across the whole sample and demonstrated the complexity of the experiences themselves. While self-perception, control and overwhelming experiences especially appeared to have triggered suicidal ideation, intrapersonal aspects of intrinsic motivation and, therefore, practising self-care could counter these cognitions and emotions.

Care-experienced young people's self-perception of their negative impact on the lives of beloved others was common and further triggering self-blame, which seems relevant for influencing suicidal thoughts. The intrinsic motivation to change their situation and mental state appears to be the crucial turning point in initiating a coping process. Role models and mentors can promote motivational factors to start coping on an interpersonal level. Hence, intra- and interpersonal aspects of suicidal ideation among care-experienced young people should be considered closely interconnected.

5.2 Interpersonal level

The interpersonal level covers social experiences in the context of suicidal ideation. Three interpersonal themes were identified from the interview data. These cover relationships, communication, and traumatic events with an interpersonal connection. Links to individual and structural levels are present and discussed later.

5.2.1 Interpersonal critical or traumatic events

All interview participants were asked about their views of what caused their suicidal ideation either the first time or at different time points. Based on previous publications about trauma triggering suicidal ideation, the interview data were also explored to find whether participants would report traumatic events that they viewed as a direct cause of their suicidal ideation. For instance, childhood traumas are common among the group of care-experienced people, as most children enter the care system in England due to childhood adversities such as abuse and neglect (Gupta, 2016).

Due to the sensitivity of this theme, follow-up questions on reported trauma were not prompted to avoid the risk of causing distress or even the retraumatisation of a participant. To give participants opportunities to elaborate further on such events if they wished to do so, further general questions about the time of the occurrence of suicidal thoughts and perceived causes were asked. Ten participants mentioned traumatic events. The analysis showed that the reported traumatic or critical events were interpersonal experiences that are covered by the following codes:

- intra-familial abuse,
- extra-familial abuse,
- loss of a beloved person,
- witness or threat of suicidal behaviour by others, and
- harassment and bullying.

While none of the participants from England reported extra-familial abuse as a perceived cause of their suicidal ideation, three young adults reported **intra-familial abuse** that was sexual or emotional if the type of abuse was specified (one person talked only about ‘abuse’ where it remained unclear whether it was the previously mentioned emotional abuse or another type). A further participant mentioned several possible perceived causes of suicidal ideation, including

physical abuse as “beating as a child” (E5). However, it was not clear whether she experienced the described violence herself.

Intra-familial perpetrators were parents or extended family members, including kinship carers as reported by participants from England and partners of a parent as mentioned among the group from Germany. One woman from England explained that she developed her first suicidal ideation because of experiencing intra-familial trauma. She further described that her suicidal thoughts at that time were based on the desire to escape from the experienced abuse:

> Interviewer: *[…] At what age did this really start? […] that you don’t want to live anymore.*
>
> E1: *[…] definitely when I was around 11. […] because, um, the reason being, […] I had been sexually assaulted by family members. Um, and when I was 11 I vividly remember it, um, my dad had sexually assaulted me and I vividly remember like just not wanting to be here anymore which is like I […] wanted to eject myself from life because I was in a situation I couldn’t get out of. So, yeah, from a quite young age.*

Another participant from England reported, “a very toxic, emotionally abusive home” (E7) related to her mother’s severe mental health issues. The young woman mentioned that she developed her first passive suicidal thoughts before social services discovered the emotional abuse and she entered care:

> Interviewer: *When was the first time you really experienced suicidal thoughts that concrete in a way? How old have you been then?*
>
> E7: *Well, […] that’s difficult to say just because I feel like looking at suicidal ideation generally, I feel like it probably started when I was about 9. 9 or 10 probably. Um, just because that was before people kind of discovered that things were going wrong at home.*

Another woman from England highlighted, as discussed in section 5.1.1, that she only became aware in her early adulthood that she was abused as a child. She reported that she developed passive suicidal thoughts when she started internalising the abuse during her pre-adolescence but developed active suicide thoughts inter alia later in life when she realised that she was abused during her childhood.

Four participants from Germany reported intra- or extra-familial traumatic experiences as a cause of their suicidal ideation. While two reported family-internal abuse, including sexual

abuse and emotional neglect, the other two reported sexual **extra-familial abuse**. One participant reported threats by his abuser to hide the abuse that further contributed to the development of suicidal thoughts, as described below:

> *[The abuse] was connected with a lot of psychological pressure, because [...] [the abuser said] that it would somehow break up my family or he would do something to my [sibling] if [the abuse] came out. Yes, that was very difficult, so that my school performance decreased. I was very depressed all of a sudden, because before that I was always a relatively normal child, and then I put on a lot of weight. […] when [the abuse] got worse and I had the feeling that I couldn't talk to anyone about it, and that my own boundaries were being crossed. Of course, I couldn't put it that way at the time, but it definitely led to me somehow rejecting myself […] and that definitely led to the first, I think, suicidal thoughts in my life.* (D5)

His report presents that not only the impact of experienced abuse itself affected the young person's self-image but that along with the abuse, further psychological pressure to protect the young person's family caused the development of his suicidal ideation for the first time. This case draws connections between abuse as an interpersonal traumatic event, family relationships, restrictions in communication to reach out for support, and the impact on the individual level.

One contrasting report by a young woman from Germany mentioned experiencing emotional abuse by her father's new partner as a reason for entering care at age 15. However, she clearly stated that she did not perceive this experience of emotional abuse as a cause or contribution to the development of her suicidal ideation at age 14. The early death of her mother and her struggle to cope with it was the solely perceived cause of her developing suicidal ideation as a teenager.

Similarly, as the young woman from Germany highlighted the impact of the early death of her mother, others also drew links to the **loss of a beloved person** and the development of suicidal ideation. However, not all of them mentioned their loss as an immediate trigger. Some noted this experience in line with multiple critical events in their lives accumulating and causing them to develop suicidal thoughts. A young man from Germany answered the following when he was asked to talk about the time when he first experienced suicidal thoughts.

> *Among other things, I still couldn't come to terms with my grandmother's death. She had died a few years before, but at the time when I was still living here [parents' home], she was the only anchor point I had in the family. And I still couldn't come to terms with*

the death, even though it was years ago. And there were still a lot of other things. Then I was also under pressure at the vocational school because I had problems (deep breath) with a few people. Then because of my other problems, which I also have. Um. At some point, the whole thing got on top of me. (D4)

One person from England mentioned that, apart from the experience of childhood abuse, multiple factors contributed to the development of active suicidal thoughts later in life. Among those factors, she mentioned that her mentally ill mother **threatened suicide**.

My mum is very severely mentally ill. Um. And she was just messaging me all the time threatening to kill herself. Um. So, that requires strain on top of everything else. (E4)

Two further participants from both countries mentioned the exposure to **witnessing suicide behaviour** or receiving an offer by a friend to attempt suicide together as a critical adverse event influencing their suicidal experiences. Apart from being bullied in school and sexually abused by a parent's partner, one young woman from Germany mentioned the following when she was asked about further reasons for her suicidal thoughts, reflecting the cognitive and emotional impact of such events:

Then another friend came and said, 'Come on, [D1], I'll come [around?] tomorrow and we'll kill ourselves together.' (.) Yes. And that wasn't so nice. (.) And then quite often, I had to stop friends from committing suicide by calling them and everything. (pause) And I caught one of them live in the clinic. (.) And that's still on my mind. (D1)

Furthermore, three participants reported **bullying** in school or the work environment that as contributing to the development of suicidal thoughts. The young woman from Germany cited in the last quote above reported being bullied by schoolmates, including receiving death threats. Among other perceived causes, one young man from Germany reported problems with schoolmates that involved false rumours and his social exclusion at school. A young man from England linked the experience of emotional and verbal harassment from colleagues to the further development of depression and suicidal ideation and prolonged experience and, thus, delayed recovery.

I was getting comments from people that did like do it basically mocking me off saying that I was a failure, that I was dropped out when I left. And that didn't make it better. (.) Yeah, I just felt like I let everyone down when I left. [...] I got a lot of harassment from the people that were in my platoon while they were in the military when I left. They still had me on social media and they were constantly sending me videos harassing me.

> *Taking the piss out of me practically when I left. Mocking me. Sending me videos and mocking me which made me feel even worse. [...] contacted the police at one point because the harassment was getting that bad.* (E2)

Several aspects added up to the development and retention of suicidal ideation in his case. The depressive thoughts of being a failure about his decision to leave his work were upheld by his bullies. He also mentioned the risk of cyberbullying that continued after direct contact with the perpetrators ceased.

Ten participants reported traumatic events as at least one cause of the development of suicidal ideation. Only three interviews were not coded under this theme, which does not exclude the possibility that they may have experienced a traumatic event but did not report it as a perceived cause during the interview.

In conclusion, many young adults linked their own experiences of traumatic interpersonal events such as abuse, violence or the loss of a beloved person to the development of suicidal ideation. In several cases, participants perceived the experienced traumatic events as one among multiple causes of their suicidal ideation. In at least six cases, the care experience was in some way linked with critical interpersonal experiences before entering the care system itself. However, as highlighted by a young woman from Germany only, not all experienced interpersonal critical or traumatic events such as intra-familial abuse that may be viewed as influencing the development of a young person's suicidal ideation. This finding may be especially important for professionals to be cautious in drawing links between critical childhood experiences of abuse and suicidal ideation without consulting the suicidal young person.

5.2.2 Social connection

A fundamental, striking theme identified from the interviews is 'social connection'. It covers important relationships and social factors relevant to developing, coping or preventing suicidal ideation among care-experienced young people and adults. This theme contains nine codes:

- the feeling of belongingness,
- loneliness and social company,
- professional relationships,
- trust,
- family relationships,

- alternative relationships (such as romantic partners),
- love and caring for others,
- peer relationships, and
- feeling understood.

The codes above are presented in four sections to structure and highlight the multiple facets of this theme, including different types of relationships, in the context of suicidal ideation and care experience.

Belongingness and loneliness

The theoretical foundation of the IPTS informed the topic about the feeling of **belongingness**. On the one hand, based on the Interpersonal Needs Questionnaire (INQ), this code covers positive perceptions of belongingness such as feeling to belong to and be connected with others and being in contact with supportive, caring people who show genuine interest, taking the young person's needs and wishes seriously, and to whom they could reach out for help. On the other hand, negative perceptions contain a feeling of missing or thwarted belongingness, as if people do not care about the person, the person is disconnected or excluded, and they lack supportive relationships. Joiner et al. (2012) included loneliness in the definition of the IPTS factor thwarted belongingness. As loneliness, including feeling left alone and being alone physically, was identified as a prominent aspect in the reflection of the young adults' care experience, this factor was extracted as a separate code. However, loneliness is still considered to be closely connected to the code 'feeling of belongingness'. Belongingness was the most prominent code and runs like a common thread through all other codes.

Belongingness among the care-experienced population has been covered in previous research as an essential aspect of young people's lives (Ehlke, 2020; Schofield, 2002; Sulimani-Aidan et al., 2021). Interviewed young adults, predominantly from England, mentioned experiences of a lack of belongingness. Negative experiences of belongingness with either the lack of feeling connected to or the exclusion from others came up in several interviews in the context of the development of suicidal ideation.

Two women from England reported how the transition from care to university affected their social connectedness and well-being and contributed to suicidal experiences. One of them said how the transition affected her well-being because, simultaneously, the contact with previous

attachment figures from school ceased, she had to leave the place where she felt at home and shortly after was excluded by her roommates at university:

> *So, I think a lot of the issue I had going through care was I had a lot of attachment issues. So, I really attached to my teachers at school. Massively. They were like my role model, you know, they were, um, I like them, they were like family. They were my consistency throughout. [...] And then she [teacher] moved me to university and there was the massive thing at school about boundaries with students and she cut contact with me […]*
>
> *I hated it because I loved [an elderly woman at supported accommodation] in [county A]. That was my home. And I felt like I worked my whole life to finally move there and I was only there for 9 months before I then, or 10 months, before I then, OK, now I am going to university, so, and leaving the people finally are in the same county as. […]*
>
> *[The situation with roommates] was awful. It was awful. I was like I just don't want to be here, I leave uni. Um, should I like, um, move out into a different flat like I am not wanted here. Like, I felt very rejected and I felt rejected my whole life.* (E1)

The other young woman felt alienated and as if she did not fit in with her peers at university while simultaneously experiencing exclusion from previous friends from colleges after entering university when she started having active suicidal thoughts (see section 5.1.1). In this context, she experienced both thwarted belongingness from the group of previous friends and the struggle to connect with new people. Notably, as she indicated, her care experience hindered her from feeling like she belonged with others at university.

> *I supposed when [the support by my foster carer] went away (.) and it was just me on my own in halls with all these weird people who came from all these backgrounds that like didn't really make sense to me. [...] And I think it was just (.) a lot of it is a lack of support (.) is that I was just out on my own in the world and it felt like a lot. And it was really hard to (.) it was really hard to connect with people and make new friends. […] And then when I've actually gone to uni (.) […] I would try and meet up with [my old friends at college] and it was just like I didn't get invited to anything anymore. […] But I think, because I was 20 minutes on the train rather than down the road, people didn't think of me. So, I think, a lot of my old friendships went away. And then I just struggled to make new ones. Um. I find it really hard to connect with people.* (E4)

A sudden cut of support when leaving care was reported as causing the feeling that nobody cared, a state which is related to the factor of thwarted belongingness. For example, one young woman from England described her experiences when she left care.

> *So, it's not just that social services changed, mental health services and therapy like I was going to for years stopped because I turned 18 […] And the social worker b(-), you know, I had before in the child-in-care team that I got on with really well, you know, suddenly she's not answering my calls anymore. She's not, you know (-) she's not (.) um, responding to me, trying to reach out to her because I'm not in her team anymore and kinda not (-) not having this just one person that I know really well that I can rely on. Um. I think that was the most difficult thing because at that point it was just like OK, well, literally no one's going to notice if I'm not around. [...] So, it's just like 'Well, if I do disappear, something does happen to me like people don't care. People don't notice. Like, you know, I'm struggling right now and I'm trying to reach out to people and they're not taking it as seriously as I (-) as I want them to.' So, it's just I think (-) it was just so painful at that time.* (E7)

Further suicide attempts could be triggered when support is cut suddenly, causing the feeling of abandonment, such as when a leaving care team closes a care leaver's case at short notice. The young woman further elaborated on the effects of closing cases abruptly:

> *If [care leavers] feel like that, you know, for example, they're being in their minds abandoned by the service […] they'd being to let go because they're doing really well. What often happens is that they'll go back to those behaviours. And, you know, say that 'OK, well, you're leaving me because I'm not an emergency. Let myself turn into an emergency.' Um. And that's something that you do see a lot across the service and that's both difficult for the young person but also for the personal advisor. […] I think suicidal ideation comes in quite, you know, significantly when you get to a point where you feel like you're really lonely and you're very isolated and you feel like people don't care. And, you know, if someone just comes to offer working with you for a couple of years and you've been really, really close and they suddenly go actually next (-) from next week on, you know, 'I'm not going to be your worker anymore' and it all just, you know, out of nowhere goes away it feels like, OK, well, maybe one of those (-) all the time you've spent together it's just (-) you know, 'You're just here because of your job. You're just doing it because you're paid to do it. And you don't really fully care.'* (E7)

As the young woman described, a chain of factors contributed to suicidal ideation and behaviour at times of thwarted belongingness due to ceased support. Thwarted belongingness seemed closely connected with multiple factors, including loneliness and abandonment.

In addition, a lack of belongingness may be caused by the inconsistency of care placements and relationships. One young adult mentioned that she felt she did not fit in throughout her life. She further reflected on the shared experience among foster children of often feeling alienated and not belonging to a foster family. Some children in care may, therefore, prevent themselves from getting emotionally attached to people as a protection mechanism.

> *So, I'd talked to a lot of foster children. […] I don't know that many of them who had stayed in a foster home for longer than a few years and that has an effect on somebody when that kind of thing happens it (-) […] it almost becomes easier to move to the next place because your brain tries to protect you and therefore stops you from being (-) being emotionally connect people. Um, trying to stop you from, um (.) from being hurt.* (E5)

Similar to the reports from England, feeling that nobody cares, notices or understands the young person's needs, feeling different to others, being excluded or being alone with one's problems without support were experiences mentioned in all German interviews in connection to triggering suicidal ideation. One young man highlighted that the ignorance of residential care workers when he tried to reach out for support for his mental health issues was the final trigger to develop suicidal thoughts while he was in care, as he felt that nobody cared.

> *And these suicidal thoughts really started when I was living in the children's home and, at some point, I just realised that nobody was interested, they just wanted me to function and they didn't give a shit about the rest. Um. I also often had the feeling that the facility got a lot of money for me, because [the residential group] is basically a facility that has a high standard and accordingly gets a lot of money from the youth welfare offices for a young person. They also got a lot of money for me, but they had almost no work from me. So, it was easy money. And they also liked to give me that feeling.* (D4)

Though this person considered multiple factors coming together contributing to his development of suicidal ideation, the final trigger was the feeling that no one even within the professional care system cared about him. Furthermore, he perceived himself as being exploited for the care providers' financial benefit without receiving the service he needed.

Loneliness seemed closely connected to a missing feeling of belongingness. For instance, the feeling of having no one to talk to resulted when professionals in the care system ignored or did not recognise the young person's problems. Particularly perceived as a vicious circle that may further contribute to feeling lonely, several interviewed people reported distancing themselves from others when being suicidal. Loneliness and being alone were crucial factors identified as triggering or focusing on suicidal ideation.

> *So, I don't necessarily, um, believe that it's the leaving care that's the problem it's the effects of, um, the things surrounding leaving care that's the problem: the loneliness, the, um, having to learn new things that you (-) you haven't even heard of before like taxes.* (E5)

Several participants from both countries echoed the critical experience of loneliness when leaving care. Participants mentioned that the living environment after leaving care with living alone and the lack of distraction let them focus on their problems and past experiences, and triggered suicidal ideation. The following quotes by two participants from Germany described the changes in their environment when leaving care to a quiet and lonely place as influencing their suicidal thoughts at that time of transition:

> *So, there was no one to distract me at that moment. And that was already a disadvantage, that I was sitting alone in my flat and no one could distract me just by being there. That was actually the main disadvantage, because I got into these circles of thought more and more often and couldn't get out of them so quickly. [...] because the environment also became quieter. It got quieter around me and then the thoughts got louder and louder over time.* (D4)

> *The suicidal thoughts, that's a good question. I think I really started having them when I was in supported individual accommodation. (.) Because of course it was also an upheaval, no?! Before, I lived with 7 people under one roof, in a shared flat, and shared meals, and then all of a sudden, I was completely alone. [...] That was just really hard.* (D6)

Following the last quote, the young woman from Germany further described the impact of loneliness and IPTS factors in the transition from care. She mentioned that she experienced perceived burdensomeness that caused her to feel not understood and she self-harmed before leaving care. When she moved into supported accommodation and lived alone, she reported feeling lonely. She indicated that these factors together contributed to her first suicidal thoughts.

Crucial times were mainly when a young person left care and could not reach out to their support networks during out-of-office hours or public holidays. The limited options to reach out for support related to feeling lonely were especially reported by several participants from England. One young woman from England described one of her suicidal experiences during Christmas when she lived in temporary accommodation as a care leaver:

> *So, all I remember is on like Christmas Day just being completely lonely. You're not having, you know, any WiFi anything, can't reach out to anyone. I'm lying in my bed. […] [PA]'s not working on Christmas Day and she's not, you know, working around that time and holidays and that sort of stuff. So, um, I wouldn't have been able to reach out to her or even if I did she'd get back to me like 2 weeks later because, you know, it's the holidays and I wouldn't expect her to respond to me on like Christmas Day or anything. So, it's just (.) services would be closed anyway. So, it's a very isolating time, I think.* (E7)

Many reflected that social company, compared to being alone, helped them distract themselves from their problems and suicidal thoughts. However, one person who also perceived this advantage of having social company reflected that loneliness could nevertheless remain despite having company.

> *Having company doesn't mean that you can't feel alone. And, that has been a big, a very big issue.* (D3)

The social company in residential care could play a crucial role in the feeling of belongingness, as discussed by several participants from Germany. On the one hand, difficulties connecting with people in the children's home or being used to having many people around while living in residential care compared to leaving care resulted in missing company and feeling lonely. This experience was often connected to the leaving care process and thwarted belongingness. Particularly, the feeling of being kicked out of care seemed linked to the sense of abandonment that one woman from Germany described resulted in long-lasting mental health impacts. On the other hand, several people reflected that the community feeling within the care home was important, and joint activities contributed to a positive sense of belongingness with other residents. One young man from Germany described the positive impact of group-based residential care on his mental health and coping with suicidal thoughts, indicating the feeling of belongingness as follows:

And all the people [in children's home] kind of wanted to take care of it [me], even though I actually behaved pretty shitty maybe. That always helped in any case. So that it wasn't so much exclusion or, um, (..) Maybe it just helped that there were other young people who also had the same problems, to some extent. (D5)

Important resources helping to cope with suicidal experiences identified were positive experiences of belongingness when feeling cared for and having suicidal thoughts or mental health issues acknowledged by family members, carers, peers or friends. Feeling cared about by others, such as a foster carer, positively contributed to a young person's well-being. Some stated that they wished for "motherly support" (E3), as one woman from England called it, and the feeling of home was essential to their mental well-being and coping with suicidal ideation. A young woman from England described her desire to feel cared for when she was suicidal as follows:

And I just wished that there was someone there to explain that everything was gonna be OK. I think just having a bit of not support from a professional or friends, but like a motherly support. Just someone to take care of you and say 'Everything is gonna be OK.' And I think that's what hurt me the most is just not having that there, um, and just being left alone to deal with things. (E3)

The findings show that the feeling of belongingness is diverse. Thwarted belongingness and loneliness were perceived as important contributing factors for developing suicidal thoughts as proximate or underlying conditions. However, positive feelings of belongingness and social company were identified as resources to prevent or cope with suicidal ideation.

Professional relationships and trust

The **relationship with professionals** was identified as an important factor contributing to a lack of belongingness and, thus, suicidal ideation or young people feeling supported. Many young people from England reported negative relationships with their social workers characterized by either a lack of trust, emotional distance or ignorance. One person explained that she felt that she was scared of social workers:

I didn't have a clue who [my social workers] were, what they did. They didn't actually tell me about any support that was offer[ed] in the care system. […] I was quite scared of them. I didn't want to go near them. […] it's like kinda like the police, you know, and you just don't want to go to the police and (-) all if, for example, you're on probation

and you have to attend probation in order not to, you know, get arrested. That's what it felt like to me that the care system was that I had to do it. I didn't feel that they were supportive. (E3)

While in care or after having left care, the feeling of being noticed, cared for and recognised by professionals appeared prominent in the interview data. A young woman from Germany talked about her key workers' lack of recognition and genuine interest when she lived in supported accommodation, which contributed to her suicidal thoughts.

Interviewer: *Was there something you really missed at that time when you had acute suicidal thoughts?*

D6: *Yes, this feeling of being noticed. So, no matter whether in care or in private, I just had the feeling that my (.) um, key worker in supported living, she just (.) came over to my flat once a month at the most, [...] and then she always only (-) let me in for a very short time. It was a quarter of an hour, half an hour at most. [...] And then she gave me my money, she got my signature, then she asked me briefly how my training was going and that was it. Just like that (.) Show some serious interest in me and not just in my performance.*

Often professionals were seen as ignoring signs of suicidal ideation among young people in care or not able to understand a young person's position. For instance, a young man from Germany highlighted that both in care and psychiatry, the focus on support was always only on behavioural problems instead of exploring underlying factors such as his experienced trauma of abuse. Because professionals did not look at the core of his behavioural issues, he felt not understood, which contributed to his suicidal thoughts.

But I still hadn't talked about the actual problem, more or less, so I was always kind of on the outside. And that always led to the fact that my behaviour was perhaps not well understood, neither by my parents, nor by my friends, nor even by doctors and therapists. Um. And this lack of understanding has somehow also led to me feeling that life is not worth living. (D5)

Furthermore, participants highlighted the importance of showing a young person that professionals take signs of mental health distress and suicidal ideation seriously, acknowledge the mental health state and needs of the young person, and check up on them regularly. Some reported that professionals such as key workers claimed that the young people's self-harming and expression of suicidal ideation were only attention-seeking behaviour. The two young

women from Germany below indicated that they felt they were not being taken seriously, affecting their relationship with the involved professionals.

> *Well, first of all, in general, I would have hoped that mental health would also be taken seriously and noticed. [...] I would have hoped that [care workers] would have asked about it sooner, because they had already (-) noticed that I had self-harmed and so on, but they simply didn't react to it and didn't respond to it at all, and they just let it go on.* (D6)

> *In any case, you have to take the problems seriously and not smile about them, because there are people who laugh them off. They say it's just attention-seeking. […] Well, not from my time in a shared flat, but from supported living. [...] The key worker really smiled it off. She said that it was all just attention-seeking. [...] She really smiled it off.* (D1)

Such experiences contributed to the impacted professional relationship and the feeling of not being understood by professionals in the care system. One young man reflected on his avoidance of forming a helpful relationship with professionals while he was in care as a teenager:

> *Well, now, when I think back to how I was, it would have been very difficult for [care workers] to teach me anything, because I simply didn't want to listen. I didn't want them to help me. And finding access to me was simply not possible for them.* (D3)

Several participants from Germany mentioned that the relationship with a professional in the care system, particularly in residential care, was sometimes impacted if they feared a lack of confidentiality. If a person doubted confidentiality in handling disclosure of suicidal ideation among the whole residential care setting – including among staff members and residents or if there had been a breach of confidentiality by professionals – the person was reluctant to reach out for support. One young woman highlighted the importance of trustworthy relationships:

> *I find it especially in relation to suicidal thoughts, depression, self-harming behaviour, it is SO important, trust is so important in so many, um (-) in so many areas of youth welfare.* (D6)

Trust was mainly mentioned concerning professional relationships with social workers or carers. Two participants reflected on the difficulties among foster children to trust professionals generally. The importance of having a trustful relationship with a social worker, PA or carer became apparent in the interviews. Trust would be the key to listening and reaching out to them

for support, which is crucial for those experiencing suicidal ideation. Structural problems with forming trustful relationships with professionals in the care system, particularly social workers, included the inconsistency due to frequent changes of key workers and their unavailability and limited time with a young person. This fluctuation would hinder a young person's effort to form a trustful relationship if they had already experienced several changes. However, one young woman compared her experiences with the reports of her friend who also has been in care and highlighted that professionals could actively work on building trust by going the extra mile for a young person.

> *And [my friend] has always said that, you know, her social worker was amazing. She was like overstep boundaries and, you know, done stuff which she shouldn't have done but it was that that was really important. And she was always stayed by her. She was able to trust her. So, I (-) well, I didn't have that with my social worker.* (E1)

Another factor contributing to a supportive professional relationship was honesty and transparency towards the young people in care and leaving care. Trustful, understanding and authentic professional relationships were crucial for professionals offering and young people reaching out for support to cope with suicidal experiences. The professional relationship was perceived as helpful when young people felt that professionals genuinely cared due to regular check-ups, going the extra mile to support them and having a respectful, trusting relationship.

One-to-one activities with key workers could also establish those trustful relationships between professionals and young people to form relationships and establish a foundation to talk about sensitive topics such as mental health. A recommendation was to give a young person a choice of support to identify professionals in the care setting, if or when starting therapy, to whom they would feel more comfortable trusting and opening up. Therefore, one woman from Germany considered the key worker concept helpful as it provides transparency on who to turn to for support. However, the lack of trust in the care professionals limits their general possibilities of getting young people to engage in suicide prevention work or reach out for support within the residential care setting.

Relationships with family and partners

The feeling of (thwarted) belongingness was also identified in reports about **family relationships**. The loss of a beloved person and attachment figure as a traumatic event relates

to lost belongingness, reflected by one young woman from Germany who perceived the early death of her mother as the single factor contributing to her experience of suicidal ideation.

> Interviewer: *You had also already said that it was connected to the death of your mother. […] What do you see as the trigger for these suicidal thoughts?*
>
> D2: *Well, I was out a lot with my mum at that time and I was actually more attached to my mum than to my dad because my dad was actually just working.*

Her attachment to her late mother reflected her intense feeling of belongingness to her. In line with reports by others, the loss of an attachment figure due to death or transitions during their early lives, from childhood to early adulthood, was repeatedly referred to as a factor contributing to the development or intensification of suicidal ideation.

A young man from Germany reported a further case of the impact of belongingness in family relationships. He reflected on his experience of missing belongingness within his family. He perceived his feeling of being the "black sheep" (D3) of his family as the underlying cause of his suicidal thoughts. This perception was linked to him pressuring himself to hide problems towards his family, causing more problems and feeling overwhelmed. He described his perception of thwarted belongingness as follows:

> *I was always the black sheep of the family. I have very (-) I have ADHD. I used to be very hyper. I was also very (-) stupid. I always broke everything or hurt myself. And my (.) my environment, my mother and father are also separated, but my environment was always, um, I have to achieve something. So, I never (-) had any kind of connection to the fact that I wanted to do that.* (D3)

However, in early adulthood, he indicated his feeling of belongingness due to the caring support he received from his mother when he felt suicidal:

> *And my mother is very, very caring with (-) for the things she has in mind. I lived in [town B], was close to my mother, visited her a lot and she gave me a lot of (.) good (-) good feeling. Again and again through being a mother, she just gave me a lot of (-) positive feelings and that helped me to get out of my thoughts. So, I often thought about myself and when such thoughts came up, I dismissed them relatively quickly because I knew that I could always rely on my mum. And if everything was going down the drain, I knew I could talk to her about the situation before I would choose suicide to solve my problems.* (D3)

Another young man reported that the separation from a **romantic partner** triggered his last active suicidal episode in early adulthood after having experienced suicidal ideation from young adolescence, as shown in the quote below. In this context, the separation was analysed as thwarted or lost belongingness. However, having an appropriate support network of formal and informal resources helped him cope with this episode quickly.

> *The last time I had this [suicidal ideation] just a little bit or it bothered me was when I broke up with my girlfriend of many years at the time. Um. It was actually a pretty unpleasant break-up with a lot of stuff going on and a lot of annoying other things with other people. [...] And then it was a topic for me again, but it didn't really relate to the problems from before or the topic from before, but rather, um, something like a personal life crisis. But it didn't last long, it got better very quickly.* (D5)

As identified in five interviews, **love and caring about beloved people** also played an important role in suicidal experiences. While family relationships can sometimes be disturbed for many children in care, some feel strongly connected with family members that prevented them from taking their own lives, as five people reported. Caring for others such as family and friends was helpful for some young people to decide against suicidal acts, as one young man from Germany highlighted:

> *But then I was very (-) you want to live and you're very afraid of not being (-) there any more and then you lose what you have. And the, you don't know what (-) the reason why I didn't do it was the fear of it and the fear of [-] hurting [how?] and my environment, my family.* (D3)

One young man from England indicated how his caring relationship with family members influenced both the development of his suicidal ideation and coping. Shortly after having left care, he started worrying about a beloved family member who fell sick, but he could not support or even be with them due to physical distance, which contributed to developing depression and suicidal ideation. Conversely, he stated clearly that thinking about his beloved family helped him not act on these thoughts and take his life.

Another young adult from England explained she actively reflected on the impact of her considered suicide on the people she held dear. She explained that a person would be at severe risk of attempting suicide when specific active suicidal thoughts make them believe that their suicide would be better for others.

> *That's the (.) one that causes the people to attempt suicide because […] it's impregnably (pause) destructive would be my best description. It basically just removes all reason, all love, it (-) it makes you believe what you're doing is the right thing, what you're doing is better for anybody else. (pause) and when you're at that stage (.) there's only one thing that'll bring you out and that's (pause) just (.) someone you love.* (E5)

Four participants described that the thought of the negative impact of their death on beloved others such as family and friends helped them decide against taking their lives. This finding may inform the direction of a professional conversation with a young person who disclosed suicidal ideation, as one young woman described how her professionals in a residential setting helped her consider the impact of her suicide of beloved family members:

> D1: *The carers showed me the positive things […] when I look now, for example, when I'm in a situation like that [thinking of suicide], I think about family. […] of my little brothers and sisters, then of my mother, like how they would react to [my death] like that. Because […] my little siblings don't understand that yet. […] They are really important to me, the little ones.*
>
> […]
>
> Interviewer: *[…] If I understood correctly, the youth welfare service had also helped you to see it that way […] How did they do that?*
>
> D1: *[…] There was a very difficult situation, I thought a lot about suicide and then the carer said, 'Yes, [D1], think about your little brothers and sisters. They wouldn't be able to cope with it.' [inaudible] and I thought about it [the idea of how it would affect them] more.*

Love and caring for others appeared to be a double-edged sword in the context of suicidal ideation. While viewing one's own death as beneficial for loved ones poses a risk factor, reflecting on the negative effects on beloved others or coping for others by reminding oneself that someone wants one to stay alive can be an initial step in early coping with suicidal ideation.

Understanding peer relationships

Positive experiences of belongingness were reflected by feeling genuinely cared for by others including peer residents, carers or family members. The **feeling of being understood** was often related to **peer relationships** with similar experiences either in care or mental health issues,

presenting a resource in coping with suicidal ideation compared to lacking professionals' understanding contributing negatively to suicidal ideation. One young woman from Germany mentioned the wish to connect with other care leavers. One young man from Germany reflected on an important turning point for starting to cope with suicidal ideation, when a peer resident in a children's home showed him that he was not alone with suicidal experiences:

> *And then he also helped a bit to get me into talking therapy and to make sure that I wasn't alone, because at some point I no longer had this feeling that I was completely alone, even [not?] at those times with suicidal thoughts. This feeling of being alone, that has always become a little less, because he was there. Unfortunately, not from the Youth Welfare Office or from the care facility, but from him.* (D4)

Particularly, having peers with care experience was linked to feeling understood and, therefore, contributing to a feeling of belongingness. Connections with people with similar experiences, such as other care leavers, seemed relevant for many people, as they contributed to the feeling of understanding each other. However, one person from England warned that connecting with other people with similar experiences such as care leavers can be tempting but may also pose the risk of impacting each other's mental health:

> *I think it's very tempting to try and find people who are in the same situation as you or people who've had the same problems as you but, um, I think if you start finding people who are just care leavers or people who are just sort of similar mental health issue as you, can be very difficult to get out of certain cycles I think. Um. Especially because mental health issues can be very competitive. So, actually if you're both trying to heal and you're trying to recover if you at some point get into the really negative trap of 'oh, but I'm worse than you' […] That can be really damaging even if you feel like the connections or the common things that you have can be really, you know, comforting in a way. It can be really destructive at the same time. So, trying to find people that are different to you and maybe don't have the same experiences as you or have had them but have actually healed.* (E7)

Extending a care leavers' support network to more informal resources such as peer mentors would also address the sometimes complicated relationships between young people and social workers. Another interviewed young adult from England highlighted that care-experienced people have already started forming a peer network to support each other. She stated that it would be beneficial for professional services to use such peers to create an extended support network, particularly as formal support is often limited by a key worker's availability. Important

for such a peer network would be to encourage the connection between new care leavers and more-experienced care leavers who are settled in life and secure in their mental health. Such peer mentoring programmes might help a person feel well connected, strengthen their feeling of belonging and identity within the care community, and feel able to reach out to somebody who cares (see sections 5.1.4 and 5.3.2).

In summary, striking was the prominence of the theme of 'social connection' across all interviews, with many cross-references between different codes. Both groups from England and Germany showed similarities in linking their suicidal ideation to relational factors such as feeling isolated, lonely and that people don't care. Particularly, the leaving care process was often linked to feeling lonely and thwarted feeling of belongingness inter alia due to the feeling of abandonment and not having people looking after or being around them anymore. Thwarted or lacking belongingness was prominent in both samples as a perceived factor influencing the development of suicidal ideation. Often, the wish for people to take the time and try to understand the suicidal young person was raised.

Being understood, mainly linked to peers with similar experiences, and genuinely cared for was considered helpful. Therefore, peer relationships were an essential resource in suicide prevention and coping. However, one English participant also raised caution, as similar mental health issues could also become competitive and pose a risk of dragging each peer down. Peer-mentoring networks were discussed as a potential resource for widening a care-experienced young person's support network to counteract the limitations of the support by professionals.

Contrasts between the two samples could be found in explanations about lacking trustful relationships with professionals. In reports of both groups, trust was essential for establishing supportive relationships, particularly with professionals in the care system. Many of the interviewed young adults mentioned that trust in professionals was often lacking. Several English participants argued that the inconsistency of social workers, PAs or carers; emotional distance; and a lack of transparency and involvement of young people in the care plan resulted in the absence of trust in line with a general distrust from children in care towards adults and professionals. Several German participants mentioned that limited confidentiality by professionals constrained their trust in them and their motivation to reach out for support. The role of residential care in positively contributing to a feeling of belongingness with other peer residents was seen as a resource by several participants from Germany. However, the English interviews lack data on residential care in England to compare this aspect between the two groups.

The role of the feeling of belongingness, whether positive or thwarted, in contributing to suicidal ideation was highlighted. Thwarted or lacking belongingness was often linked with loneliness and not feeling understood. Loneliness as a trigger of suicidal ideation was often related to transitions between placements, leaving care or closing cases. Relationships with professionals, family or peers can promote the feeling of belongingness, thus preventing and coping with suicidal ideation.

5.2.3 Communication

Another interpersonal theme that was identified from the data was 'communication'. It covers multiple aspects of communication about suicidal ideation related to access to support or relevant coping resources. This theme contains seven codes:

- stigma,
- forming a support network,
- masking,
- non-verbal signs,
- communication skills of the young person,
- offer and option to talk, and
- communication with professionals.

Three interviewed care-experienced adults from England mentioned that they had experienced a particular **stigma** related to mental health or their care experience. Some care-experienced young people have felt they get treated differently than others without care experience. For instance, one participant described that because of her care experience, she was excluded from previous supportive relationships with professional attachment figures and prevented from having the same developmental experiences during adolescence compared to her peers. One person mentioned that she actively hid her care background when she left care for university:

> *I didn't wanna be treated differently with how I was thinking about it at the time about what sick that everyone'd know my business. […] And so, I didn't tell anyone at university that I've been in care and nobody approached me to talk about it or offering support. […] I felt like I was hiding something really big all the time. So, I didn't want people to know. I thought this is a big dreadful thing.* (E4)

Her hiding her care experience limited her from **forming a necessary support network** in her new environment when she struggled with her mental health and suicidal experiences. Participants from England reported on stigmatising occasions about the mental health of care-experienced young people that professionals in the care system communicated. For instance, one person talked about mental health as a perceived taboo topic among social workers:

> *That's one thing they don't try and discuss is mental health with foster children. It's because a lot of foster children do have mental issues. I (-) like obviously it's a very traumatic event going to care. […] But there's such like it's a taboo. So, people don't want to talk about mental health when it comes to foster children at all.* (E2)

Another person reported that professionals reacted in a stigmatising manner when she reached out for mental health support. She reported on stigmatising practices that she experienced when she was a child, inter alia due to referrals to unsuitable counselling services instead of appropriate specialised psychotherapy, as described in the following quote:

> *If [the social workers] got a sense that I wasn't telling them something where I was not doing amazing, then they would have basically just try to refer me to a counsellor. Um, and I do remember that every time they try to refer me to a counsellor on the hall I would be like 'No! There's nothing wrong with me. Leave me alone!' It's (-) It felt stigmatising. [I] was trying to express that […] there are some problems here that are happening to me and I need you to help me with that. […] And it was causing me mental health problems about what I was trying to communicate and they would always jump straight to 'Oh, you're having a mental health problem, let's get you a counsellor.' I think, it felt like, it's been (-) that it's been put back on me. […] like 'you're having a problem.' […] I felt like being accused. So, other people would say that there's something wrong with me. And I was felt like that's very unfair. Um. And actually it was about what was happening to me.* (E4)

Stigma was also mentioned as an important aspect in developing suicidal ideation across the German sample. The interviewed young adults from Germany reflected less on their care experience as a stigma but on mental health. One reported having had prejudices against mental health needs and that he perceived the use of mental health services as a weakness. When he struggled with his mental health and experienced suicidal ideation, he first avoided reaching out to mental health support, until his attitude changed after talking to a friend who coped with his previous suicidal ideation with psychiatric support.

Seven participants from both groups reported **masking** behaviour to hide problems and mental health issues due to stigma and fear of consequences. One young woman from Germany reported fears about negative consequences if she would disclose suicidal ideation to her key worker when living alone in supported accommodation.

> *I've had depression for a long time. And, um (.) they just weren't (-) treated. […] whenever the carers asked how I was, I always said 'Yes, I'm fine. I'm fine. Everything is great.' Because I didn't want (-) well, I didn't want to let people see that I was [inaudible] or something, because I was under pressure, if I said that I wasn't doing well or that I was overwhelmed with the situation, I would definitely have to go back to the grouped-based children's home. And I didn't want that.* (D6)

A young man from Germany reported that greater physical distance from close contacts contributed to easily hiding problems compared to living close by and having much contact, which made masking more difficult. Two further participants described their masking of suicidal thoughts as follows:

> *Nobody knew. I felt like I was in my own world. Whatever I do I just kept it between myself and didn't tell anybody. (pause) Nobody knew.* (E3)

> *I found it very, very difficult to meet other people, because I didn't want everyone to know how I was feeling. So, I put on a mask, where I appear to be in a good mood. Over time, I've managed to do that really well, so that hardly anyone has noticed. Um. The problem was that at some point I didn't want to wear this mask any more, because I realised that (.) it doesn't do me any good and that it only makes things worse when I say all the time that everything is fine and show it, even though nothing is actually fine. The problem is that I always put on this mask for a very, very long time […] at some point I could no longer take it off properly.* (D4)

In the quote below, the young man (D4) mentioned that professionals would have difficulties assessing and identifying his suicidal ideation with his masking behaviour. However, he and others mentioned that even when they communicated verbally that they were doing well, they may have communicated **non-verbal signs**. Focusing and noticing non-verbal signs would have enabled professionals to identify that the young person was experiencing mental health issues such as suicidal ideation.

> *I simply put on this mask, so well that no one noticed. And then, of course, it's extremely difficult for the carers to detect something like that at the time. I don't want to reproach*

them for that. But the other way round, they should have noticed it much, much earlier. Because in my eyes, they are all trained [...] they should actually be trained enough to (-) notice that they take these signs seriously when someone withdraws, when other residents come up to them and say 'here, there's something wrong with [D4]'. (D4)

Reported non-verbal signs of emotional distress and suicidal ideation included changes in character and behaviour, distancing oneself, being more unmotivated, passive attitudes, panicky reactions such as sudden aggressive impulses, self-harm, or even gushing language to hide sadness. Paying attention to non-verbal signs would help professionals assess and address a young person's mental health needs and suicidal state. When signalling emotional distress, several young people would have wished for professionals to approach the young person instead of waiting for the young person to reach out to them. However, some participants from Germany reported that care workers ignored apparent signs, as the following quote indicates:

And then simply approach the young person. Because I have often had the experience that the care workers say, 'No, the young person has to approach us', which is sometimes really difficult in such moments when one is in such a bad way that one cannot approach other people at all. That's why I would advise care workers to approach the young people when they notice that something is wrong. And a care worker also notices that [...] when the young person changes a lot in a relatively short time. They notice that something is not right. That they simply approach the young person and say, 'Come here, something is wrong with you. What's wrong? What do you need? Can we help you?' (D4)

As reported across both interviewed groups, non-verbal signs of suicidal ideation included behavioural changes or desperate acts. One person from England highlighted certain professional blindness concerning the impact of abruptly closing cases and ceasing support on a young person's mental health, particularly when being suicidal, by placing themselves in an emergency situation as a cry for help. She reported her view on how social workers and leaving care services decided to reduce support when she left care.

The worst part was that people didn't look after me as much because I'm a very high functioning person. I think they think 'OK, she, you know, she's not involved with the police. She's not, you know, making any sort of trouble. She's not as loud as other young people. She's not as aggressive. She'll be fine. Like let's not check in with her all the time because she'll be (-) she'll be fine.' So, I think, that impacted me most kind of negatively because that's when I thought 'OK, well, I need to do something really

> *drastic. I need to do something really dramatic for them to just realise that I'm not OK.'* (E7)

Several highlighted the attention and assessment of non-verbal signs as an essential communication factor for professionals to identify a suicidal young person, because the **communication ability** of a young person may be too low to express their needs or explain the causes, especially when being suicidal. Similarly to a young man from Germany, one person from England reported that she tried to communicate her experienced abuse to social workers and mental health professionals as a child. However, at that time, she lacked the necessary language and understanding to express the situation, resulting in unidentified abuse for several years. She later considered this abuse and the delayed intervention by social services as the reasons why her mental health deteriorated to the point of suicidal experiences.

> *I remember social workers very occasionally would have a call like I tried to express like that something was wrong and in hindsight when I was really young when I was trying to articulate but couldn't was I think I'm being abused. Um. But when I tried to articulate that something was wrong because, at that point, I didn't know that it was abuse I was just like just something (-) something is wrong and it's really bad. I don't know what it is but something [inaudible].* (E4)

Cognitive protection mechanisms such as memory blocks of traumatic events to describe the causes of the young people's suicidal ideation could limit the ability to communicate past experiences and mental health problems, as expressed by a few participants. Some of the interviewed young people reported difficulties opening up in counselling and therapy sessions or feeling that talking-based therapy would not be suitable for them. However, many participants from both countries described talking about their mental health, including their suicidal ideation, as an essential coping strategy. Generally, the **option and offer to talk** to someone as suicide prevention became apparent throughout the data.

> *I kind of wished for someone to just come and talk to me. That's what I wanted. I wanted someone to come and (.) like put a hand on my shoulder and say 'Oh, OK. Let's talk about it!' […] I have the experience of being suicidal but it's a lot of people just make it seem like they need to do more work with a suicidal person. They do, like, no. Literally, it's probably just they want someone that they can scream and shout to, that would sit there and is just quiet and listen. So, that's what I would probably do, is I would be sitting, being quiet, being tell them 'OK, rant! Talk to me!' And just be quiet and let them scream and shout until they are done.* (E2)

Talking about their suicidal thoughts and the initial triggering traumatic event was highlighted as an effective way to cope and get quickly tailored help for coping. A young man from Germany discussed the role of talking as a coping strategy:

> *It sounds so banal, it's really hard for the young person or the person in the situation, but to talk about it [...] but simply to get a lot of weight off your chest, because this saying '[Just?] talk about it, you'll feel better afterwards!' It's just true. If you talk about what's bothering you and the framework is created for you, that you feel comfortable there (-) well, what does 'comfortable' mean (-) that you definitely feel safe in the situation, that you can talk about it and know that it won't (-) have any consequences.* (D3)

Talking to cope with suicidal ideation would involve both informal and formal contacts. Several participants highlighted that the foundation to talk would require trust and a confidential environment without fearing consequences, but rather showing the young person that the professional will listen and genuinely cares about them. One young woman from Germany reflected on the advantage of the key worker concept in residential care to reach out for support more easily:

> *Well, I talked a lot with [my key worker] because she was my key worker. Everyone had their own key worker they could talk to.* (D2)

Four young adults mentioned that when they were suicidal, they wished that social workers, PAs or carers would have approached them with an offer to talk about their problems and feelings. A young man from Germany recommended the following for practitioners to do:

> *I have often had the experience that the carers say, 'No, the young person has to approach us', which is sometimes really difficult in such moments when you are in such a bad way that you can't approach other people at all. That's why I would advise carers to approach the young people when they notice that something is wrong. [...] A carer notices something like that, when the young person changes a lot in a relatively short time. They notice that something is not right, so that they then simply approach the young person and say, 'Come here, something is wrong with you. What's wrong? What do you need? Can we help you?'* (D4)

One young woman from England reported a positive, appreciating example from her PA. She highlighted her PA's awareness of her needs and availability to talk to:

If I've got periods of times where you know loads of very traumatic things are happening or I'm really emotional, I'm not well like [PA] will come and she'll, you know, visit me in hospital if I'm in hospital or she will call me every two days or every single day or meet me twice, three times a week. So, […] she was very aware of my needs and that most of the time I didn't actually need anything from her. It was just that I needed someone to talk to. Or someone just someone, you know, to know what I'm going through. And she's always been very good in terms of being in advocate for me. (E7)

Though the relationship with professionals in the (leaving) care system played an important role in having a conversation about suicidal thoughts, some recommended that young people also get informed about alternative neutral options to talk to someone. For example, a possible option would be finding a suitable mental health service.

Communication with professionals appeared to be difficult generally. A dominant feature throughout the interviews was a lack of communication with social workers or carers, either caused by professionals themselves or the young people. On the one hand, young people mentioned having hidden mental health problems from their social workers or PAs or avoided opening up to a professional due to a lack of trust, as described above. On the other hand, some professionals also showed an avoidance of communication or a lack of involving young people in communication. The latter included a lack of transparency, honesty and respect towards the young person by not involving them in decisions about their lives, resulting in a lack of appropriate mental health support. The communication about mental health needs with social workers was diverse. However, some highlighted that social workers or PAs would avoid a conversation about this topic and directly refer to a counselling service, an action that was experienced as stigmatising (see above). Young people would have wished professionals from the care system to listen more to their wishes and needs. For example, one young man from England reported that his social worker did not check up on him for six months until the next required meeting, despite knowing that the young person was depressed and living alone in semi-independent living. At this point, the young person had already developed suicidal thoughts, though he had not disclosed the severity of his depression.

Yes, so he just didn't know what was going on because he never talked to me. Like I got depressed a (-) eh, seven months, and he came and saw me for the first month I was depressed. All he kind of said was 'Oh, like, get better!' And through the next six months he just never had any contact with me. (E2)

Some participants from Germany talked about related experiences with professionals. Professionals' downplaying of expressed suicidal thoughts, mental health needs, or non-verbal signs such as self-harming behaviour resulted in disappointment by the young people. A young man from Germany described his experience of poor communication about mental health needs with residential care workers:

> *I couldn't talk to anyone [in the residential home], that I couldn't confide in anyone, that no one wanted to help me either. I tried to talk to [the care workers] and they didn't listen and didn't notice. And with the words 'Yes, it's normal that you're not well. It will be alright. It doesn't matter.' It was dismissed with something like that.* (D4)

Some young people from Germany had the impression that care workers avoided talking about problems or would breach their confidentiality. Confidentiality as an element of trust was mentioned by several young people from Germany as an essential factor to talk to professionals in the care system about mental health issues. However, some reported having experienced or witnessed a breach of confidentiality by professionals in residential care, resulting in a lack of trust and, therefore, affecting their willingness to communicate their needs.

How professionals dealt with a disclosure that a young person in care experienced suicidal ideation varied across several reports. For instance, one young man reported that he disclosed depressive feelings and that care workers respected his needs by giving him space and time. However, this disclosure was not followed up, and suicidal thoughts were not communicated or identified by the professionals.

To enhance the communication between a young person and professionals in the care system, another young man from Germany suggested involving an "emotional translator" (D3) with similar experiences as the young person, for instance, their own care experience or having had experienced suicidal ideation in the past. Related to this suggestion, a young woman from England proposed involving additional professionals in the meetings between young people and their PAs or social workers to follow up on whether the communicated needs of the young person were addressed. Speaking openly about suicidal ideation with social workers, care workers, and therapists helped get targeted support quickly, as reported by several young people.

Several of the participants, often from England, suggested educating young people with care experience on mental health, training that would contain suicide prevention training and provide them with information about suicide prevention helplines to reach out for support. Additionally,

professionals would need to know how to react to suicidal young people and even beforehand form a trustful relationship to enable the young person to listen to them.

In summary, many similarities were found between the reports from both countries. One of the main overlaps was the importance of talking about suicidal thoughts as a coping strategy, and the direct offer to talk and having someone to listen to. However, problems in communicating such matters were common, as not every young person could talk about sensitive topics and open up to professionals.

One reason for masking suicidal thoughts was a stigma against mental health issues and the fear of negative consequences in the care system. However, the stigma of care experience and the impression of mental health among care-experienced people as a taboo among professionals were predominantly reflected by several participants from England compared to Germany. German participants instead reported the experience that professionals such as key workers in residential care labelled self-harm and expressed suicidal thoughts as attention-seeking behaviour that affected the young people’s relationship with professionals.

A foundation to open a conversation about suicidal experiences is trustful and respectful communication. Participants from Germany especially highlighted the role of confidentiality in enabling open communication about a young person’s mental health issues and the negative effects of a breach of confidentiality by professionals in the care system.

In conclusion, communication of suicidal ideation is multi-layered. One’s ability to express emotional distress or communicate about traumatic experiences – through non-verbal signs and masking up to direct conversation about suicidal thoughts – were identified as components related to suicidal ideation. Professionals involved need to be very cautious about stigma and stigmatising practices and the quality of their relationship with a young person, enabling them to open up about sensitive topics.

5.2.4 Summary

Interpersonal factors are multi-faceted and appear to influence suicidal ideation. On the one hand, relational factors contributing to the development of suicidal ideation can involve interpersonal traumatic events, thwarted belongingness, loneliness, and lack of understanding and communication, for instance. On the other hand, factors such as a positive feeling of

belongingness, trustful relationships, offering to talk, and foundations of open communication contribute to coping and suicide prevention.

Apart from the quality of relationships, especially with professionals, communication plays a major role. Awareness of stigma, masking of suicidal ideation, non-verbal signs, and the offer of trustful, confidential communication would be crucial for suicidal prevention.

5.3 Structural level

With the focus on care experience and the involvement in the care and social services systems, two themes were identified on a structural level. One structural theme covers the experiences of transitions within or from the care system. The other one presents characteristics of structural, mainly formal and organisational support within relevant systems. Both were identified as relevant themes to understand the occurrence of suicidal ideation and reflect on suicide prevention within the (leaving) care systems. While some were reflections on their influence on personally experienced suicidal thoughts, others were recommendations and ideas for suicide prevention within the care system.

5.3.1 Transition

A special focus was put on the transition from care to early adulthood and a more independent living. The theme 'transition' covers the leaving care experience and other transitions during care between different foster families or residential placements, between various services, the impact of closing cases, and changes between places concerning physical distance and environment. Five codes were identified under this theme:

- transition,
- processing past,
- physical distance,
- place and environment, and
- challenges and expectations.

The impact that **transitions** can have on a young person's well-being is clearly described by a young woman from England:

> *Most of the time when somebody is going to be at their lowest, it's going to be after the move to a new place. I'm not saying that's the only time but I'm just saying that's when you have a high risk.* (E5)

As she explained in the quote above, transitions within or from the care system, such as changing foster families or moving into their own flat or semi-independent living, could negatively affect a young person's mental health and increase their vulnerability. She highlighted that young people were at high risk of suicidal experiences after a transition to a new place.

Generally, young adults from England reported that the transition impacted their mental health, particularly when leaving care. One person explained that all transitions and significant changes, whether between changing foster placements, leaving care or entering university from care, impact a young person's mental health, as feelings of abandonment may be caused. The impact of transitions and big changes on a young person's mental health was echoed across several interviews. One young woman reflected on how her experienced instability of care placements impacted her well-being.

> *I was unlucky enough to move around 48 times in the space of 6 years. Um. This was very kind of traumatic for me. This was very kind of unsettling and it brought a lot of instability to my life. So, I found it very hard to form relationships. And actually I can see it was affecting other areas of my life such as education. Um, you know, if you're moving so frequently how are you expected to engage in education? How are you expected to engage in mental health services when you're constantly up there leaving? [...] actually it affected me in my older life now because when I in somewhere for too long, for example, [...] I feel like I need change because I'm just used to the, you know, instability. I've kind of (-) I was never in anything actually long. So, my longest placement whilst I was in care was 6 months which is not very long at all.* (E6)

The young adults from Germany reported various experiences in the transitions from care and their effects on their well-being. As the quote above, one young woman from Germany reflected on the negative impacts of transitions across different places by the same care provider. She started living in a group home, moved to an intermediate single supported apartment in the same building for a few weeks, then moved into supported accommodation with her own flat, and finally moved back to her parent's place after a suicide attempt. Before moving into supported housing, the short intermediate stay that she perceived as making room for another young person felt like a massive disruption in her life.

The transition from care is generally based on age in both countries. Turning 18 is crucial for every young person in care, as this age comes with many changes, including previous long-term support services within the care system or (mental) health support. An example of the impact on young people's mental well-being was a report by one young woman from England:

> *For example, there's, you know, the mental health services, there's the hospital, there's social services and all of these things change when you turn 18. And the amount of care that you receive changes when you turn 18. And I didn't feel like I fully understood what was ahead of me. [...] All my friends around me they were all really excited about turning 18 and I was there like scared (laughing) petrified about turning 18. And I think turning 18 was really difficult in itself because I-I (-) I had a lot of attachment difficulties as well. Um. And in my head I was always really scared of (-) of getting older because I felt the older I get the less of a chance I have of someone adopting me or someone taking me in. [...]*
>
> *Before 18 it was more, you know, I hope I get terminal illness or I hope this may happens or, you know, little kinda attempts here and there but once I turned 18 and all of these changes happened it was just like looking at things a bit more seriously. And I think planning things a bit more seriously. I think that's when more planning started.* (E7)

Six interviewed adults reported limited or lacking support after leaving care and becoming care leavers. Two participants from Germany decided against ongoing support when they left care. Three women from England left their last care placement for university, involving a **change in their environment**, physically and socially. Two of them reported that leaving a placement where the young person felt at home or leaving for somewhere far from a place and people who they felt they belonged with made their transition from care even more challenging (see section 5.3.2).

The feeling of being prepared for this transition and choosing a suitable time and circumstances for this step was crucial. The participants from Germany reflected on their transition from their last care placements to either supported accommodation as a care leaver, into their first own flat without further support or returning to the parental home. The time and circumstances, abruptness of leaving care and ceasing of support for the young person were felt very disrupting and disappointing. A young woman from Germany reported that she had to leave her children's home to move into supported accommodation in another city during the final exams at school, which resulted in stress and later, though not directly, was considered as contributing to suicidal ideation:

> *Well, I moved into supported living accommodation when I was 17. But then I was in the middle of the oral and written exams for my school-leaving certificate […] because I was in the middle of the exams and that was quite stressful for me. On top of that, I had to move and then study for the exams. That was too much.* (D1)

As another reported case of the impact of transitions from care, one young woman from Germany expressed even years after transitioning from care and supported accommodation huge disappointment when the care provider "kicked her out" (D6) of her flat shortly after a recent suicide attempt.

> *Well, I already had these depressive episodes in (-) the group-based residential home, um, (.) and then they became stronger and stronger in (-) the supported accommodation living alone. […] I had a serious breakdown [suicide attempt] and they [care provider, key workers, including social worker] gave me the bum's rush without any help. I don't know (quieter, more to herself). Sorry. I just had to get that off my chest.* (D6)

Reports about the development of suicidal thoughts during early adulthood varied across the sample. One person from England who entered the care system at age 17 described that while she was growing older, her suicidal thoughts became less. In contrast, some of the English group mentioned that their previous passive suicidal ideation while being younger changed with the transition from care at this point in life to the development of active suicidal ideation. Several aspects triggered the worsening of suicidal ideation: the change of previous support while in care to less or limited support when leaving the care system; simultaneous changes in the environment and social contact, when struggling to connect with new people; and new expectations of managing daily life (see section 5.3.2).

After leaving the last care home, living by oneself also caused the feeling of loneliness that increased risking the prominence of suicidal ideation, as described earlier (see section 5.2.2). Loneliness at this stage in early adulthood due to the transition may also come with processing their past as a care-experienced young adult, such as childhood traumas reported by a young woman from England.

> *It was just so painful at that time and I think because I was so lonely and I was in this empty space with nothing that I kinda distract myself with, you know, no TV, no Internet, so it's just kinda just sitting in an empty space. Like I can do anything but think all of the time and everything that's kept coming back to me was my childhood and my, you know (-) my time being in foster care and all of it had been too negative.* (E7)

Furthermore, the **physical distance** to the support system, particularly informal support networks such as family and friends, after leaving care turned out to be a risk factor for deteriorating mental health. One person from Germany reported that the distance from his family, particularly his mother, who was a crucial figure of support for him, enabled him to hide his problems from his family easily. However, hiding his problems resulted in the deterioration of his mental health, as he did not receive any support. Only when he moved close to his support network and could not hide his problems were his mental health problems revealed: this disclosure meant he received the necessary support that helped him cope with his suicidal ideation at that time. He described the role of physical distance and closeness to relevant supportive people in dealing with his problems as follows:

> *But contact with my mother over the phone has always been very difficult for me. I didn't want to confess to her on the phone when something stupid happened or when I was overwhelmed with a situation and couldn't solve it. And it was much easier for me when I moved back to [city B].* (D3)

Moving into a privately rented flat without any further support was experienced as **challenging due to new responsibilities**, particularly bureaucracy and bills, that a young person was not familiar with and that caused stress. Reports from both countries show how bureaucratic requirements challenge young adults in the transition from care and impact their well-being. For instance, two young adults from England described their experiences of new bureaucratic responsibilities after the transition from care for which they did not feel being prepared for as follows:

> *And then changing your area and then actually […] the responsibility of me living in my council house. For example, […] everything is paid for obviously individually everything […] for example, a TV licence that I didn't even know existed. So, all of these additional expenses had to be added on to my bills budget which obviously meant that I had to work more to be able to survive and live a comfortable life.* (E6)

> *Having to learn new things that you (-) you haven't even heard of before like taxes and working at, um, what to do in an office environment because these aren't the things that you're taught very well in schools and it's not like (-) it (-) anybody really told you (.) what life as a grown-up is like because (.) you're still a kid until the day you stop being child. […] So, most things they have to learn themselves […] those are the things that have an effect on the person's ability to cope with situations because when, um, something you're not used to is suddenly thrust upon you, especially if it is literally the*

first time it happened or even the first tenth time it happened it, um (.) it starts to have an effect because you realise that you were completely and utterly clueless and you've no idea of what you're doing. So, that can have a serious negative effect because if somebody is already vulnerable and then they have all these new things thrust upon them they can convince themselves that maybe they are not capable of living as an adult and it can convince them that maybe they (pause), um, they don't have the ability to (breathing out) do (.) what normal people do. (E5)

In addition, a young man from Germany who moved far away from the area he lived in during care to a city to go to university reported similar bureaucratic challenges and the negative impacts on his well-being at that time:

D5: *There were also a lot of things that I hadn't really done before, things like GEZ [TV licence], electricity bills, utility bills, um, any kind of insurance, […] whether you need it or not. Um. Then there were also things like my water damage in the flat, where there was stress with the landlord and insurances of course. Um. These are all things where it would have been really good to have had some kind of leaving care support to somehow deal with it. […] And I felt rather overwhelmed by all the stuff and maybe let a few things slide a bit because I didn't know exactly what I should do. Which then led to more problems, especially at the beginning. And then I applied for leaving care support later and it was rejected. […]*

Interviewer: *How did that affect your suicidal thoughts, if you were still having them at that time?*

D5: *They weren't as acute as you might think, but after a while you were very exhausted, um, having to deal with all the red tape […] because I've already made an ['Bundesausbildungsförderungsgesetz' (BaFöG), translated by IJAB: German Federal Training Assistance Act; relevant for financial support for students] application and I've already told [the job centre], so they simply stopped paying. That was (-) the biggest stress of my life. [...] because if you don't know how you're going to pay the rent for the next month, that already sucks, but if you don't know how you're going to live for the month, then it's even more shitty, even though you've actually done everything right. You've done your A-levels, you want to study, you're just dependent on state aid, […] and in any case it wasn't necessarily that I thought, 'Well, now I'm going to kill myself somehow, because everything sucks.' It was just that you were so exhausted that everything was already stressful anyway. […] I at least already felt very stressed by*

> *having to study all at once and having to do everything all over again. A completely new circle of friends, um. I didn't know anyone here.*

His detailed report reflects the complexity of a young person leaving care for university. He reported a change in his social and physical environment, bureaucratic demands and financial challenges that he had to deal with by himself without support from social services as the youth welfare office rejected his request. He clearly stated the negative impact of the transition on his well-being, which indicated stress and disappointment. All reports from the three participants indicated that the transition from care could put a young person into a highly vulnerable state without the necessary support.

Recommendations to contribute to a smooth transition from care included the organisation of local support both for advice on life hacks and bureaucracy, and mental health support in the place the young person moves to for those who were already known for having mental health issues. Furthermore, one participant also recommended that a young person should not move to a new area alone, far away from existing social contact and support, especially if the person has mental health problems:

> *I think that for young people with psychological problems, especially in the area of depression or suicidal thoughts, which were really an accompanying theme during their youth, we should always make sure that they don't live all alone in a flat, that they don't move somewhere where they don't know anyone.* (D5)

Particularly important would be to ensure that the young person would not move into a flat alone in a new social environment without any local contacts. Furthermore, one person also mentioned the wish for previous key workers such as social workers or carers to check up on the young person after the transition to keep in touch, show interest in them and ensure their well-being.

The social and physical **environment** during care and in places such as semi-independent accommodation could impact a young person's mental health. One person from England who lived in several foster and residential placements felt that her suicidal ideation was more prominent when surrounded by people with mental health issues while in care than after leaving care. After having left care, she actively surrounded herself with people who were secure in themselves and positively influenced her well-being. This experience stood in contrast to the reports about the adverse effects of leaving care mentioned above, possibly due to different experiences of foster and residential care.

Another crucial transitional point identified was the closing of cases by the leaving care team. A young woman from England talked about “the end of the line of support” (E7) that could have an enormous negative psychological impact, particularly triggering suicidal ideation if a young adult tended to be suicidal beforehand. Professionals seemed to be unaware of the effects of this sometimes very abrupt, less reflected cutting point of support for a care leaver. However, the findings identified this transition as crucial and one that needed thorough preparation.

> *Then not having kinda the service to rely on as well, I think, it’s just knowing that you don’t have some sort of network to fall back on and knowing that actually now. Like when you’re turn 18 they say that you’re an adult and you (-) you know, you’re really lonely and all of these things but actually when your case gets closed that’s for the first time where you’re actually completely by yourself. And that can be really scary. And I think if you’ve already had suicidal ideation before that point, I feel like that can be just kinda the last straw for some people if they’re not prepared for it at all when it just suddenly hits them that ‘Actually I’m just completely alone now.’* (E7)

Generally, the transition from care can offer positive experiences as well. A good preparation over several months and the option to come back to the previous care placement promote a positive smooth transition. A woman from Germany described how a carer at the children’s home where she was living supported the transition back to her parent’s place when she turned 18.

> *[My key worker] took me to my dad’s house first and checked whether I felt comfortable there. We also had a lot of conversations. And, yes, that really helped. Because I knew that I wouldn’t be abandoned. And I was able to change my mind [...] if I hadn’t wanted to, I could have stayed there anyway. [...] We certainly did that for two or three months.* (D2)

Furthermore, moving to a secure, safe place with a positive atmosphere could contribute to a young person’s mental health. As identified in the interview data, living in a place where a person felt comfortable was mentioned as a resource contributing to life satisfaction.

Overall, there were many similarities in the reported experiences of the transition from care between the two groups. Both highlighted that the transition from care might result in a limited or lacking support as a young adult. The most striking part was the impacts of living alone and feeling lonely that could trigger or draw focus on suicidal ideation or the processing of a person’s past, as discussed in the English group. In both groups, some young adults experienced

an abrupt transition and a cut in support often related to a negative experience, highlighting the importance of a more prepared transition with ongoing support. The environment, place and distance to a home or people a young person felt they belonged to could also contribute to a care leaver's mental health. Continuing to stay in residential care beyond someone's 18th birthday, a more common option in Germany, and ongoing contact with previous key workers could contribute to a smoother transition.

Transitions within and from the (leaving) care system were diverse and numerous. Changes from one care home to another, moving into a single flat or semi-independent living, including supported accommodation, or closing cases from leaving care teams were identified as important factors influencing a young person's mental well-being and suicidal experiences. Particularly important to highlight is the reduction in support both when leaving care and closing cases by leaving care teams. These aspects appeared to contribute to an increased risk of suicide if a person was already more vulnerable due to previous suicidal ideation.

5.3.2 Structural support

Interview participants discussed support on a structural level. This theme covers both formal and informal resources and support networks, though it predominantly focuses on professional support. Professional support in this context covers social work from children's social services, PAs and leaving care teams; residential care workers and foster carers; and mental health professionals. Professionals from other systems, such as school teachers, are not covered in this theme, though included as resources of support networks in general if they were mentioned. Essential topics that were mentioned concerning suicidal experiences and collected as codes cover:

- the access and availability of support,
- assessment,
- general awareness of (mental health) needs,
- person-centred approaches,
- professional qualification and skills,
- social work and care practice, and
- therapy and mental health support.

Starting with reports from young adults from Germany, diverse experiences were reported about the **access and availability of support**. Three reported highly supportive key workers in residential care and social workers from local authorities, while two said their social workers were unavailable.

A problem was reported by a young man whose requests for further support by staying slightly longer in supported accommodation and later for leaving care support were denied by the responsible local authority. The problem, in this case, seemed to be the so-called ‘transition jungle’ of different authorities and laws in Germany (Schröer et al., 2016). As soon as social services closed his case and rejected his request of leaving care support, he was only advised to seek support from the job centre. In a similar case, a young woman from Germany reported that she felt “kicked out” (D6) of supported accommodation shortly after a suicide attempt, as she refused to move back into the children’s home at age 17. This decision resulted in her leaving care at short notice (within a few weeks) and moving back to her mother’s place without further support. As she reported, this cut caused great disappointment that had affected her mental health further in life.

The option to stay in residential care and transit to supported accommodation provided by the same care provider was also an option of further support beyond turning 18. However, one person who started an apprenticeship while in care decided to leave care as soon as he turned 18 years and ceased any further support from social services because he would have otherwise needed to compensate for the costs of his care from his apprentice loan (*Kostenheranziehung* before the revision of the legislation in 2021, see section 2.2.2). In his case, further support was available, but the financial hurdle made ongoing support less attractive.

> *If a young person is in a youth welfare measure and then goes into training, he has to give up 75% of his salary. I thought that was pretty stupid (-) shit, I’ll put it that way. Accordingly, I said relatively soon after my 18th birthday that I wanted to move out and completely end the youth welfare measure, so I didn’t want to be looked after any more [...]. So that I can simply have my money, [...] so that I can afford my own flat. And that was the reason why I moved out early. If that hadn't been the case, I could have stayed there longer, but because it was a lot of money that went away every month, I said, OK, I’m moving out. Of course, in the end I don’t necessarily have much more money at the end of the day, but I’m not obliged to anyone.* (D4)

Findings from the English group show that the access and availability of support during and after leaving care was an important topic discussed by all these participants. The support from

professionals from the care system, primarily focusing on social workers and PAs, varied from case to case. Some professionals were described as supportive and committed to offering different support options. In contrast, others participants described a lack of support, even when the professional knew that the young person was depressed. Those who expressed a lack of support provided various explanations.

For instance, an often-raised problem among participants from England was the availability of social workers or PAs. Their usual working hours from 9 to 5 Mondays to Fridays, and high caseloads limited the time a social worker could spend with a young person. Three interviewed women from England particularly critically reflected the limited availability of key workers at times when the risk of acute suicidal ideation is high. At these times, a suicidal young person needs to access their support system in which the social worker or PA would play a major, sometimes the single role. Problematic was that suicidal thoughts were often more prominent in the evening, at the weekend or on public holidays such as Christmas, mainly when professionals in the care system were usually not available, as explained by one young woman.

> *People [social workers] are only available between 9 to 5 Mondays to Friday. And when you're suicidal probably the hardest times of the (-) is night-time.* (E4)

Three participants from England reflected in this context on the importance of an informal support network such as family members, friends or peer mentors. Informal social resources were available to support a young person currently struggling with suicidal ideation during out-of-office hours or after the formal support ceased to extend the availability of support. It also needs to be kept in mind that some people may not reach out for support when being actively suicidal. An informal support network was particularly crucial, as many reported receiving less support as soon as they left care, such as leaving care for university. Similarly, some participants from Germany also mentioned the importance of informal resources, including family and friends. One person highlighted the wish to connect with other care leavers and peers with similar experiences. Involving mentors with similar experiences either in prevention programmes in care facilities or schools or in conversation as a translator between the young person and professionals without care experience was suggested to improve the access and availability of support.

> *If the youth welfare services or the carers have the feeling that this [a young person is suicidal] could be the case, that they then also involve people from outside who do not belong to the institution and who have already experienced this situation and have overcome it. That they perhaps act like a kind of interpreter between the professional,*

for example, between the care worker [...], who can, so to speak, emotionally translate the language that the child or young person speaks. (D3)

One young man recommended involving people with personal experience as a strategy for suicide prevention, for instance, to raise **awareness** in schools about support options. In addition, he further reflected on options of integrating prevention programmes into the care provision to strengthen coping skills while a young person lives in care. Furthermore, general support services for care leavers that would help with new challenges after leaving care, such as bureaucracy and responsibilities when renting one's own place, were recommended.

Furthermore, some interviewed care-experienced adults from England mentioned that less or no support was offered by leaving care teams if a young person appeared to be independent, despite being known to have mental health issues. One young woman from England highlighted that when a leaving-care team announced closure of a case because the young person seemed well and independent, this ceasing of support may motivate the young person to place themselves in an emergency situation to keep and reaccess support.

Because often what you will get is you will get young people where you will call them OK 'I'm closing your case because you seem OK.' And then that young person will try and turn them into an emergency. (E7)

Two participants mentioned that information about further support options offered by social services or leaving care teams (such as children in care councils) or external support (such as posters informing about suicide prevention hotlines) were not shared with the young people. As a result, young people would not be aware of available support options. A young man from England reflected on the lack of information and support options about suicide prevention.

Even if the key workers didn't want to do it [talk about mental health and suicide prevention] themselves they can hire (-) they can get people in to talk about it [suicide prevention]. There are so many ways that they can do it. They could even put posters up on the walls with numbers what they can call or email addresses or people that they can talk to in private. But there, like (-) there's nothing. There's so easy way how to solve it that down to just putting a phone number on the wall like this is what you need to ring if you have suicidal thoughts. (E2)

In comparison, two young adults reported integrated **mental health support** within their residential care home or having received support in finding a suitable psychotherapist while in care. However, a further two participants mentioned that non-verbal signs and information

about poor mental health and, in one case, even the request for external psychological support was ignored by residential staff as a form of denial.

> *Well, and then this counselling centre, eh, suggested that I should go to a psychologist [...] I brought that up [in the children's home]. They [care workers] didn't listen, it didn't matter. 'That's OK, you can talk to us.' When I tried to talk to them, they had no time, no desire to listen. So, I stopped talking about it and started to keep everything bottled up again.* (D4)

Others reported that their key workers were especially highly supportive by having open conversations about mental health and finding suitable support. For instance, one person highly praised the key worker concepts as a transparent and low threshold to access support while in care.

> *I think it's good that [my children's home], for example, has introduced the fact that every (-) child who is admitted has a key worker. Of course, the key worker has several referenced children, but that also helps because then you know that you can go to him, that you can trust him, that you can confide in him, that you can talk to him. That helps immensely.* (D2)

All but one interviewed young adult from Germany accessed mental health support, including ambulant psychological support, inpatient psychiatric treatment and medication. They accessed mental health support either before entering care, in care or after leaving care. For some, only their individual effort let them access mental health services. Psychotherapy or psychiatric services were considered crucial to coping with trauma and mental health issues related to suicidal ideation.

For participants from England, a critical factor influencing coping with suicidal ideation was the access to suitable mental health support, reflecting a lack of professional qualification among mental health professionals. Some young adults reported struggles in finding the appropriate support to help them deal with mental health issues that included suicidal ideation. One young woman said that she was rejected by several counsellors and less qualified therapists before she was able to receive suitable specialised mental health support to treat her complex PTSD only when she had the necessary financial resources to pay for private therapy.

> *I couldn't afford a therapist, like a proper what I actually needed until I got to the point where I have a full-time really good job [...] and I know I can afford the help that I needed 10 years ago. Which is a bit backwards. (laughing) Yeah.* (E4)

Access to suitable mental health support was often related to participants' own efforts, similar to the reports from some participants from Germany. In addition, support to help cope with suicidal ideation would need to be on a long-term basis. Some participants expressed the wish for lower thresholds for mental health support and came up with ideas about special mental health services tailored to all people with care experience implemented within the care system.

Providing access to suitable mental health support may also be related to the relevant **skills of professionals** in the care system. Some interviewed young adults from England raised concerns about how some, but not all, professionals in the care system, particularly social workers, viewed and dealt with the topic of mental health among care-experienced young people. Some spoke of naivety, ignorance or avoidance, but also fear of this topic.

> *I think there's a lot of ignorance to it. I think a lot of the times where social workers actually acknowledge that, you know, a young person may be acting now in a certain way because of their mental health, I think a lot of the times they choose to ignore the signs and like I said until it's too late.* (E6)

Naivety was mentioned in how social workers and other professionals, including some mental health professionals, dealt with mental health issues expressed by young people from England. For instance, one person reflected on her experience when she tried to express living in an abusive environment. However, social workers and mental health professionals made too-early judgements, resulting in missing out on external factors and delaying the identification of abuse, which further contributed to long-lasting mental health problems and suicidal experiences.

The professionality and skills of professionals, whether in the care system or mental health services, were considered crucial. The lack of professionality among social workers was raised in line with the avoidance or ignorance about the mental health of care-experienced young people. Several participants called for higher qualifications for social workers, foster carers and residential care workers to deepen their understanding of clinical psychology and mental health among care-experienced young people, especially in trauma and attachment. They hoped that intense training enhancing the assessment of mental health problems would strengthen the identification of those at risk of suicide and promote adequate responses to suicidal young people. For instance, in the following quotes, two young women from England criticised the limited qualification of social workers and their responses to dealing with mental health issues such as suicidal ideation and behaviour among care-experienced young people.

I mean all I know is they [social workers] probably go (-) go with you to the GP. Um, ring around some support centres and other organisations and (.) let you talk to them. And then that is it really. That is nothing more that they could do because there's some of them that I've spoken to which say 'We're not qualified in mental health, we're just support workers or social workers or personal advisors. So, we wouldn't know anything about that.' I think if maybe if they had special training in it, so they could offer that extra bit of support […] where young people can come and chat to, um, knowing that they could talk to their own personal advisors and social worker about these things. And maybe it could help, but half of them say that because they are not qualified in that profession they can't really talk about it. (E3)

I think, that social workers need to know a lot more about attachment, a lot more about trauma. Um. Almost just they need to know more about psychology. Um. As that should be (-) that should be baked into what social workers are taught [...] I don't think they talk very much about attachment and trauma which concerns me. Um. So, at least if they do, they kind of gating over the top of it rather than really getting into what it means and what that means to how you behave and what you do in practice. […] So, I think, the best thing they can do as professionals is to (.) just understand better, so where they're starting from is that they're informed and then now make best decision in the moment about how to respond. (E4)

Two interviewed young adults from Germany also raised criticism of inadequate qualification of social workers or care workers. While three reported very supportive and professional support from care workers and social workers, two reported inadequate responses by professionals when expressing the need for mental health support, as mentioned earlier. The qualification and professional skills of social workers and residential care workers to work with young people in care, and particularly address mental health issues such as suicidal ideation adequately, was a topic that four participants from Germany mentioned. One person highlighted that he never expected that care workers or social workers would be able to help him deal with his mental health problems compared to psychologists. However, he would have expected them to be able to take signs of distress seriously and have a professional conversation with a young person enabling a reflective view of his situation and figuring out possible solutions.

Because in my eyes they are all trained […] to be able to recognise such things. When someone lives in a residential facility for young people, they always have to carry their own baggage. Everyone. (.) and (-) and, um, in my eyes they should actually be trained

> *enough to (-) notice that they take these signs seriously when someone withdraws, when other residents come up to them and say 'here, there's something wrong with [D4].' Then they have to take it seriously. And unfortunately, they didn't do that.* (D4)

Several participants from both groups expressed their expectations that social workers and care workers should be able and confident to ask and talk about suicidal ideation. An important skill or characteristic of a professional is to show genuine interest in the young person to be able to have such conversations and for the young person to accept support.

In general, the wish for more awareness from professionals about the mental health among children in care and care leavers, particularly about suicide prevention, was echoed among interview participants. One young person from England stated that the mental health of children in care seemed to be a taboo topic affecting the accessibility of adequate support (see section 5.2.3).

As mentioned earlier, crucial to supporting coping with mental health issues and suicidal ideation would be inclusion of non-verbal signs such as behavioural changes or self-harming behaviour into the **assessment** and further planning of support. Some participants from both groups wished for more substantial acknowledgement and a more thorough assessment of the mental health of young people in care by social workers and care workers. Four participants from Germany called for professionals to pay more attention to non-verbal signs to identify a suicidal young person:

> *In any case, pay attention to the young person. So, if there are any cries for help or something like that (-) also pay attention to the body, not to mention the character, how he normally behaves, comparatively speaking.* (D1)

> *Don't let up if the child says that nothing is going on, even though you notice that something is going on. Just try to talk to the child and don't let go.* (D2)

> *That exactly in these moments, when things are going particularly badly, that you don't do something great, but that at that moment you definitely, um, have the certainty that someone is there, that it is noticed that you are perhaps not doing well.* (D5)

Furthermore, young adults called for a more child-centred assessment, including a systemic view as well as regular, preferably daily check-ups on care leavers to prevent them from feeling alone. Similarly, **person-centred approaches** based on individual abilities and needs were also raised by several participants from Germany. For instance, they suggested that one-to-one

situations with a professional and a young person would help build important trustful relationships to have conversations about mental health problems and enable support.

Apart from tailored support to address mental health issues among care-experienced adults, participants reflected on support more generally. For instance, a young adult from England called for support to help a care leaver who has been institutionalised integrate into society. One person wished for less problem-focused access to support, for example, from teachers in school, as she was only able to receive their support when raising an issue. So, she wished for unrestricted access to support from a positive and strengths-based perspective that would help young people in care develop a positive identity. Many mentioned that they would wish for a more robust person-centred approach with less focus on protocols and guidelines. They hoped that such a shift in professional approach would increase an empathic, more trustful relationship with professionals and help young people listen to professionals who try to help them cope with suicidal ideation. Furthermore, the availability of support, for example, of a PA, should be based on the young person's needs.

> *Social workers follow this strict guideline of what they have to do, what they have to talk about and everything which it where is fails because one case is different to the next case. Like, you can't talk to one person the same as another person. That's where it fails it's because they're trying to be robotic. And, like they may be robots but we're not.* (E2)

As mentioned above, the structure of the **social work and care system** also posed some restrictions in making support available for young people with care experience. Mentioned restricting structures included high caseloads resulting in overworked and burned-out social workers, the inconsistency of a responsible caseworker, and the feeling of the inflexibility of guidelines and pressure of filing reports instead of individual casework. This topic also included the wish for more involvement of care-experienced young people in decision-making processes both in their own case and on organisational levels. Among those wishes was the call for offering support for all care leavers until the age of 25, regardless of how independent a young adult would appear.

In summary, the findings of the theme 'structural support' show many similarities between both groups with a wide range of positive and negative experiences of accessing support. Both groups mentioned the value of the combination of formal and informal resources in a young person's support network to enhance the availability of resources. The appropriate qualification of relevant professionals in the care system and mental health services seemed crucial for young

people in care and after leaving care to be able to receive the necessary support to deal with mental health issues, mainly to cope with or prevent suicidal ideation. Therefore, professionals in the care system, whether social workers, PAs or residential or foster carers, would need to understand the mental health of the care-experienced population thoroughly. Participants highlighted the need for adults working with people in care and care leavers to deepen their knowledge of trauma and attachment. Such deepened understanding would enable practitioners to identify at an early stage young people with mental health problems, prevent the deterioration of their mental health and even the risk of suicide, and have professional communication with the young people to provide support. Access to suitable mental health support was mentioned to be often based on the young person's own initiative. Providing a low threshold and finding appropriate mental health support involving the young person in decision-making about the kind of support appeared crucial to ensuring mental health and early suicide prevention.

One striking case should be highlighted that reflected the positively experienced support from the key worker in residential care. The young person from Germany was able to discuss suicidal experiences and causes with her key worker, who was perceived as supportive in finding suitable mental health support. The open, trustful relationship with professionals, committed available support from her key worker and social worker, as well as the young person's choice of suitable children's home and psychotherapist were crucial for her mental health, positive experience in care and a smooth transition from care back to her father in early adulthood. Her positive experience reflected several recommendations and wishes by others with less positive experiences on how care professionals may be expected to deal with the mental health needs of young people in care.

While the English sample mainly reflected on the limited availability of social workers and unsuitable mental health support, this topic did not seem to play such a prominent role in the support system for German participants from residential care. Though mentioned in different ways, more awareness of young people's circumstances and mental health should be raised to offer more early support, including suicide prevention.

Further contrasts between the two countries could be found in the support for care leavers. While the English sample reflected on the statutory support for care leavers, at least on paper, they often wished for more support. In comparison, some participants from Germany actively decided against requesting leaving care support due to the wish to experience more freedom. In Germany, it is generally possible to extend a young person's stay in residential care beyond 18 with different options within the residential care system to prepare the young person for

independent living. In addition, the opportunity to visit the children's home and stay in touch with key workers on a more informal basis was appreciated. However, a hurdle to accepting this support seemed to be the concept of *Kostenheranziehung* that would compensate the costs of the support from residential care from the young person's income with up to 75% of their income. With the introduction of the KJSG (Act to Strengthen Children and Youth) in 2021, the amount of cost compensation has been reduced to up to 25% of a young person's income (see section 2.2.2).

Overall, structural support, mainly from professionals in the care system and appropriate mental health support, were identified as important factors contributing to the prevention and coping with suicidal ideation. Generally, availability and access to support were reoccurring topics across the interviews. As reported by several participants from both countries, the necessary support in the care systems in England and Germany, especially the support for care leavers, that would contribute to suicide prevention appeared to require tailored enhancements. Several interviewed young adults called for improvements, especially in the qualification of professionals as well as the access and availability of support.

5.3.3 Summary

Multiple aspects of the care system and related transitions demonstrated structural factors influencing suicidal ideation among care-experienced young people either while in care or after leaving care. Transitional experiences between care placements, services and from care were often reported as having a negative impact on a young person's mental health and potential trigger of suicidal ideation, such as the processes of leaving care to move into a flat alone or the closing of cases by support services. The majority of interviewed participants reported low mental health at stages of transition. However, if a young person was adequately prepared and had access to adequate support, including informal resources, the transition from care was experienced positively.

Access and availability of support were important for all interviewed young adults. This demand included support from social workers, PAs and carers, but mainly access to adequate mental health support. Often the individual effort was crucial to access necessary psychotherapeutic support. The qualification and skills of professionals, whether in the care system or mental health services, were essential though often criticised as inadequate to identify and support a suicidal young person to offer relevant help in terms of suicide prevention.

Among others, there were recommendations for deepening the understanding of professionals for a young person's situation, ongoing support in early adulthood, general awareness and access to information about suicide prevention, as well as low thresholds to adequate mental health support services, for example, directly within the care system and tailored to all people with care experiences. All of those suggestions were considered options for suicide prevention within the (leaving) care system.

5.4 Towards the bigger picture: An example of thematic interconnections

The previous sections presented 10 themes distinguished between the individual, interpersonal and structural levels. However, the 10 themes are not to be understood as independent from each other. Moreover, they often interconnect, indicating the complexity of the topic of suicidal ideation among people with care experience (see Figure 24). Based on reviewing the applied simultaneous coding as a means to narrow the focus on cross-thematic relationships, several reoccurring connections between codes and themes from different socio-ecological levels were identified. This section presents an example of the most prominent interconnections identified: feeling supported and cared about during the transition from care. The presentation aims to convey the bigger picture of the findings to understand further the experiences of suicidal ideation among people with care experience, an understanding that can provide the foundation of comprehensive suicide prevention strategies within the care system.

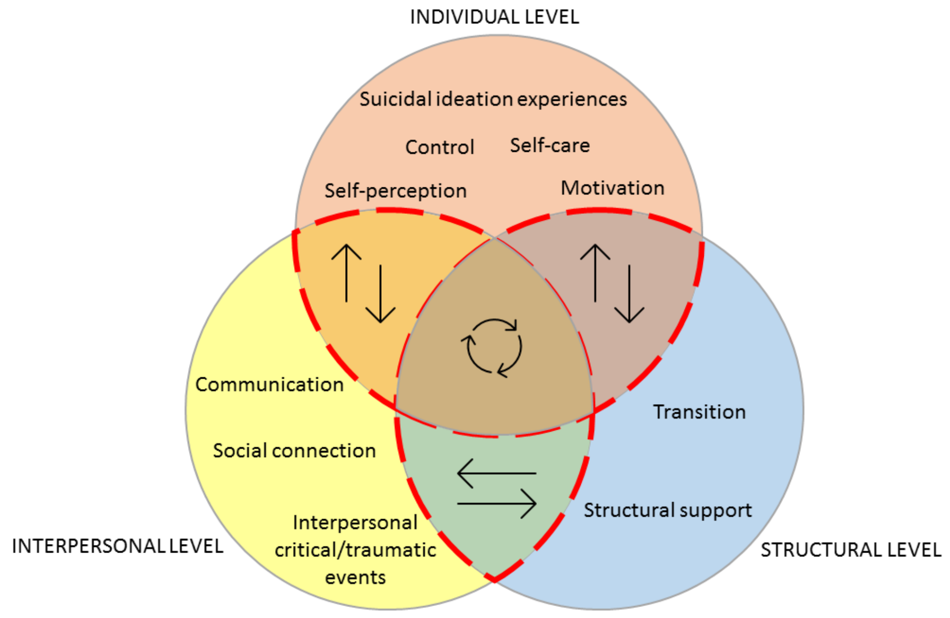

Figure 24: The overlapping socio-ecological levels highlighting interconnections between themes.

The example reflects relational factors influenced by the transition from care. The theme ‘social connection’ on the interpersonal level frequently appeared together with the two structural themes ‘structural support’ and ‘transition & places’. The codes ‘feeling of belongingness’ and ‘loneliness & social company’ commonly referred to ‘access & availability of support’ and ‘transition’. Belongingness in the context of transition and access to support was often identified as the feeling of being genuinely cared about by professionals.

Whether a young person felt that support was accessible or available was related to changes in the support system when leaving care and their feeling of (thwarted) belongingness. For instance, as mentioned previously, a young woman described how she perceived a lack of support when she left foster care for university, as she felt that the foster carer had supported her, showed interest and genuinely cared about her (feeling of belongingness):

> *[My foster carer] just showered me in compliments all the time. She was really nice to me. Um. She wanted to spend time with me like she wanted to go shopping […] And I supposed when that went away (.) and it was just me on my own in halls [...] a lot of it is a lack of support (.) is that I was just out on my own in the world and it felt like a lot. And it was really hard to (.) it was really hard to connect with people and make new friends. […] a big thing is just a lack of (-) a lack of support and then not being able to form new connections very easily.* (E4)

Furthermore, this report, even more, highlights that the transition from care with a change in the social environment with losing contact with peers and previous carers can trigger thwarted belongingness, as the young woman mentioned that she struggled to connect with new people and felt lonely. She highlighted that she developed active suicidal thoughts with a plan of suicide for the first time after the described transition from care to university. This case presents the interconnection between the transition from care, thwarted belongingness due to losing contact with people who made the young person feel cared about, and, thus, losing access to support that demonstrated an influence on the development of active suicidal ideation.

Another participant also presented how the transition from care and restrictions of available support can influence the development of thwarted belongingness and, thus, pose an elevated risk of suicide. As a young woman from England described (see also 5.2.2), leaving-care services terminate support based on the assumption that the care leaver can live independently. She explained that young adults might feel abandoned by their support services (thwarted belongingness) when closing their cases. Furthermore, this can cause the feeling of loneliness,

and trigger suicidal ideation and risky behaviour as a way to regain control to reaccess support if a young person felt they had no support available to rely on.

> *If they [young people leaving care] feel like that, you know, for example, they're being in their minds abandoned by the service [...] they'd being to let go because they're doing really well. What often happens is that they'll go back to those behaviours. And, you know, say that 'OK, well, you're leaving me because I'm not an emergency. Let myself turn into an emergency.'* (E7)

The findings show that circumstances that come along with transitions from care and leaving care services could cause feelings of abandonment, loneliness and thwarted belongingness. Especially critical were relational changes if the transition was connected with the loss of a relevant supporting person such as a foster carer that contributed to the young person's mental health, such as their self-esteem. Thwarted belongingness and loneliness during the transition were connected with the availability of relevant support. Similarly, the reports about the availability of professionals due to office working hours and public holidays were mentioned in connection with care leavers' feeling alone, as the following quote indicates.

> *Particularly the younger ones get almost angry about like, you know, you're supposed to be the person who supports me and you're only available between 9 to 5 Monday to Friday and 90% of the time you don't pick up the phone because you're too busy. Um. And I think that's an understandable like you're supposed to be my support network and you aren't available, so I don't have one actually. Um. It's a really reasonable response. [...] So, I think, actually what we need is (-) is more peer support, is more kind of making the connections between people who've been in care who are able to pick up the phone in the evening or on the weekends.* (E4)

While the interconnection of themes identified helps to understand a possible underlying mechanism of the development of suicidal ideation among care leavers, participants also suggested recommendations on how relational and structural factors can decrease the risk of suicide during this critical phase. The young woman from England explained in the last quote above how peer mentors can enhance the availability of support, especially for young adults transitioning from care. Several participants recommended extending the support network of care leavers and, therefore, the availability of support if additional social resources such as peer mentors are used. As the findings showed, peer relationships that include shared experiences would contribute to the feeling of belongingness as feeling understood. They could further be used in semi-formal peer mentoring programmes connected to leaving care services as a means

of suicide prevention. Furthermore, mentors and role models were identified to be able to contribute to a person's motivation for starting to cope with suicidal ideation (individual level).

The findings from the interviews showed that the feeling of belongingness as feeling cared for by others, especially by professionals, can positively impact a young person leaving care. The following example given by a young woman presents how a specific offer within formal leaving care support (structural level) can demonstrate to a young person that the organisation cares about them and their future (interpersonal level), which can strengthen the care leaver's self-esteem and motivation (individual level):

> *So, this programme, um, it's for any care leavers who are going for their first interview and they don't have work clothes which you find a lot of young people in care do not own suitable clothes for an interview. Now, this organisation, were amazing by the way, um, and they got me in my first lady suit [...] Now, not only are you looking really good, super professional and feeling [pepped-up?] to, you know, try and actually do something with your life, but also they gave me something designer which at that time was only designer item that I owned [...] Um, at the time it really (.) it really helped and it pushed me 'cause I was like not only do I look good for this interview but I feel good and people have actually gone out their way to invest in me because it's not like I've just even got my basic work stuff like someone's really (.) believed in me enough to get me something like this to be able to push me to make the first steps. [...] So, I think, doing that (-) and it was just a simple thing, you know, [...] And from that day I was like, OK, these people I don't know, really believe in me to get this job and to, you know, get the work done.* (E6)

The young woman described that she felt supported. She perceived that the professionals showed genuine commitment to her and her success in her career through their financial investment, which further contributed to her self-worth and self-esteem and even to her motivation to succeed in her working life. The value of the material contribution that she perceived as extraordinarily high for a care leaver seemed to make her re-evaluate her self-worth positively as being higher than she had thought before. Similarly, further participants described the positive effects when professionals went 'the extra mile' for them and 'invested' their time and effort (interpersonal level) to further push their self-worth and motivation to work on their future goals (individual level). The case presents the individual–relational–structural interconnection of themes on how a simple act of structural support for care leavers could

empower young people in the transition from care to an independent life and, therefore, has the potential to contribute to their life satisfaction.

The presented interconnection of multiple factors shows how critical the time of transition in early adulthood can be for a young person in the development of suicidal ideation. The transition affects a young person on multiple levels: in the access and availability of support (structural), changes in their social environment (interpersonal) and also their self-perception and, thus, suicidal experiences (individual). Therefore, this understanding can help address specific risk factors identified in the transition from care with targeted practices within the (leaving) care system.

In conclusion, the findings propose that the factors influencing suicidal ideation among care-experienced young people are diverse and interrelated across various socio-ecological levels. The results indicate the complexity of understanding suicidal ideation in the context of care experience. Moreover, they indicate how specific aspects of the care experience and care system (for example, access and availability of support and transitional experiences) connect to interpersonal components (such as the feeling of being cared for) and individual elements influencing suicidal ideation, its development or related coping strategies.

Suicidal ideation among care-experienced young people can occur before entering the care system, while in care or after leaving care. However, transitions, particularly from care to an expected independent living, appeared to play a major role for several interviewed young adults.

The findings from the interviews present the multi-faceted components of suicidal experiences and coping factors. Looking only at factors would neglect the complexity, but considering their interconnections helps to identify underlying mechanisms to understand suicidal ideation among this group. A socio-ecological perspective contributes to the bigger picture to deepen our understanding of factors influencing suicidal ideation among people with care experience. Thus, the comprehensive reflection on interconnections of factors can inform suicide prevention strategies tailored to young people in care and transitioning from care to adulthood.

6. DISCUSSION

In light of the critical realism approach, this chapter starts by reflecting on the identified demi-regularities based on the patterns identified in the quantitative survey data to discuss the range of the occurrence of suicidal ideation among people with care experience in England and Germany. The following section, reflecting on the qualitative findings, focuses on the socio-ecological perspective on the interconnections of factors identified as underlying mechanisms influencing suicidal ideation among this group.

With the interpersonal-psychological theory of suicide (IPTS) guiding this research, the discussion about the complexity of this phenomenon centred on relational factors helps better understand the experiences of suicidal ideation among adults with care experience. This focus further helps inform recommendations for policy and practice for suicide prevention tailored to people with care experience. In the end, the limitations of this research are presented before closing this thesis with a conclusion of the main key contributions of this research and outlook for future research.

6.1 The occurrence of suicidal ideation among care-experienced adults

This section discusses the findings to answer the first research question – ***What is the occurrence of suicidal ideation among people with care experience in England and Germany?*** – based on the analysis of the survey complemented with additional information gathered from the interviews. The following presentation has a mainly quantitative focus to establish how common specific occurrences of suicidal ideation among care-experienced people are, while the interview findings help add a more detailed description. The results propose a wider understanding of the complexity of the experience of suicidal ideation in the context of care experience that may not allow a single clear answer to the question above.

The survey findings reflect previous research that people with care experience have a high risk of experiencing suicidal ideation and, thus, suicidal behaviour also (Evans et al., 2017; Pilowsky and Wu, 2006; Vinnerljung et al., 2006). While not everyone would act on their suicidal thoughts, the risk of doing so and, thus, the risk of dying by suicide is increased due to the high prevalence of the cognitive components. These findings highlight how important this topic is for people working with people with care experience.

Furthermore, the findings show that suicidal ideation occurs in various experiences. Knowing the range of suicidal occurrences is necessary for professionals to understand this phenomenon better when working with people with care experience. The following three main areas of findings identified present the range of the occurrences of this complex phenomenon: age(s) when participants experienced suicidal thoughts for the first time, different times of the occurrence of suicidal ideation, and different types of thoughts.

First, suicidal ideation among care-experienced people can occur from a very young age. The pre-adolescent age identified at which many participants reported having experienced their first suicidal ideation, reflecting the findings of the US study by Taussig et al. (2014), highlights the need for early awareness of the risk of suicidal ideation and behaviour among children in care. For others, their first suicidal thoughts occurred during adolescence or in adulthood. Therefore, while many care-experienced participants had already faced suicidal thoughts from a very young age, the first suicidal ideation can occur at different ages, from pre-adolescence to adulthood. Understanding the range of first occurrences requires a long-term perspective of suicide prevention and continuous awareness across all ages. However, initiating preventive steps early would help address the young people's needs and, thus, reduce the risk of suicide from a young age and in their future. As discussed in the following sections, several factors can influence whether and when a person develops suicidal ideation, and the age of occurrence does not rely on a specific age.

Second, suicidal thoughts can reoccur and develop further at different times. Early awareness and prevention are even more important when looking at the reported trajectories of suicidal ideation up to early adulthood. Emerging adulthood appears to be a vulnerable time when suicidal ideation increasingly occurs. The occurrence of suicidal thoughts seems to stay high in early adulthood, as the survey data of recent Paykel Suicide Scale scores (PSS) show results similar to the high level for care-experienced adolescence as the study by Evans et al. (2017) estimated. While the study by Evans et al. (2017) looked only at data from minors with care experience, the findings of this study have identified critical times that suggest that the risk of suicide may even increase in early adulthood.

The responses to the open-ended survey questions show that suicidal ideation often occurs during transitions. As identified in the interview data, transitions, especially during emergent adulthood, were times when suicidal thoughts increased in severity, such as when participants started to make suicide plans. As reported by Rodway et al. (2016), late teenage and early adulthood are times when a sharp rise in suicides among young people in England was

observed. Similarly, in the German national statistics published in 2018, the young adults aged 18–19 in Germany demonstrated the highest age-related number of suicides among all other causes of death (Statista, 2018). Apart from many changes at age 18 as the typical leaving-care age in both countries, the findings support Boeninger and Conger's (2012) report that the risk of suicide among care-experienced young people is even likely to increase during emergent adulthood compared to adolescence.

The findings indicate an increased risk of (re-)experiencing suicidal ideation at specific times in early adulthood when young people age out of care. Furthermore, considering the young age that some participants reported having experienced their first suicidal thoughts, these times during emerging adulthood and transitions may also risk an increase in their severity, as discussed further below. Therefore, the risk of suicide may even escalate in early adulthood during the transition from care and later when leaving-care services close the young people's cases and cease their support. While the specific time when suicidal ideation occurs cannot be pinpointed, these times with a higher risk of the occurrence of suicidal ideation among young adults with care experience need to be considered for suicide prevention. Thus, suicide prevention for people with care experience would not only need to start from a young age but continue until adulthood, as suggested above, which would help counteract the further trajectory of the occurrence of suicidal ideation, especially by paying particular attention to emergent adults.

Third, suicidal ideation can occur in different forms. Suicidal ideation ranges from passive to active suicidal thoughts and can sometimes be chronic. Continuous, possibly chronic experience of suicidal ideation, identified in the interviews as 'continuous background noise', has been found in the context of emotion dysregulation and as a risk factor for future suicide attempts and hospitalisations among young people (Wolff et al., 2018). Considering that suicidal thoughts can reoccur or be experienced as a continuous background noise contributes to a realistic understanding of different trajectories of suicidal ideation and recovery.

The severity of suicidal thoughts can be distinguished between passive and active suicidal thoughts. Those types were reported, though not named directly as those, in the interview data: passive suicidal thoughts, on the one hand, were identified in statements such as, "it would be great if I could just disappear" (E1), "life is not worth living" (D5), "I should just die" (E4), "hoping to not have to […] exist […] for much longer" (E7), or "it's easier if I am not here […] [but] six feet under" (D4), which are in line with van Orden et al.'s (2015) definition based on the PSS (Paykel et al., 1974). Active suicidal thoughts, on the other hand, were classified as

serious thoughts of taking one's life and serious suicide plans (Paykel et al., 1974; Van Orden et al., 2015). There were specific times that were identified to trigger the occurrence of active suicidal ideation, such as the transition from care in early adulthood that was identified from the interview data.

Any kind of suicidal ideation needs to be taken seriously. Passive suicidal thoughts from a young age can further develop into active suicidal thoughts that increase the risk of acting on them and, thus, dying by suicide. Significantly, the previous or simultaneous occurrence of self-harming behaviour is crucial when looking at the risk of suicide for young people with care experience.

The IPTS explains suicide attempts and death by suicide with the simultaneous presence of the desire to die and the acquired capability. The IPTS factor 'acquired capability' would enable suicidal people to act on their intent to die by self-inflicting lethal injuries (Joiner, 2005). As the focus of this research was on suicidal ideation, the acquired capability was not assessed in the study. However, in the survey and interviews, several participants reported self-harming practices such as trajectories from non-suicidal self-harming to later experiencing suicidal ideation. Increasing the tolerance of physical pain due to non-suicidal self-harming experiences may contribute to the increased risk that young people may act on suicidal ideation and, hence, the risk of suicide (Joiner et al., 2012). As previous research reported, non-suicidal self-harm is considered highly prevalent among young people with care experience (Wadman et al., 2017), indicating the elevated risk of attempting or dying by suicide in combination with the increased risk of experiencing suicidal ideation.

Critically in this context appears the report by one young woman who described that residential care workers ignored her self-harming practices while she was in care, and she attempted suicide when she lived alone in semi-independent accommodation. Ignoring such behaviour previously and later not checking up on a young person who lived by themselves for the first time appears highly risky and negligent regarding suicide prevention by the professionals acting as the corporate parent. The description by Harvey et al. (2015) also highlighted that young people especially in the transitions from places and institutions, inter alia from care, can trigger the occurrence of self-harming behaviour as a coping strategy to deal with their emotions. While the transition from care in early adulthood is a critical time at which suicidal ideation can occur, especially active suicidal ideation, the risk of suicide is increased if a person additionally engages in self-harming behaviour. Therefore, the findings imply that practitioners need to take

self-harming behaviour seriously as a potential suicide risk factor in case the young person develops suicidal thoughts at some point, especially during transitions.

In conclusion, the range of suicidal ideation, possibly occurring first from a very young age but reoccurring or maintaining up to adulthood, even further highlights that suicide prevention needs to start early and cannot end when young people with care experience turn 18. The findings provide insights into a range of trends (demi-regularities) of the occurrence of suicidal ideation among people with care experience, with many similarities found among care-experienced people from England and Germany. While the main differences identified appear to be the number of placement changes in care and access to appropriate mental health services, the risk and range of suicidal ideation are similar. Thus, the findings indicate that the higher vulnerability to experiencing suicidal ideation among care-experienced people is likely to apply cross-nationally, as several studies looking at different countries reported similar trends (Berlin et al., 2011; Evans et al., 2017; Katz et al., 2011; Vinnerljung et al., 2006).

This extended knowledge about the range of the occurrence of suicidal ideation and behaviour among care-experienced young people, to which the findings of this study contributed, is essential for policymakers and practitioners working with care-experienced people to plan and implement tailored suicide prevention strategies. Therefore, an understanding of underlying mechanisms explaining the occurrence of suicidal thoughts among people with care experience is vital for suicide prevention within the (leaving) care systems, as discussed in the following section.

6.2 Factors influencing suicidal ideation: A socio-ecological perspective

The second research question – ***Which factors influence suicidal ideation in people with care experience?*** – aims to identify underlying mechanisms to deepen the understanding of the experiences of suicidal ideation among care-experienced young people. With the findings of the personally reported experiences of interview participants, supplemented by the analysis of the survey data to identify relationships between specific variables and suicidal ideation, several factors were identified influencing suicidal ideation.

This research question and discussion cover two types of factors. Identified factors contributing to the development of suicidal ideation that participants perceived as potential triggers are discussed to answer the subquestion: ***Which factors do young adults with care experience perceive as causative for the occurrence of suicidal ideation?*** This investigation seeks to

inform practitioners to identify those at greater risk of developing suicidal ideation. In addition, resources and coping strategies are discussed considering the second subquestion – ***Which factors do young adults with care experience perceive as helpful for coping with suicidal ideation?*** – to reflect further on suicide prevention in light of empowerment of young people with care experience. The interview data lead to answering the research question to develop an in-depth understanding of factors and mechanisms influencing suicidal ideation, on the one hand. On the other hand, the reflection of the interview findings further offers a comprehensive understanding of the bigger picture by applying a socio-ecological perspective. The socio-ecological perspective helps to explore crucial relationships between different factors and their interconnection. The individual, interpersonal and structural levels are fluid and cannot be viewed independently from one another.

The IPTS was the theoretical foundation guiding this research project with a focus on relational factors. Hjelmeland and Knizek (2020) viewed the IPTS critically, for instance, for confusing intra- with claimed interpersonal factors, for its simplicity and for neglect of a broader socio-ecological context. Suicidal ideation is a complex experience that needs to be considered across all socio-ecological levels to understand this phenomenon in depth. The two authors underlined the need for qualitative research to understand the risk of suicide across broader developmental and relational issues (Hjelmeland and Knizek, 2020). In contrast to Hjelmeland and Knizek's (2020) criticism, by reviewing the findings of the socio-ecological framework identified from the interview data, the concepts of thwarted belongingness and perceived burdensomeness appear not only to be prominent factors influencing suicidal ideation among people with care experience but interconnected with the individual and structural levels.

Before proceeding with the interpretation of the study's findings, a brief theoretical reflection demonstrates the IPTS's broader socio-ecological potential. As Carmer and Kapusta (2017) showed in the multi-level suicide risk theory of their socio-ecological model, the factors of the IPTS overlap from the individual level via interpersonal up to the community and societal level. The two researchers considered that the feelings and perceptions of a person (individual level) – based on Shneidman's (1998) psychache theory – and structural changes of a person's environment (structural level) – referring to the military transition theory by Castro and Kintzle (2014) – interconnect with the IPTS factors (Cramer and Kapusta, 2017). The research group led by Joiner proposed a combination with hopelessness: on an individual level, a person is at risk of developing active suicidal ideation if they perceive the two experienced IPTS factors as constant and thus are hopeless for a positive development (Joiner et al., 2012; Van Orden et al., 2010). Joiner (2005) drew parallels of his concepts of perceived burdensomeness and thwarted

belongingness to the sociological suicide theory by Durkheim (1897 cited by Selby et al., 2014), namely altruistic and egoistic suicide, widening his theory to the societal level. Therefore, IPTS not only focuses on only one level but also draws links across multiple levels. As this section illustrates in the following discussion, the focus on interpersonal factors proposed by the IPTS helps inform the socio-ecological perspective for an in-depth and comprehensive interpretation of the study's findings exploring factors influencing suicidal ideation among people with care experience.

Based on the novel knowledge provided from this study, I argue that individual, interpersonal and structural factors are not independent but influence one another, affecting the occurrence of suicidal ideation among people with care experience. Several examples can be given to illustrate the interconnections and interdependencies centred on interpersonal factors.

Starting with a factor often reported as a perceived cause of suicidal ideation by participants, critical and traumatic events are commonly associated with both care experience and the risk of suicide. Many young people enter the care system because of childhood adversities (Department for Education, 2021; Gupta, 2016; Statistisches Bundesamt, 2021a), which are considered to be risk factors influencing suicidal ideation and behaviour (Angelakis et al., 2020; Angelakis et al., 2019; Hamilton et al., 2015; Schönfelder et al., 2021), as reflected in the findings of this study. The higher exposure to such interpersonal adversities offers one part of an explanation for why care-experienced people show an elevated risk of suicide. However, such traumatic experiences per se only seem to scratch the surface of a possible explanation of why people with care experience have an elevated risk of suicidal ideation and behaviour, as the in-depth analysis of the interview findings showed. The question arises as to what such experiences further mean for a person that cause them to develop suicidal ideation. Exploring the underlying mechanism of suicidal ideation in greater depth, the findings show that traumatic interpersonal experiences often interconnect with individual factors and feelings of belongingness. Furthermore, interpersonal critical or traumatic events identified from the findings go beyond those resulting in becoming looked after by the local authority. They also cover the loss of a beloved person, bullying by peers or other traumatic events experienced in adolescents or early adulthood after having left care.

Relational factors often influence how an individual perceives themselves. The interview findings show that a negative self-perception and self-blame relate to experienced interpersonal traumatic events that also affect a person's self-worth and the feeling of losing control.

Negative self-perceptions – including self-blame for traumatic events such as abuse, the feeling of being a failure triggered by the fear of letting down beloved ones initiated or maintained by harassment, or the feeling of being a burden for others – are individual factors that contain relational components.

The findings identified components of belongingness incorporated into such perceptions and experiences. On the one hand, interpersonal traumatic events imply a missing feeling of protection and being cared for, and being alone in dealing with these experiences and emotions. On the other hand, a negative self-perception can reflect the feeling of being a burden or letting others down, which reflects a close social-emotional connection and, thus, belongingness to beloved people. Therefore, these individual perceptions relate to belongingness, either thwarted as feeling alone and not cared for or having strong reciprocal caring relationships. IPTS argues that perceived burdensomeness and thwarted belongingness simultaneously cause suicidal ideation.

The statistical findings from the survey present that perceived burdensomeness is related to suicidal ideation, and this reflects the results of previous studies (see Ma et al., 2019; Van Orden et al., 2012). Self-blame, for instance, is a component of perceived burdensomeness (Van Orden et al., 2010) that has been identified in reports about experienced abuse, mainly sexual abuse. However, as highlighted by one interview participant, self-blame seems to be common among young people for being in care. This negative individual and interpersonal experience would further underline the magnitude at which care-experienced people are at risk of developing suicidal ideation. When looking at the qualitative data in which perceived burdensomeness was identified, this factor illustrates its connection to the impact of close reciprocal caring relationships, which van Orden et al. (2010) defined as absent in the second IPTS concept of thwarted belongingness.

The findings highlight that belongingness needs to be placed at the centre of understanding suicidal ideation among people with care experience and incorporated into a comprehensive, multi-level perspective. Individual needs contain the fulfilled wish of being loved and feeling of belongingness by having reciprocal caring relationships. However, structural processes within the care and leaving care system sometimes imply tensions in providing the necessary circumstances within the care system to address these needs adequately. For instance, structural processes such as changes in the physical and social environment and the availability of support may trigger the interpersonal factor of 'thwarted belongingness' due to the feeling of abandonment, rejection and being alone. On an individual level, these feelings triggered by

interpersonal changes can further trigger young people's feeling of being overwhelmed with having to deal with challenges and emotions all by themselves, causing losing control and feeling powerless to solve their problems. If this feeling persists in the hopelessness that the situation will not get better due to a lack of support, suicidal ideation is more likely triggered.

Belongingness has been identified as the crucial factor influencing suicidal ideation among people with care experience. Thwarted belongingness due to people's perception that others do not care for them, exclude them, and do not notice them and their needs was especially prominent in the context of care experience. From entering care and shared care experiences with siblings to professional relationships of relevant practitioners to the transition from care and closing care in early adulthood, (thwarted) belongingness was identified across multiple components of the care experience that promote the understanding of the elevated risk of suicide among this population. Five primary interconnections identified across the socio-ecological levels illustrate that belongingness is a central component of the underlying mechanisms influencing suicidal ideation among people with care experience.

First, entering care, separation from siblings and breakdowns of foster placements were often called critical events that come along with feeling abandoned and being different from others. Thwarted belongingness offers an explanation of why survey participants whose siblings lived with their family while they were the only family member in care showed higher suicidal rates in adulthood. The shared experiences, feelings and sense of identity among siblings together in care, as discussed by Ashley and Roth (2015), as well as a stronger feeling of connectedness to the foster family home when living together with siblings (Hegar and Rosenthal, 2011) relate to the feeling of belongingness. Loh and Vo (2021) offered a possible reason for the impact of siblings with care experience in later life. The authors underlined that siblings who lived separately in different care placements may share some experiences only in adulthood. Care leavers in adulthood are likely to feel connected with their siblings because of a shared care experience and identity, even if they did not live together in the same place while in care (Loh and Vo, 2021). Hence, this finding further implies that the shared care experience with siblings is a relevant resource contributing to a positive feeling of belongingness and presents a protective factor against suicidal ideation in adulthood. Shared care experience as a protective factor contributing to belongingness would also explain the potential role of peers in suicide prevention, which is discussed further below.

Relationships especially with birth or foster family members of young people with care experience can affect both the feeling of belongingness and perceived burdensomeness. The

interview data illustrate that, on the one hand, strong positive relationships with beloved people, which imply a positive feeling of belongingness, are essential resources to decide against suicide and not act on suicidal thoughts. On the other hand, as soon as a person develops the ideation that they are a burden (perceived burdensomeness) and that beloved others would benefit from their death, these strong relationships and the feeling of belongingness become risk factors. Therefore, family relationships can influence the self-perception of a young person in care as being a perceived burden, their sense of belongingness and their motivation to act on or against suicidal thoughts, which are all identified factors for developing or coping with suicidal ideation.

Second, belongingness as feeling cared for and recognised or also thwarted belongingness were identified in relationships with professionals in the care system, such as social workers, PAs or carers contributing to the development of suicidal ideation or coping strategies. Relationships play a crucial role in the development of suicidal ideation, and thus, practitioners within the care system form an important relationship with young people in care. Care-experienced young people especially often raised the wish of feeling cared for and having people who are genuinely interested in them and their well-being.

If a young person felt that practitioners genuinely cared for them and went the extra mile to support them, this commitment contributed positively to their well-being and a positive relationship with the professional. However, as identified in several interviews, some young people explained that at times of their suicidal ideation, they did not feel that those responsible for them, namely professionals within the care system, would consider and address their needs. If the professional relationship was experienced as distanced, untrustful and not recognising the young person's needs or if a positive, supportive contact terminated due to the transition from the service, negative impacts on the young person's mental health, for instance, on their self-worth, were reported. Similarly, due to changes in responsible professionals such as social workers, the inconsistency hindered forming a supportive relationship between professionals and young people, and this barrier risked causing the young person to feel lonely and that their needs were not recognised. The impact of relationships between professionals and a young person with care experience are central components of the underlying mechanisms explaining suicidal ideation.

If services close the young people's cases or they leave a foster family abruptly, the feeling of belongingness can be further affected, as the young people are more likely to feel abandoned or rejected by the professional. There is a need for caring, reciprocal relationships. However,

structures within the (leaving) care system do not, in every case, enable practitioners to fulfil this need of young people in their work. For instance, as identified both from the interview and survey data, young people who present themselves as 'functioning' receive less attention and support. The reduced support and care risk that the young person feels not cared for and, thus, develop suicidal ideation, which further risks their developing dangerous behaviour to access the support they need.

Caring relationships are essential in the prevention of suicidal ideation among a care-experienced group of young people. The desire to feel belongingness and maintain essential relationships seems to be impacted by organisational practices on a structural level. There is a tension between the individual needs for love and care and the structures, guidelines and caseloads of the care systems that restrict professionals from implementing caring relationships. While young people have the desire for belongingness and support, the care system's structures are often described with high caseloads, high fluctuation in staff and demanding working conditions.

Additionally, Kaip et al. (2022) reflected on the positive impact relationships with professionals can have on the young person's mental well-being. At the same time, they also identified issues and dilemmas impacting the relationships. While they showed that professionals often face challenges in their work with looked-after children, practitioners receive little support from their organisation, which further impacts their job performance, health and personal life. For instance, practitioners are exposed to traumatic experiences themselves when working with often traumatised young people with care experience. Therefore, practitioners require adequate support to help they themselves cope with these challenging working conditions. Among the professionals interviewed by Kaip et al. (2022), most reported insufficient support from their organisation to help them deal with the strains of their work.

Additionally, the authors identified negative perceptions of the professional from other professions and the wider society and challenges in inter-agency collaboration, including the police and mental health services, to offer the support young people need, which impacts the service provision (Kaip et al., 2022). As the findings show, these challenges would further affect young people's access to appropriate mental health services. Such described working conditions for professionals are likely to result in high staff fluctuations and, thus jeopardise the opportunity for both practitioners and young people to establish a long-lasting, caring relationship with each other. The fluctuation of key workers risks thwarted belongingness

among the young people, as they are likely to feel abandoned by the professionals changing roles.

This tension between service provision and individual needs appears to be a structural problem that can cause looked-after young people to develop a negative, even hostile, perception of social workers, as described by Kaip et al. (2022). Furthermore, such tension shapes practitioners' options to establish a caring professional relationship, as individual key workers are likely to be blamed for inadequate care. Therefore, current social work and (leaving) care services structures hinder fulfilment of the young person's need for a long-term, reliable and caring relationship, reflecting a dilemma that many practitioners possibly face. However, interview data highlight that adults with care experience understand that the inconsistency and unavailability of key workers is a structural problem rather than a personal fault of the professional. If these structural problems cannot be solved to enable practitioners to offer caring relationships, which not every young person would even accept due to the lack of trust, an extension of positive relationships with family members, carers or peers would be an option to consider.

The programme 'Lifelong Links', developed by the Family Rights Group, is a practical example of how extended, long-lasting relationships with young people with care experience can be established and maintained as a positive support network during care and in adulthood (Holmes et al., 2020). The evaluation conducted by Holmes et al. (2020) showed that the project had positive effects on the young people with care experience, including reduced loneliness and social isolation. In addition, the researchers found that the project reduced the costs for the support per involved young person due to placement stability and some young people no longer being looked after (Holmes et al., 2020).

Especially when young people or professionals leave the service or support ceases, the young people feel lonely and abandoned by professionals and service providers due to a lack of support. These are often structural components associated with (leaving) care services, leading to one main area impacting suicidal ideation: transitions.

Third, transitions on a structural level bring changes in a young person's physical and social environment. Especially in England, complaints about and impacts of instability of relationships with social workers and PAs were often raised. Placement changes, with higher numbers in England, or fluctuations of staff members within the social services present instabilities in relationships. Bollinger et al. (2021) argue that the simple counting of placements would not justify the meaning of stability or instability within the care associated with the

outcomes of young people later in life. However, consistent, genuinely caring relationships within the care placement would instead contribute to the experience of stability and related outcomes (Bollinger et al., 2021). While no significant correlation between placement changes and suicidal ideation could be found, survey participants mentioned transitions as one of the most common changes when they first experienced suicidal thoughts. The reported impact of instability of placements and relationships related to thwarted belongingness was supported by the qualitative data gathered in this study.

Times of transitions within and from the care system, such as when support ceases, were crucial times identified when suicidal ideation occurred more prominently, as reflected in the survey findings. These times were often related to loneliness and thwarted belongingness. Loneliness is an essential factor associated with suicidal ideation (John et al., 2021; McClelland et al., 2020; Samaritans, 2019; Stickley and Koyanagi, 2016), common among care leavers with low well-being and increasing with age (Briheim-Crookall et al., 2020b). Loneliness as a risk factor for suicidal ideation especially occurs in early adulthood when a young person leaves care and moves into a flat alone or when support terminates, leaving the young person without having an established support network to rely on.

As interview data showed, thwarted belongingness at times of transition seems to be caused if young people had the perception that their care and professionals' decisions about transitions, such as abrupt moving out of a placement or ceasing of support, were based on financial or organisational reasons rather than on their needs. Such decisions made by services or organisations (structural level) about a young person's transition can affect the young person on an individual and interpersonal level. For instance, they can mean that a young person's need to feel cared for remains unfulfilled, causing them to feel abandoned, excluded and losing control, and possibly affecting their self-perception. Therefore, such decisions about transitions are crucial practices required to reflect on, considering their effects on the young person from a socio-ecological perspective.

Fourth, the broader societal background is another major interconnection between structural and interpersonal levels and their impact on suicidal ideation. As the findings identified, feeling alienated and lonely due to the care experience may be another individual risk factor for reaching a societal context. In light of Durkheim's conception of egoistic suicide (1897 cited by Selby et al., 2014), specific, time-related risk factors constitute cultural holidays that are often family-focused events, such as Christmas, Mother's or Father's Days. During these days, some people with care experience are more likely to perceive a lack of social integration as

feeling alienated and lonely. As one survey participant reported, this alienation due to her care experience can be permanent, reoccurring at specific societal or cultural holidays. This feeling of alienation in her report seems to cover an overall societal level beyond the focus of the person's closest social contacts. A report by an interview participant supports the risk identified of this time-related societal factor, with the feeling of loneliness at Christmas due to having no available and accessible support while living in temporary accommodation as a care leaver, which triggered suicidal ideation and behaviour.

Butterworth et al. (2017) underlined that the feeling of being different as a kind of lacking belongingness can continue from childhood to adulthood after leaving the care system. Thus, if the care experience and the care identity trigger a person's feeling of generally thwarted belongingness during specific societal or cultural events, then especially young adults with care experience living alone need to be particularly supported during those times to prevent an escalation of suicidal ideation and behaviour. This targeted support requires awareness of the risk of suicide among care-experienced young people, especially care leavers, on a structural, wider community and societal level to ensure that they are not alone and have appropriate support available.

Peer relationships and mentoring programmes can address several needs, including the feeling of belongingness and the availability of support on a structural level. Study participants indicated the value of such schemes as a potential component of suicide prevention strategies, especially for young adults who have left care. As Stein (2012) discussed, mentoring schemes provide support in the form of advice for young people leaving care, especially relevant for vulnerable care leavers to assist in dealing with problems. Mentors as consistent, caring adults in the support network of care leavers could be placed between formal support and informal support, such as family and friends (Stein, 2012). Furthermore, the study by Newton et al. (2017) investigated mentoring schemes during the transition from care regarding their impact on depression. The authors found that care leavers concerning their emotional well-being would benefit from a long-lasting, open-ended, natural and empowering relationship with a mentor who is available during out-of-office hours and genuinely cares instead of being paid to care (Newton et al., 2017).

Like the finding of the role of siblings sharing the experience of being in care in adulthood, the shared experience with other care-experienced people seemed to address the desire for belongingness and understanding. While peer relationships would need to be assessed on their contribution of support for a young person, they have the potential to gain higher acceptance as

an alternative source for support than professionals or family, especially among care leavers who would be classified as survivors (Stein, 2012).

Furthermore, peer mentors may continue the relationship even after their cases are closed and formal support ceases. A peer mentor with a shared care experience who genuinely cares and is available independent of strict timeframes addresses the desire for a positive feeling of belongingness among young people leaving care that, as the current study showed, is associated with suicide prevention. Mentoring schemes can contribute to a young person's motivation for coping and self-care on an individual level, provide an additional social resource and feeling of belongingness on an interpersonal level, and extend the accessibility and availability of a care leaver's support network on a structural level. As reflected in several interviews, peer mentoring programmes can be an option to contribute to continuous, reliable relationships, which many professionals often cannot offer due to their working conditions, as described above. However, peer mentoring programmes would also need to consider the well-being of the mentors themselves by avoiding overburdening those who take on the role of offering appropriate support. Therefore, (peer) mentoring schemes are valuable components of suicide prevention tailored to young people leaving care. They can contribute to the feeling of belonging by offering long-lasting reciprocal relationships.

Finally, another major finding that illustrates the interconnection between individual, interpersonal and structural factors is communication, which affects relationships and, thus, the feeling of belongingness. Communication of young people's needs is essential and requires promotion on a structural level to empower the relationships and help-seeking actions of young people with care experience. As highlighted in the interviews, having the option to talk about the experience of suicidal ideation and feelings related to those thoughts is a desire of many suicidal young people and a coping strategy if this communication is enabled.

However, stigma about the care background or mental health is often impacted by communication that seems to be grounded on the structural level. The report by Samaritans (2019) underlined that stigma, fear of consequences and uncertainty about options to deal with loneliness and suicidal ideation were barriers for young people in the UK to reaching out for support. The consequences of stigma on suicidal ideation and behaviour described were reflected by the study's findings, indicating a vicious circle in which the person would feel more distanced and alone with their problems and then overwhelmed. As identified from the interviews, this chain of factors could trigger suicidal ideation.

Stigma on mental health and suicidal experience is a risk factor on the societal level (Cramer and Kapusta, 2017), which further affects organisational structures and, thus, professional relationships. The interview data showed that stigma on mental health was perceived in the work procedures as social workers 'fearfully' avoiding the topic of the mental health of a child in care, having inappropriate conversations about mental health issues or referring to inadequate counselling services instead of specialised support. This avoidance of communicating about this topic risks the young person perceiving that professionals or the service do not care about the young person's needs and further may cause the feeling of being alone with their problems.

Communication needs the foundation of trust, the feeling that professionals genuinely care for the young person and transparency of support to address the young person's needs. As also described by a young woman in an interview, open communication about mental health needs and suicidal ideation help to find appropriate support in collaboration with the young person. However, key workers' time limitations and inadequate skills can restrict the necessary foundation of communication and risk developing stigmatising practices due to insufficient responses.

Belongingness is crucial to establishing effective communication incorporated for suicide prevention for care-experienced people. Communication requires a caring relationship and is the foundation for building a good professional relationship based on feeling genuinely cared for. However, society, culture and the structures within the (leaving) care system influence how people – in this case, practitioners and young people with care experience – feel about communicating about mental health, including the experience of suicidal thoughts.

Reflecting on the unprecedented times during which the study took place, namely during the COVID-19 pandemic, concerns were raised that the pandemic and safety measures including lockdowns and social distancing would have severe mental health impacts such as an increase in the risk of suicide.

Indeed, the 'Care leavers, COVID-19 and the transition from Care' (CCTC) study by Munro et al. (2021) found that care leavers in England had increased mental health needs during the pandemic with additional barriers to accessing appropriate support. The study published by the Partnership for Young London et al. (2020) further supported these findings that the pandemic affected young care-experienced people's mental health and increased their feeling of isolation, which is reflected by the current study's finding of a negative impact on the feeling of belongingness. Furthermore, John et al. (2021) reported that a rise in loneliness that was significantly associated as a factor for suicidal ideation was observed in the general population

in the UK, inter alia among young adults, during the first lockdown of the pandemic. The study further shows that 7,7%–10% of participants among the UK-wide general population sample reported suicidal thoughts during this time. The authors found evidence of the association between suicidal ideation, loneliness and struggles to cope in young people at the beginning of the pandemic and raised concerns about the impact of increased loneliness due to the pandemic (John et al., 2021). Care-experienced young people, especially care leavers, were at risk of becoming socially disconnected from others and experiencing a lack of support due to the digital divide discussed in section 3.3. These findings further reflect the role of thwarted belongingness due to loneliness and social isolation in the risk of experiencing suicidal ideation, as highlighted by the pandemic.

As shown by the CCTC study, social services and care providers implemented structural adaptions to address the needs of the young people in the transition from care. Some care leavers benefited from staying longer in their care placement, which provided them with housing security, continuity of relationships and support from their recent carers. Practitioners employed by local authorities developed creative solutions such as relationship-based practice models to make the well-being of care leavers a priority during the pandemic. These adapted practices were flexibly oriented to the individual needs. They included increased contact and newly introduced offers such as programmes to prevent needs escalating and outreach teams to build relationships. While these times presented further challenges to practitioners, the authors highlighted practitioners' resilience and dedication to the well-being of young people (Munro et al., 2021). These are examples that, despite the dilemma and tension between service structures and a young person's need for caring relationships even independent from the pandemic, adaptions towards a relationship-based practice to address the need for belongingness can be implemented on a structural level. Such models provided by services and organisations can inform suicide prevention beyond the pandemic as they focus on relationships, prevention and longer-lasting access to support.

This study shows that suicidal ideation among care-experienced young people is complex. While the findings show the incredible strength and resilience young adults with care experience reported by often finding their own way to cope with suicidal ideation by developing their intrinsic motivation to establish positive changes, the study contributed to identifying multiple factors to inform suicide prevention to tackle the elevated risk this group is confronted with. The IPTS provided an important foundation for this multi-level perspective and helped identify (thwarted) belongingness as a central factor influencing suicidal ideation among people with care experience. The socio-ecological perspective is vital for comprehensive suicide

prevention tailored to young people with care experience that can help to inform policy and practice to tackle the risk of suicide within the (leaving) care system.

6.3 Implications for policy and practice

With the WHO and governments such as England's making suicide prevention a public health agenda (HM Government, 2012; World Health Organisation, 2014), the elevated risk of suicide among care-experienced people requires targeted suicide prevention within the care system. This study shows that care experience intertwines many individual, structural and especially interpersonal factors influencing suicidal ideation among care-experienced young people up to their early adulthood. Relationships to address the desire for belongingness need to be placed at the centre of policy and practice to develop suicide prevention tailored to people with care experience.

The findings argue that suicide prevention needs a socio-ecological approach. Cramer and Kapusta (2017) formulated a social-ecological suicide prevention model (SESPM) that suggests a population-specific approach integrating risk and protective factors next to a general prevention concept. Their overarching concept suggests suicide prevention methods across the individual, interpersonal and structural levels, with the latter separated into community and society levels.

In a brief overview, the SESPM by Cramer and Kapusta (2017) suggested that suicide prevention on the individual level can include the promotion of positive health behaviour, psycho-education and training in positive coping skills. A combination of individual and group therapy and gatekeeper training is suggested on the relational level. In particular, gatekeeper training for practitioners working with care-experienced young people is discussed in detail below. Reaching a structural level, support in the community would contain access to crisis support lines and adequate mental health support, including free screenings and school-based or care-internal programmes focusing on mental health and suicide awareness and information to access accordant support services. Considering the focus on young adults leaving care, the community level of suicide prevention could also cover the preparation for a gradual transition, including raising awareness of challenges and expectations, the option of ongoing contact with previous attachment figures from care and connecting with a new community, for example, a care leavers' network. The societal level would cover resources provided by the state and local authorities, improvement of regulations, guidelines and funding for the support of young people

leaving care and suicide prevention, and awareness campaigns to reduce the stigma of care experience and mental health including suicidal ideation and behaviour. While the authors of the SESPM argue that more research on such a framework is necessary to develop prevention programmes based on best practices, their model gives an orientation on how a multi-level approach to suicide prevention could look (Cramer and Kapusta, 2017).

Cramer and Kapusta's socio-ecological suicide prevention model helps to gain orientation on how general suicide prevention can be implemented across all different socio-ecological levels. However, the provided example of their SESPM would need to be adapted to the needs of people with care experience and the structures the care system offers. As follows, I discuss how policy and practice can develop suicide prevention approaches targeted to people with care experience and the steps suggested to help tackle the dilemmas practitioners face in their work.

The SESPM suggests gatekeeper training for social workers, PAs, foster carers and residential care workers, service managers and further relevant practitioners working with care-experienced young people. Such training would address the awareness of suicide prevention, the role of relationships and the promotion of belongingness. For instance, training would generally cover communication skills and enhanced knowledge about the mental health needs of this group, suicide intervention practices and the young person's motivation to engage in the support offered.

However, more specifically, such training for practitioners focusing on relationships with care-experienced people of different ages would benefit from trauma-informed approaches. Kaip et al. (2022) highlighted in their research with practitioners working with looked-after children that "a crucial support structure to incorporate is the concept of a trauma-informed approach" (p. 12). Such an approach has the potential to support forming positive relationships between young people and practitioners and promotes a better understanding of person-centred practices (Kaip et al., 2022; Lotty et al., 2020; Perry and Daniels, 2016; Hall et al., 2016).

The trauma-informed approaches suggested by Harris and Fallot (2001) go beyond knowing simply about a person's history of past and recent traumas but promote understanding the role that traumatic events play in the lives of survivors and, thus, how practitioners can understand the person and their behaviour. A trauma-informed system would move away from focusing on the 'functioning' of a young person and instead concentrate on the person and their needs. Organisations' "commitment is to provide services in a manner that is welcoming and appropriate to the special needs of trauma survivors" (Harris and Fallot, 2001, p. 5). They focus on understanding the experience and the person; on the service's emphasis on supporting

service users to develop self-management and coping skills to prevent problematic situations and learn how to deal with crises; and reflecting on the role of the association between the service and the service-user in a collaborative, trustworthy relationship. The authors further highlight that organisations need to establish a trauma-informed approach throughout their services by enabling training for every staff member, introducing brief screenings, hiring a trauma expert and reviewing policy and practices that may cause harm to trauma survivors (Harris and Fallot, 2001). As traumatic experiences are common among care-experienced people and associated with the causes of suicidal ideation, trauma-informed concepts present relevant principles that help to inform suicide-prevention strategies within the care system(s).

First, training for all staff members provided by the administrative body of an organisation reflects a service’s commitment to taking this topic seriously. By promoting trauma-informed suicide prevention, training for every person caring for or working with these young people would raise awareness for the young people’s well-being and facilitate communication of mental health needs. Training to enhance the awareness of the elevated occurrence of suicidal ideation and the range of experiences would help carers, social workers, PAs, and other relevant practitioners to identify young people at risk as part of secondary suicide prevention strategy, as Cramer and Kapusta (2017) suggest. They would highlight the need for early and long-term suicide prevention and the awareness of vulnerable times and their increased risk of loneliness or the feeling of abandonment and, eventually, suicidal ideation and behaviour particularly during holidays and transitions. These times require caring relationships.

Furthermore, suicide prevention would start with practitioners who are working with people with care experience establishing an open conversation about mental health and the risk of suicidal ideation and behaviour to tackle the stigma of this topic and mental health. A deepened understanding of trauma, the risk of suicide and the young people’s needs would help practitioners develop an enhanced awareness and skills to address the emotional needs of the young people.

To identify a young person at risk, professionals are urged to develop trauma-informed practices and a greater awareness of non-verbal signs of distress and suicidal ideation. The calls for higher qualification, understanding and awareness of the mental health needs of young people with care experience would also draw implications not only for organisations but also for the education and training system for social workers, PAs, mental health professionals and carers. A holistic training on multiple levels in the careers of essential practitioners would form a

necessary foundation of knowledge and skills for everyone involved in the support of young people with care experience.

Second, as trauma-informed approaches suggest, brief universal screenings would help identify traumatised young people and those at risk of suicidal ideation and behaviour. Whether using self-assessment tools or assessing the needs and emotions signalling the risk of developing suicidal ideation and behaviour during a casual conversation with practitioners, such approaches would inform services about the young person's experienced traumata, mental health state and needs.

Third, relationships between professionals and a young person with care experience were identified as an essential factor contributing to identifying and working with a young person at risk of suicide. Bunting et al. (2019) describe trauma-informed care as meaning that "services strive to build trustworthy collaborative relationships with children and the important adults in their lives, as well as improve consistency and communication across linked organisations and sectors, with the aim of mitigating the impact of adversity by supporting and enhancing child and family capacity for resilience and recovery" (pp. 1–2). This description aligns with the needs identified, such as trust and consistency. The required professional structures such as communication and collaboration across organisations discussed in this study are essential for suicide prevention among people with care experience.

Bollinger et al. (2021) described that residential care workers reported that their awareness of the impact of trauma changed the way they interacted with the young people and, in some cases, resulted in long-lasting relationships after the young people left care. When persistence characterises the relationship between practitioners and young people as one essential component of a trauma-informed approach, young people can develop trust, self-confidence and capabilities to use relevant resources to reach their goals (Hickle, 2020). Trauma-informed practices were found helpful in promoting the well-being of young people and their carers, including improving the stability in the young people's lives and care (Bunting et al., 2019). Furthermore, through trustworthy, persistent relationships and acknowledging signs of distress and young people's needs and reacting accordingly, the feeling of belongingness in the sense of 'feeling cared for by others' could be implemented as an active strategy in suicide prevention.

However, as discussed in the previous section, the dilemma faced by practitioners between addressing the needs of the young people they are responsible for and their working conditions within the social work and care system would make the persistency of professional relationships with the young people challenging to actualise. To establish a trauma-informed suicide

prevention approach, the support for the practitioners themselves would need to be strengthened. With raised awareness of the needs and trauma-informed approaches, including improved inter-agency collaboration, practitioners could assess critical experiences in the work with care-experienced young people better and, thus, be able to better address and deal with such situations. Adjusting working hours to extend the availability of support for young people leaving care would also address the needs of the young people. For instance, services could shift office hours later than the usual 9-to-5 schedule or introduce rota systems to offer emergency contacts on weekends and bank holidays. However, organisations and policies would need to acknowledge the well-being and needs of practitioners as a vital component to actualise necessary preventive service provision. Doing so would enhance the stability of the workforce and, thus, persistence in the lives of the young people.

Generally, this research suggests a focus on trauma-informed approaches centring on the relationships of a young person in care or a care leaver for suicide prevention within the care system, promoted on a structural level. Ideally, on a policy level, lower caseloads and, therefore, more time for each professional to spend on a young person to establish a well-working relationship and supportive structures for carers and practitioners involved would contribute to a young person's well-being and suicide prevention. However, extra financial resources to ensure such structures would be required. Especially in England, research has criticised the government's austerity concept that resulted in cuts in funding for relevant support services for young people and families (Gupta, 2016). While these recommendations on structural changes would benefit the service users and practitioners and enable stability in relationships and service provision, it is questionable how realistic it is to implement such claims and reshape whole service structures and systems to lower caseloads.

Nonetheless, trauma-informed approaches implemented on an organisational and structural level can offer steps to improve the challenging working conditions for practitioners. For instance, organisations could hire or collaborate with an expert on trauma therapy and suicide intervention whom practitioners can approach for advice and refer a young person to. Furthermore, joint trauma-informed training across different disciplines working with young people with care experience can enhance effective inter-agency communication and collaboration and develop a common understanding of the needs of the young people contributing to the young people's outcomes (Kaip et al., 2022). Trauma-informed inter-agency partnerships would offer better management for support and more respect for specific professions working with care-experienced people.

Such approaches enhancing inter-agency collaborations would also promote access to necessary therapy for children in care and adults with care experience. Thresholds to access suitable therapy are often for children in care high and sometimes impassable, especially if they are in unstable or temporary placements, as reported in research from England (Mooney et al., 2009). Even more problematic are the gaps in the transition from child and adolescent mental health support to adult services, which have been criticised in both countries investigated (Butterworth et al., 2017; Schmid, 2008). Measures to enhance inter-agency collaboration and communication would benefit the service management and the young person supported.

Furthermore, when focusing on long-lasting relationships and belongingness, which practitioners are restricted from offering to every young person, holistic suicide prevention within the care system would benefit from enlarging the support network of a young person. For example, apart from inter-agency collaborations as formal support, semi-formalised (peer) mentoring schemes, especially when previous support terminates in the transition from care, contribute to suicide prevention within the (leaving) care system with a relationship-based approach and availability of support. Such mentoring schemes offer additional relational resources that have the potential to contribute to a positive feeling of belongingness, for instance, due to shared experience in the case of care-experienced peer mentors. However, mentors such as practitioners require support to reflect on their role and their own needs in order to maintain a caring relationship.

Finally, organisations need to commit to implementing a holistic suicide prevention approach across their services by reviewing harmful policies and practices and enhancing the understanding by introductory training for all staff members about suicidal experiences among young people with care experience, their needs and behaviour. Among the intensified knowledge of mental health needs of young people with care experience, practitioners need to understand transitions, particularly leaving care and closing cases, as a crucial factor that poses a risk of suicide if they are experienced as abrupt, unprepared for and distressing due to the simultaneous occurrence of multiple stressors. Professionals and the structural context necessary for their actions can help establish gradual transitions as a resource of suicide prevention in early adulthood if, for instance, contact with previous attachment figures during care is maintained and access to social and structural resources stays available. The programme Lifelong Links, as mentioned in section 6.3, presents the practical implementation of an extended positive support network and its benefits for young people with care experience (Holmes et al., 2020).

An example of changes on a policy level that provide the potential for suicide prevention approaches can be found in the recently published KJSG (Act to Strengthen Children and Youth) in Germany in 2021. As Achterfeld et al. (2021) described, the coming-back option proposed in the KJSG that allows care leavers to reaccess placements and support from the care system seem to be a relevant structural resource for the transition to adulthood. This option would also enable re-establishing previous relationships in care and avoiding a clear cut of contacts. Furthermore, a required collaboration between different support systems for young people would ensure a smooth transition from the youth welfare (care) service to adult services (for example, the job centre) that meets a young adult’s needs with an early preparation (Achterfeld et al., 2021). However, Achterfeld et al. (2021) criticised that the reform of the legislation still keeps the age ranges of 18 and 21 as a general frame for leaving care support instead of considering the individual development and circumstances.

On a policy level, the often-criticised fixed age limits to receive care and mental health support for children or adults would benefit from adjustment. For instance, in Germany, ambulant youth psychiatric and psychotherapeutic services offer a continuation up to 21, which overlaps with the age requirements for adult services and may ease the transition (Fegert et al., 2017). Fegert et al. (2017) further called for better-coordinated transition processes to prevent treatment discontinuation and develop specific offers for care leavers.

Practices of abruptly closing cases of care leavers without ensuring further support affect a young adult’s relationship with professionals because such perceived experiences of abandonment further relate to thwarted belongingness. Hence, keeping cases open for a longer time, especially without making a clear cut at a certain age, or ensuring a smooth transition to further services would be helpful for people with care experience so they know that they can get support whenever needed. The report by Munro et al. (2021) about adaptions of services to support care leavers in England during the COVID-19 pandemic, described in section 6.2, showed that organisations and their approaches can adjust to the needs of the young people by establishing relationship-focused practices and prolonging young people’s stay in placements promoting stability and mental well-being. In addition, by promoting young people to develop their own reflection and coping skills, trauma-informed approaches assume that people would need less support from the service provider in the future (Harris and Fallot, 2001). Therefore, keeping cases open and support available without strict age limits would not necessarily require more resources.

In conclusion, a reflection on the findings shows that general awareness of suicidal prevention and holistic trauma-informed practices would enrich service provision and address the needs of young people. Policies and organisational structures should support professionals to focus on establishing positive, stable relationships with young care-experienced people that offer a foundation of belongingness in the sense of caring and understanding.

In this study, many young adults who had experienced suicidal ideation found ways to cope by themselves, presenting the great strengths these young people have to overcome the risk of suicide. Politicians and professionals should not rely on a young person's internal strengths to find a way to deal with their mental health impacts and suicidal ideation. Instead, organisations benefit from providing a holistic trauma-informed framework for suicide prevention for each young person that promotes belongingness, the development of coping skills and participation focused on each young person's needs from an early stage. Early suicide prevention aims to prevent young people with care experience from developing active suicidal thoughts and behaviour. Strengthening the awareness of the risk of suicide and protective factors among professionals and informing young people can constitute an essential part of a suicide prevention strategy tailored to young people and adults with care experience, also across national borders.

Raising awareness of the risk of suicide and suicide prevention is not to be understood as a deficit perspective or pathologising. Deepening the understanding of suicidal experiences among young people with care experience can inform proactive preventive and empowering structures and practices promoting the mental well-being and life satisfaction of young people within the (leaving) care system as a contribution to their resilience against challenges they may face. With an enhanced understanding of risk and protective factors and the value of positive professional relationships, young people at risk of suicide are likely to be identified earlier. Then, they have a better chance to be provided with tailored support more quickly. Trauma-informed suicide prevention within the (leaving) care system should be a comprehensive approach incorporated across socio-ecological levels of service structures and the daily work with young people with care experience. Moreover, by making suicide prevention a matter of course in the work with care-experienced young people, the stigma of mental health issues such as suicidal experiences is tackled, further reducing the barrier of reaching out for support.

6.4 Limitations

The presented study provides new insights into the topic of suicidal ideation among care-experienced young people. However, it has limitations that need to be considered for the interpretations of the findings.

Considering the small size of the survey sample, especially the subsample from England ($n = 16$), and the non-randomised sampling method, the findings would need to be treated cautiously to identify trends, as the representativeness of all care-experienced adults in both countries is limited. To further investigate the identified factors and themes to better understand suicidal ideation and suicide prevention strategies within the (leaving) care systems of the examined countries, it would be useful to repeat the study with larger sample sizes that would also provide more insights into the transferability of findings across borders. However, with a total survey sample of 45 participants, despite hopes and attempts to find more respondents, several factors such as the group under investigation, recruitment process and options, and timewise circumstances of the data collection would need to be taken into account for reflecting on the contributions of this part of the research.

While large sample sizes and randomised sampling methods are generally considered the best practice standard in quantitative research, such research demands may not always be possible to actualise in (leaving) care research. Mezey et al. (2015) discussed the challenges of recruiting young research participants in the care system for a randomised controlled trial, which implies that statistical sampling desires may be complex to accomplish in reality. The authors explained that a lacking research culture, awareness and understanding of the research process and requirements among professionals in the social work and care system demonstrate barriers to research processes. Gatekeepers from local authorities often act protectively both towards the young people and their working time in light of their professional demands, including a sometimes-experienced antipathy against research. The dependencies on and reactions of gatekeepers in the care system influence the sizes of the accessible population and samples for the recruitment of care-experienced young people involved with social services. While the authors reflected on their approach of a randomised controlled trial and an online survey with young people with care experience that also resulted in a similar sample size as the current study (Mezey et al., 2015), their explanations about the challenges in getting access to the population of young people in care and care leavers and recruiting participants are likely to apply to other studies in this field.

Multiple factors would explain the sample size of the survey. First, in line with the explanation by Mezey et al. (2015), finding organisations that are willing to support the study as collaboration partners was challenging. If organisations have even responded to my request, their restricted capabilities due to personal or time-related resources often explain why they rejected the study. Such conditions may have also been an unseen reason why despite several organisations confirming their support, often by managers, the professionals in direct contact with the young people may not have the time to share the information, as also discussed by Mezey et al. (2015).

Second, the survey's low response rate could also be explained by some gatekeepers adding an extra trigger warning when sharing the information about the study. Including additional trigger warnings to the recruitment information is likely to have discouraged some people. Some organisations shared the information only with a few selected young adults whom they felt were emotionally most eligible for participation in this study due to possible fears of triggering effects. Due to the selection process conducted by some professionals for safety reasons, fewer young people would have been informed about the study.

As a third explanation for the small survey sample size, some approached young people might have been sceptical about the study, for instance, if professionals who the young people mistrusted shared the information. Alternatively, due to the growing leaving-care research field, some young people might have been already engaged with other research projects or would have limited time available due to a focus on their education or employment. Similarly, Mezey et al. (2015) identified that older care-experienced young people from the age of 18 were more difficult to recruit for research, as they often engage less with support organisations or services.

However, while the small survey sample poses a limitation to the study findings concerning their statistical power, it also reflects the circumstances involved in the sampling processes in leaving-care research apart from additional challenges caused by the pandemic. Sydor (2013) states that "limited research data are preferable to no information from groups that are hidden and hard to reach" (p. 33). Hence, considering the challenges of recruitment of hidden or hard-to-reach groups, for example, due to structural barriers such as the 'digital divide' during a pandemic allows recognising the value and contribution of the survey findings with a sample of 45 adults with care experience.

Generally, as the recruitment strategy was not randomised and depended on volunteers in both parts of this research, a particular bias cannot be excluded among study participants as another limitation. However, non-randomised sampling is common practice in qualitative research. Due

to the anonymisation and recruitment process of the survey, it may be possible that adults with experience of mental health issues and suicidal ideation, as well as those with specific online activities, may have been more prominent in the survey sample than other eligible adults with care experience.

The survey has a cross-sectional research design that includes some retrospectives. Thus, the results would need to be interpreted as reflecting a specific moment in time. For instance, the possible double-response of the survey sample at two time points several months apart shows time sensitivity if it is proven that this was made by the same person.

As a mixed-methods design, the survey data complement the qualitative findings from the interview data, for instance, to indicate the prominence of some of the identified themes on influencing factors and perspectives. At least four interview participants mentioned that they had filled out the survey, as it was also encouraged to do so. In conclusion, these few survey answers would not add to but repeat the information gathered in the interviews.

While the survey findings show limitations, the prominent focus was on the qualitative data and analysis. As the topic of suicidal ideation among young adults with care experience and the impact of the transition from care, especially in England and Germany, has received only a little attention, the survey contributes to new insights and complements the qualitative interview findings.

For the qualitative interviews, the sample size is reasonable. It provides a broad spectrum of characteristics and experiences, providing rich, in-depth data to answer the research questions and identify underlying mechanisms of suicidal ideation among care-experienced young people and adults. While qualitative research does not intend to be representative of a whole population, a limitation may be that some characteristics – such as voices from adults who entered the care system as asylum-seeking minors present in neither group and from those who lived in foster care in Germany – were not included in the interview sample. Future research about this topic could focus on specific subgroups of care-experienced adults who may be harder to reach and more underrepresented in empirical research.

7. CONCLUSION AND OUTLOOK

This study reflects the findings from previous research that the risk of suicide among young people and adults with care experience remains unfortunately common, starting from a young age up to adulthood. This thesis highlights the broad spectrum of experiences and occurrences, and the complexity of suicidal ideation and the care system, reflecting on intertwined factors across socio-ecological levels. The aim of this study was to provide a unique contribution to social work and leaving care research. This research contributes with new cross-national insights from England and Germany to fill research gaps on suicidal ideation among care-experienced young people and adults and the underlying mechanisms to deepen our understanding.

The concern of young people and adults with care experience being at greater risk of suicidal ideation than those without care experience constituted the motivation to conduct this research. It aims to inform suicide prevention strategies tailored to care-experienced young people and adults by collecting the voices of people with lived experience. Global and national public health agendas on suicide prevention strategy aim to address the ongoing concern on young people's risk of suicide. With the growing research field on the transition from care to adulthood and young people's needs, this research offers a novel cross-national perspective that enhances the knowledge of the risk of suicide among care-experienced young people and adults. This research contributes to informing suicide prevention for people with care experience by improving our understanding of the occurrence of suicidal thoughts among care-experienced adults and identifying factors influencing suicidal ideation.

This empirical investigation of suicidal ideation among care-experienced young adults from England and Germany based on primary data from lived experiences offers new insights for and beyond both countries. The cross-national perspective adds another innovative approach to (leaving) care research on the risk of suicide. Despite some differences in the care systems, the findings show that many similarities in the investigated topic were identified, implying the potential to cross-nationally transfer the knowledge about suicidal ideation among care-experienced young people and suicide prevention strategies within the care systems.

As part of suicide prevention, a broader and deeper understanding of suicidal ideation and behaviour among care-experienced people is crucial. The mixed-methods study has shown that the experiences of suicidal ideation are diverse and complex, ranging from pre-adolescence to early adulthood, with different severities and potential reoccurrences or chronic occurrences.

The complexity of suicidal experiences among care-experienced adults was also shown with dense interconnections between multiple factors, some closely related to the young people's care experience or structures within social work and the care systems. The applied socio-ecological perspective distinguishing between individual, interpersonal and structural levels helped organise the complexity of the underlying mechanisms contributing to suicidal ideation and coping. The multi-level framework highlighted the interconnections between these levels. By narrowing the complexity of suicidal experiences among people with care experience, the socio-ecological perspective underlined the factor of belongingness as the central component influencing suicidal ideation.

The feeling of belongingness interconnected with multiple factors was identified as a central need of young people with care experience. If this need was not fulfilled, the thwarted belongingness experienced related to the occurrence of suicidal ideation. Caring relationships are protective factors identified and can help a suicidal care-experienced young person develop the motivation as a crucial turning point to start coping actively with suicidal ideation. As informed by the interpersonal-psychological theory of suicide (IPTS), the feelings of belonging to and being genuinely cared for by others are essential resources supporting coping with suicidal ideation among young people with care experience.

As identified in this study, multiple factors can address the young person's need for belongingness. For instance, shared care experiences with peers or siblings seem to meet this desire and constitute a protective factor. Interesting for investigating this topic in further depth is that the separation of siblings between care and the parents' home appeared to pose a risk factor for suicidal ideation in adulthood, as it indicates possible thwarted belongingness. The impact of such separations between care and the family's home on a young person's mental health and the risk of suicide in adulthood requires further exploration. A particular focus should be placed on long-lasting effects in adulthood, as only recent suicidal ideation among the adults who participated correlated with the experience of this separation during care.

In light of the care experience, in particular, professionals within the care system play an important social role for young people they work with. A trustworthy, caring relationship and effective communication between practitioners and young people with care experience were found to be crucial for a young person to develop a feeling of belongingness. However, structures and working conditions for professionals in the care system can restrict the opportunity to establish ongoing, caring relationships with young people in care and adults who have left care.

Despite many challenges to forming a well-working relationship with a care-experienced young person, practitioners have a crucial role in early suicide prevention. Their role can contribute to identifying those at risk and providing the necessary support for suicidal young people to enhance their resilience and develop coping strategies against suicidal ideation. Caring relationships promote the feeling of belongingness of a person with care experience and contribute to suicide prevention. Trauma-informed suicide prevention approaches as a holistic attitude established on an organisational and cross-agency level would further support suicide prevention within the (leaving) care system.

As social workers, carers and PAs are in close contact with young people with care experience, these professionals and the service providers need to establish a strong and committed mindset to contribute to suicide prevention in the same way as keeping young people safe. On a structural level, trauma-informed conditions within the social work and care system and practice can support professionals in building the necessary relationships that can benefit young people in care and during the transition from care, and further contribute to the motivation for starting a coping process. Therefore, policies and service providers need to commit to establishing preventive structures throughout the system, which can constitute understanding, stability and belongingness for people with care experience and also support practitioners and carers working with young people in care and care leavers.

Previous research investigating the risk of suicide among people with care experience often neglected to implement a suicide theory as the foundation or research tool. This study helped draw a connection between theory and applied research to identify underlying mechanisms of suicidal ideation among care-experienced people. The study was informed by the IPTS and, therefore, paid extra attention to interpersonal factors of perceived burdensomeness and thwarted belongingness. So far known, this is the first study that applied the Interpersonal Needs Questionnaire (INQ) to assess the two IPTS factors, perceived burdensomeness and thwarted belongingness, to investigate suicidal ideation in a group of care-experienced people.

As the IPTS has received much popularity in suicide research, this research also adds insights about care experience to the previously existing studies with the INQ. While future research is encouraged to test the INQ within the context of care experience with larger, if possible, randomised samples, the IPTS provides a helpful foundation to explore underlying mechanisms influencing suicidal ideation in this study with care-experienced young adults. However, the challenges of recruiting a representative sample of adults with care experience would need to be considered when planning future quantitative studies on this topic.

The IPTS has been demonstrated to be a valuable theoretical framework that can inform suicide prevention within the (leaving) care system. The application of the IPTS that was mainly used within psychiatric or psychological disciplines instead of social work research shows that looking beyond one's professional horizon by interdisciplinary approaches is invaluable for the development of suicide prevention within the social work and care system.

The role of the care system and conditions of the professional practical work with young people in care and the transition to adulthood can be crucial to suicide prevention but also may pose certain risks if neglecting a young person's needs, restricting the availability of professionals or causing abrupt changes. The care system can provide the relevant structure for professionals by enhancing their understanding and communication skills; allowing opportunities to form trustful, caring relationships with young people and flexible approaches based on a young person's needs; and providing infrastructure of relevant resources. Though the involvement in the care system is not a direct cause of suicidal ideation, it can contain challenging circumstances such as abrupt, insufficiently prepared transitions, loneliness, and thwarted belongingness that can contribute to the development of suicidal ideation.

The transition from care to adulthood was identified as a crucial point that posed for many a higher risk of suicide, as it was related to loneliness, instability, ceasing of support and thwarted belongingness. While the transition would not pose the risk of triggering suicidal thoughts for everyone leaving care, the circumstances connected with this meaningful change can be crucial for increasing the risk. However, such conditions can be controlled to a certain extent to prevent care leavers from feeling lonely, abandoned and helpless.

While this study provides important new insights to deepen our understanding of suicidal ideation among care-experienced young people and adults, more research is needed to further explore this issue within the context of care experience and help inform suicide prevention tailored to young people in care and adults after having left care.

For instance, longitudinal study designs would provide further insights to explore trajectories of suicidal ideation among care-experienced young people from early adolescence to the transition to adulthood and associated factors. A life-course approach would enrich the current knowledge on suicidal ideation among people with care experience.

Future research could also investigate structural problems and practical options for suicide prevention within the (leaving) care system from professionals' perspectives. This would allow researchers to gain more information on the necessary professional qualifications, skills and

practices and required organisational structures to enable professionals to provide suicide prevention.

Finally, future studies could evaluate potential or existing suicide prevention practices within the (leaving) care system regarding their short- and long-term effectiveness for care-experienced people. While not every young person may be prevented from developing suicidal ideation and not every suicidal person may be prevented from acting on such thoughts, research can help raise awareness of the necessity of suicide prevention within the (leaving) care system.

In summary, this thesis contributes to a deeper understanding of the occurrence of and factors influencing suicidal ideation among young people with care experience up to adulthood and the impact of care. Furthermore, this study draws on a socio-ecological framework to provide a comprehensive understanding of suicidal ideation and relevant resources and coping strategies that can help to inform multi-level suicide prevention strategies tailored to young people with care experience. As shown, if the necessary conditions on a structural level are provided, relationships and effective communication between professionals and young people can be developed to support a young person in acquiring relevant resources and coping skills.

The topic of suicide prevention among young people with care experience is of major importance for social work, care and public health. If local authorities ignore this topic in policy and practice, they will miss their safeguarding duty as corporate parents for young people in care and those transitioning from care to adulthood. Organisations would benefit from committing to a holistic suicide prevention strategy oriented on trauma-informed approaches. While several professionals already take this topic seriously and have established a suicide prevention practice, the risk of suicide among people with care experience and prevention strategies needs to become a central component of social work and care practice for everyone working and supporting young people in care and care leavers. Suicide prevention needs to have a stronger foothold throughout social work, especially when working with young people with care experience. This thesis contributes to a better understanding of an under-researched topic that needs more attention in policy and practice to support the resilience of young people in care and the transition from care to adulthood and their coping skills.

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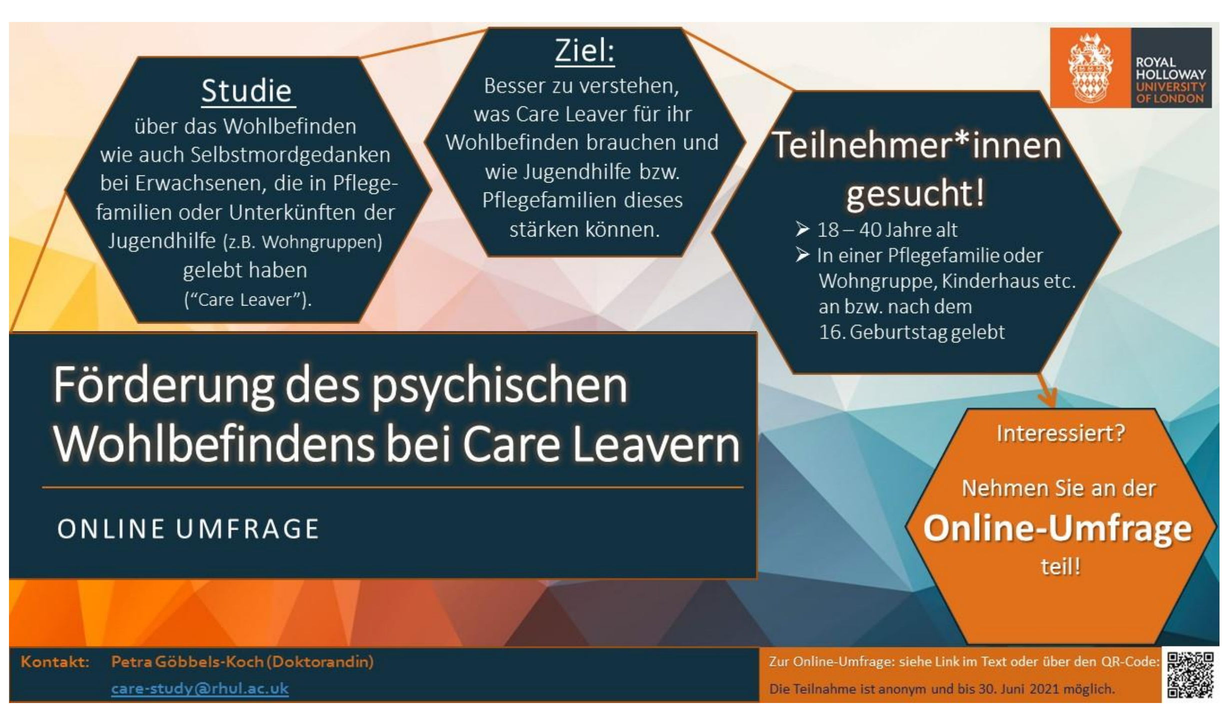
Appendix 1: Overview of scoping review results

Author(s), year	Location	Method	Sample		Focus			Most relevant results
			Children in care <18 years	Care leavers / adults with care experience	Suicidal thoughts	Suicidal behaviour	Suicide	
Kalland et al., 2001	Finnland	quantitative	✔	✔			✔	The study found that among 106 children in care who died before their 25th birthday 35 died by suicide aged 15-24 years, mainly male.
Mallon, 2005	UK	qualitative		✔		✔		The study found that one third of 9 interviewed adults with care experience with no higher education (total sample: 18 adults with care experience, age 26-69) attempted suicide, with a higher risk identified in the group with no higher education background.
Pilowsky & Wu, 2006	USA	quantitative	✔		✔	✔		The study found the following rates of the past year among adolescents (age 12-17) involved in foster care compared to peers without care experience: 27% suicidal ideation (foster care) compared to 11% (non-care), 15% suicide attempt (foster care) compared to 4% (non-care).
Vinnerling et al., 2006	Sweden	quantitative		✔		✔		Former looked-after children are 4 to 5 times more likely to be hospitalised for suicide attempts.
Goddard & Barrett, 2008	England	quantitative		✔		✔		The study found that 11% of 70 care leavers in England attempted suicide.
Cousins et al., 2010	Northern Ireland	quantitative	✔			✔		The study reported that after one year living in care about 6% of 165 children in foster and residential care (age 10-15) attempted suicide based on the reports by social workers.
Berlin et al., 2011	Sweden	quantitative		✔		✔		Poor school performance is a risk factor for suicidal behaviour among the overall sample; more female than male (3♀:2♂) care leavers attempted suicide, 14%♀ (2% control) and 9%♂ (1% control).
Katz et al., 2011	Canada	quantitative	✔			✔	✔	Looked-after children (age 5-17) are about 4 to 5 times more likely to attempt or die by suicide than peers without care experience. The risk seems to be highest before entering care.
Stein & Dumaret, 2011	England, France	review	✔	✔	✔	✔		The review of French and English studies presents inter alia the risk of suicidal ideation and suicide attempts among young people leaving care in both countries.
Ward, 2011	England	qualitative	✔	✔	✔	✔		The study reports that the first few months after leaving care are considered to be the most difficult time for care leavers affecting their mental health including suicidal ideation and behaviour reported by previous studies. Loneliness was identified during this time.
Bullock & Gaehl, 2012	England, Wales	quantitative		✔			✔	Care-experienced young people have 1.5 times higher rates of early, unnatural death incl. suicide compared to peers.
Daly, 2012	Northern Ireland	mixed		✔		✔		Aftercare workers identified suicidal behaviour as a mental health issue among care leavers. Adequate planning and access to practical and emotional support is important for the transition from care.
Harkess-Murphy et al., 2013	Scotland	quantitative	✔		✔	✔		The study found among 102 looked-after children (age 11-17): 15% suicidal ideation, 4% suicidal behaviour inclduing suicide attempt, 13% self-harm thoughts and behaviour both with suicidal and non-suicidal intent.
Andrew et al., 2014	N/A	review: therapeutic model	✔	✔	✔	✔		The author presents a therapeutic approach by reviewing several studies that indicate a higher risk for care experienced young people for suicidal ideation and behaviour.
Hamilton et al., 2015	Northern Ireland	quantitative		✔	✔	✔		The case file study identified the following rates among care leavers age 16-21 (n=164): 18% suicidal ideation, 27% suicidal behaviour, 7% suicide attempts.
Slater et al., 2015	England	quantitative		✔		✔		The secondary data analysis focus found that young people with care experience 16+ in private accommodation without contact with a social worker have a higher risk for suicide attempt than those who were in contact with a social worker.
Evans et al., 2017	N/A	meta-analysis	✔		✔	✔		The meta-analysis informed by studies from different countries estimated the following prevalences among children and young people in care compared to non-care populations: 24.7% suicidal ideation (in care) compared to 11.4% (non-care), 3.6% suicide attempt (in care) compared to 0.8% (non-care).
Baiden & Fallon, 2018	Canada	quantitative	✔		✔			The study found that 6.5% of about 57,000 children involved with child welfare services (due to child maltreatment) in Canada showed suicidal ideation. 2/3 of the maltreated children who expressed suicidal ideation were not referred to mental health services.

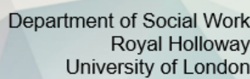
Appendix 2: Recruitment flyer

Social Media flyer (English and German version)



Flyer: interviews (English and German version)

Department of Social Work
Royal Holloway
University of London



Call for participants: interview

Progress and Coping:
Influencing Factors of Suicidal Thoughts among Care-Experienced Adults

My name is Petra Göbbels-Koch. I am a PhD student from the Royal Holloway, University of London.
As part of my PhD project, I look at the experience and influencing factors (e.g. coping) of suicidal thoughts among adults with care experience in England and Germany. I would like to hear about your experiences and your opinion on how care and social services can help to prevent the experience of suicidal thoughts.
You can help by taking part in an interview.

RESEARCH TEAM:

Researcher: Petra Göbbels-Koch

Supervisors: Prof Anna Gupta
Dr Katrin Bain

Contact: care-study@rhul.ac.uk
+44 7916401375 (WhatsApp)

Sign up for the study if you…

- are living in England or Germany,
- are between 18 and 40 years old,
- lived in care (foster family or children's home) in England or Germany on or after your 16th birthday,
- experienced suicidal thoughts during or after leaving care,
- have not experienced any suicidal thoughts and attempted suicide for several months,
- feel alright talking about your experience of leaving care, suicidal thoughts and how you coped with those experiences.

What will happen if you take part:

- Duration: About 60 minutes
- Location: Online
- Reimbursement: £15
- Voluntary: The participation is entirely voluntary.
- Confidential: You will be not identified as a participant of the study.
- Before the interview: We will have an introductory talk (by phone) first so that you get informed about the details of the study and to decide whether you can and want to take part. This will happen a few days or weeks before the interview.
- During the interview: You will be asked several questions about your experience of leaving care and suicidal ideation. Some questions may seem to be sensitive and may cause distress as they might remind you of unpleasant experiences. At any time, you can take a break, skip questions or stop the interview. Contact details for support services will be provided to you. You can bring a person to support you during or after the interview.
- After the interview: We will have a short follow-up telephone call a day after the interview.
- Results: The results will be used for my PhD dissertation, publications and presentations.

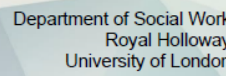
Interested in taking part in the study? Please contact me:
care-study@rhul.ac.uk or by WhatsApp +44 7916401375

Participation possible until June 2021

Funded by:

(For more information about me as the researcher, have a look at my Royal Holloway Pure Profile)

Department of Social Work
Royal Holloway
University of London



Teilnehmer*innen gesucht: Interview

Entwicklung und Bewältigung:
Einflussfaktoren von Suizidgedanken bei Care Leavern

Mein Name ist Petra Göbbels-Koch. Ich bin Doktorandin an der Royal Holloway, University of London.
Ich untersuche Einflussfaktoren und die Bewältigung von Selbstmordgedanken bei Erwachsenen, die in Pflegefamilien oder Jugendhilfeeinrichtungen gelebt haben (Care Leaver). Die Ergebnisse der Studie sollen helfen die psychische Gesundheit von Care Leavern besser zu verstehen und unterstützende Angebote zu gestalten.
Sie können helfen, indem Sie an einem Interview der Studie teilnehmen.

FORSCHUNGSGRUPPE

Doktorandin:
Petra Göbbels-Koch, M.A.

Betreuung:
Prof. Dr. Anna Gupta
Dr. Katrin Bain

Kontakt:
care-study@rhul.ac.uk
+44 7916401375 (WhatsApp)

Sie können an einem Interview teilnehmen, wenn Sie...

- In Deutschland oder England leben,
- Zwischen 18 und 40 Jahre alt sind,
- In der stationären Jugendhilfe (wie Wohngruppe) und/oder Pflegefamilie in England oder Deutschland an oder nach Ihrem 16. Geburtstag gelebt haben,
- Selbstmordgedanken während oder nach dem Verlassen der Jugendhilfe erlebt haben,
- Seit mehreren Monaten keine Selbstmordgedanken und -versuche mehr erlebt haben,
- Sich bereit fühlen über Ihre Erfahrung zu reden.

Was erwartet Sie, falls Sie teilnehmen:

- Dauer: ca. 60 Minuten
- Ort: Online
- Vergütung: 15€
- Freiwillig: Die Teilnahme an der Studie ist freiwillig.
- Anonym: Sie werden nicht als Teilnehmer*in identifiziert werden können.
- Vor dem Interview: Wir werden ein Kennenlerngespräch (telefonisch) führen, um Details der Studie zu besprechen und zu entscheiden, ob Sie an der Studie teilnehmen können und auch möchten. Es wird ein paar Tage oder Wochen vor dem Interview stattfinden.
- Während des Interviews: Es werden Fragen zu Ihrer Erfahrung von dem Verlassen der Jugendhilfe/Pflegefamilie, Selbstmordgedanken und deren Bewältigung gestellt. Manche Fragen können unangenehme Gefühle oder Erinnerungen hervorrufen. Zu jeder Zeit können Sie eine Pause machen, Fragen überspringen oder das Interview abbrechen. Kontaktdaten von Hilfsorganisationen werden Ihnen gegeben.
- Nach dem Interview: Wir werden ein kurzes Nachgespräch einen Tag später führen.
- Ergebnisse: Die Ergebnisse werden für meine Doktorarbeit, Veröffentlichungen und Vorträge verwendet.

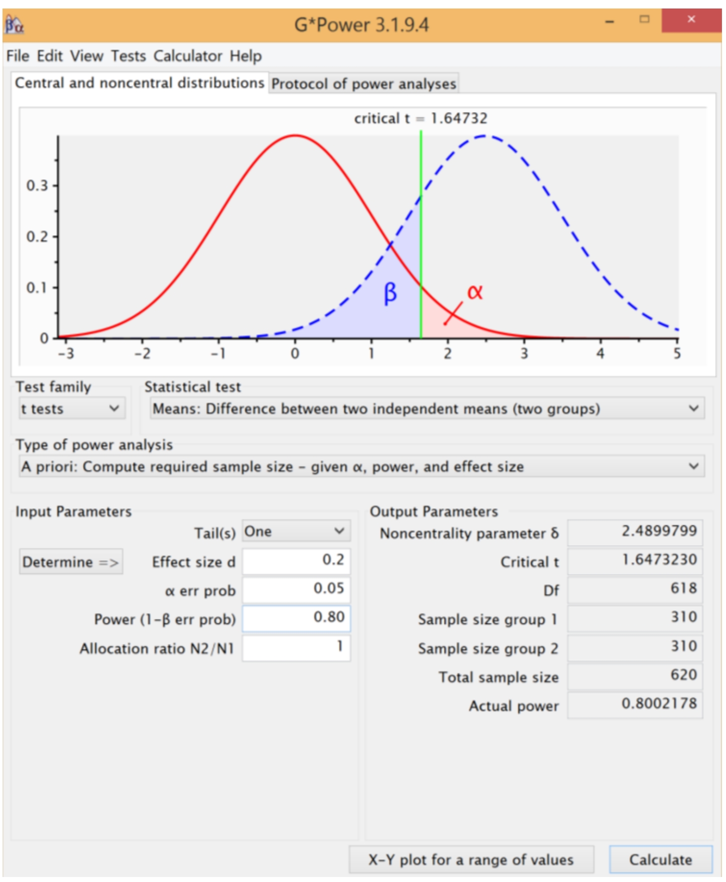
Interessiert? Dann melden Sie sich bei mir: care-study@rhul.ac.uk oder über WhatsApp +44 7916401375

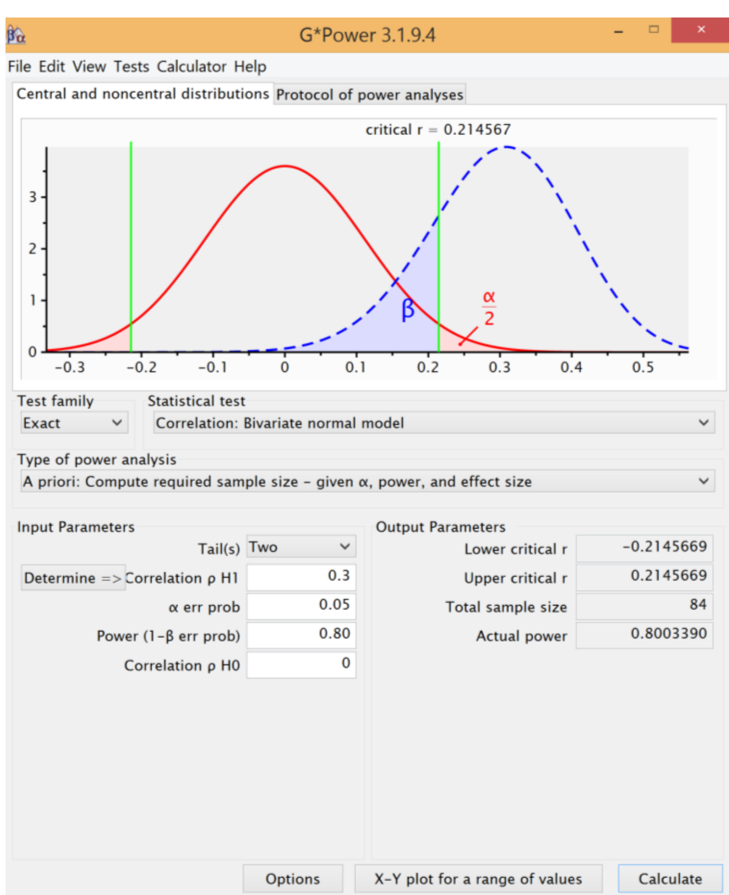
Teilnahme bis Juni 2021 möglich

(Mehr Informationen zu mir als Wissenschaftlerin finden Sie auf meinem Royal Holloway Pure Profile)

Gefördert von:

Appendix 3: A priori power calculations with G*Power (version 3.1.9.4)





Appendix 4: Survey

English (United Kingdom)

Language/Sprache & informed consent form

Welcome / Willkommen.

Welcome!

The currently chosen language is **English**.
Click the arrow at the bottom corner to continue with the survey in English.

Zur **Umfrage auf Deutsch**:
Bitte Deutsch als bevorzugte Sprache im Kästchen in der rechten oberen Ecke auswählen!

Q_Info.

Department of Social Work, Royal Holloway, University of London

Promoting Mental Wellbeing among Care-Experienced Adults

Researcher: Petra Göbbels-Koch
Supervisors: Prof. Anna Gupta & Dr Katrin Bain
Contact: care-study@rhul.ac.uk

My name is Petra Göbbels-Koch. I am a PhD student from the Royal Holloway, University of London. As part of my PhD project, I look at the mental wellbeing as well as suicidal thoughts among adults with care experience in England and Germany.
It is hoped that the results might have an impact on a better understanding of the mental health of care-experienced adults and on supportive work for those still in care and future care leavers.

It will take you about 20 to 30 minutes to answer all the questions of the anonymous online survey (open until June 2021).

You are welcome to take part in the study if you…

- are living in England or Germany,
- are between 18 and 40 years old,
- lived in care (e.g. foster family, Children's home, residential care home) in England or Germany on or after your 16th birthday.

Q69.
Before you start the survey, please note:

- **Voluntary:** The participation is entirely voluntary. You can withdraw from the survey at any point while filling it out.
- **Confidential:** Participation is confidential. Only the research team will have access to the answers.
- **Anonymity:** No information will be asked or collected that would identify you as a participant.
- **Skipping Questions:** You can skip questions or have the option of some questions to select "prefer not to say".
- **Take a break:** You can take a break and continue later. (You can continue where you stopped when you access the survey from the same device within the next 2 weeks.)
- **Click-Through:** Your answers will only be counted in when you reach the end of the survey (otherwise it will be assumed that you withdraw from the study).
- **Sensitive topic:** Some questions may seem to be sensitive and may cause distress as they might remind you of unpleasant experiences. At any time, you can take a break, skip questions or stop the survey. If you feel upset and want to contact support services, please do so. Contact details for support services like Samaritas (Telephone: 116 123) will be provided in the course and at the end of the questionnaire. Further information for support can be found on https://www.nhs.uk/conditions/suicide/.
- **Results:** The analysed results will be used for my PhD dissertation, publications and/or presentations.

If you have any questions about the study, please don't hesitate to contact me.

Q34.
Consent form

Promoting Mental Wellbeing among Care-Experienced Adults

Researcher: Petra Göbbels-Koch

Please tick:

	YES	NO
I confirm that I am between 18 and 40 years old.	○	○
I have read the information sheet about the study.	○	○
I confirm that I understand the sensitive nature of this study.	○	○
I understand that I am free to withdraw from the study, without giving a reason.	○	○
I agree to participate in this study.	○	○

General Information 1

Q1.1.
How old are you?

Q1.2. **What is your gender?**

- ○ Female
- ○ Male
- ○ Non-binary
- ○ Other: ______
- ○ Prefer not to say

Q1.3. **What country do you live in?**

- ○ England
- ○ Germany
- ○ Other: ______

Q1.4. **What is your housing situation currently?**
(You can choose several answers.)

- ☐ living alone
- ☐ with partner
- ☐ with own children
- ☐ with parents
- ☐ with (an)other family member(s) apart from parents
- ☐ with (a) foster parent(s)
- ☐ with (a) friend(s)
- ☐ with room-mates (shared-accommodation)
- ☐ semi-independent living (e.g. Social Services)
- ☐ residential care placement
- ☐ student hall or similar type of accommodation provided by the college/university
- ☐ unstable housing situation (e.g. homeless, couch-surfing)
- ☐ Other: ______

Q1.5. **Have you ever been in care** (looked-after by the local authority and lived in an out-of-home placements e.g. foster family or residential care like a children's home)**?**

- ○ No
- ○ Yes

Q1.5.1. **If yes, did you live in out-of-home care (e.g. foster care, residential care placement) on or after your 16th birthday?**

- No
- Yes

Q1.5.2. **In which country did you live in care?**

- England
- Germany
- Other:

Q1.5.3.
What kind(s) of out-of-home care placement did you live in?

- Foster family (not with relatives)
- Residential care home/children's home
- both residential care and foster care
- Other:

Q1.5.4.
At which age did you go into care?

Q1.5.5.
How long did you spend in care?
(For example: Type "2 years and 6 months" or "2.5 years")

Q1.5.6.
How often did you change the placement during your time in care?

- 0 (never)
- 1 time
- 2 times
- 3 times
- 4 times
- 5 times
- 6 times

- 7 times
- 8 times
- 9 times
- 10 times
- more than 10 times. How many times?

Q1.5.7. **At what age did you leave care?**
(Please type in your age at that time. If you are still in your care placement, please type "still in care" or "Staying Put".)

Q1.5.8.
At which age did you stop receiving support for care leavers from the local authority?

- 15 or younger
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24
- 25
- 26
- still receiving support for care leavers from the local authority

Q1.5.9.
Do you have a pathway plan?

- No
- Yes. How does it support you? (please describe it in a few words)
- I don't know

Q1.5.10. **Are you still in touch with your social worker/personal advisor or former carer from a care placement?**

- No
- Yes

Q1.5.10a. **If yes, with whom (of carers and professionals in the care system) do you still have regular contact? How often?**
Please write down in the empty box underneath the person's role how often you have contact with this person (like several times a months, once a month, once every six months, less than every six month). You can choose several answers.

- Social worker
- Personal advisor
- Former carer from a residential care placement
- Former foster parent(s)
- Other: (Please write down the role and how often you have contact with this person!)

Q1.5.11. **How are/were you supported when you left care?**
Please describe this in a few sentences (max. 300 characters)

Q1.5.12. **Did you have contact with members of your birth family during care?**

- No
- Yes. How often?

Q1.5.13. **Have you been in touch with your birth family after you have left care?**

- No
- Yes. How does your family support you?

Q1.5.13a.
To whom of your family members do you have regular contact after you have left care?
(You can choose several answers.)

- [ ] Mother
- [ ] Father
- [ ] Sibling(s)
- [ ] Grandparent(s)
- [ ] Uncle(s)/aunt(s)
- [ ] Cousin(s)
- [ ] Others
- [ ] Foster family
- [ ] None

Q1.5.14.
Do you have siblings?

- No
- Yes

Q1.5.14b. **Was/were your sibling(s) in care at the same time as you were in care?**
(You can add a short note under your selected answer to give more details.)

- Yes, all of my siblings were in care at the same time as I was
- Yes, one/some of my siblings was/were in care at the same time as I was
- No, my sibling(s) lived with our family while I was in care
- No, because of other reasons
(e.g. my sibling(s) was/were already adults or lived with a parent who is not my parent (different mother or father)):
- Other:

Q1.5.14c. **If yes, did you live together at the same place while in care?**

- No
- Yes
- Partly
- Other:

Part 2: Personal Wellbeing

Q2.
Part 2: Personal wellbeing
The following questions are related to your emotional wellbeing, especially about your feelings and thoughts about life.
Some of the questions could be sensitive and may cause distress as you might remember some unpleasant memories or feelings. You can skip questions or withdraw from the survey at any point.
If any of the questions asked upsets you in any way and you feel you would like to access support services, please do so. There is a list of support services provided at the end of this survey and by the NHS: https://www.nhs.uk/conditions/suicide/, or call directly Samaritans: 116 123.

Q2.1.
On a scale from 1 (not positive at all) to 10 (extremely positive) how do you feel about your current life?

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○

Q2.2. **How would you describe your mental wellbeing recently?**

- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor
- ○ Very poor

Q2.3. **Have you been in touch with a mental health service recently (within last 2 months)?**

- ○ No
- ○ Yes
- ○ Prefer not to say

Q2.4.
How positive do you feel about the future? On a scale from 1 (not positive at all) to 10 (extremely positive):
In other words: How much are you looking forward to the future? (1 = "not at all" to 10 = "very much")

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○

Q2.5.
What do you hope for your future in the next 5 years?

- ○ Please describe your hopes and plans here:
- ○ I don't know

Part 3: INQ-R

Q3.
Part 3: INQ-R

The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, **not** what you think is true in general, or what might be true for other people.
Please base your responses on how you've been feeling recently. Use the rating scale to find the number that best matches how you feel and circle that number. There are no right or wrong answers: we are interested in what *you* think and feel.

Some of the questions could be sensitive and may cause distress as you might remember some unpleasant memories or feelings. You can skip questions or withdraw from the survey at any point.
If you feel upset and would like to get in touch with support services, here is a list of contact details provided by the NHS: https://www.nhs.uk/conditions/suicide/ or call directly Samaritans: 116 123.

Q3.1. INQ

	Not at all true for me		Somewhat true for me			Very true to me	
	1	2	3	4	5	6	7
1. These days the people in my life would be better off if I were gone.	○	○	○	○	○	○	○
2. These days the people in my life would be happier without me.	○	○	○	○	○	○	○
3. These days I think I am a burden on society.	○	○	○	○	○	○	○
4. These days I think my death would be a relief to the people in my life.	○	○	○	○	○	○	○
5. These days I think the people in my life wish they could be rid of me.	○	○	○	○	○	○	○
6. These days I think I make things worse for the people in my life.	○	○	○	○	○	○	○
7. These days, other people care about me.	○	○	○	○	○	○	○
8. These days, I feel like I belong.	○	○	○	○	○	○	○
9. These days, I rarely interact with people who care about me.	○	○	○	○	○	○	○
10. These days, I am fortunate to have many caring and supportive friends.	○	○	○	○	○	○	○
11. These days, I feel disconnected from other people.	○	○	○	○	○	○	○
12. These days, I often feel like an outsider in social gatherings.	○	○	○	○	○	○	○
13. These days, I feel that there are people I can turn to in times of need.	○	○	○	○	○	○	○
14. These days, I am close to other people.	○	○	○	○	○	○	○
15. These days, I have at least one satisfying interaction every day.	○	○	○	○	○	○	○

Part 4: Attitudes towards life and death

Q4_Info.
Part 4: Attitudes towards life and death

Please remember that some of the questions could be sensitive and may cause distress. You can skip questions or withdraw from the survey at any point.
If any of the questions asked upsets you in any way and you feel you would like to access support services, please do so. There is a list of support services provided at the end of this survey and by the NHS: https://www.nhs.uk/conditions/suicide/ or call directly Samaritans: 116 123.

Q4.
Please tick the boxes next to the following questions about how often you have experienced the following.

	generally			If yes, when did it occur the last time?				If yes, when did it occur re[g]		
	No	Yes	Prefer not to say	Last month	Within the last 12 months	Earlier than the past year	(not experienced)	Only while I was in care before I left care	While I was in care and after I left care	Only after left care
1. Have you ever felt that life was not worth living?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
2. Have you ever wished you were dead? For instance, that you could go to sleep and not wake up?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
3. Have you ever thought of taking your life, even if you would not really do it?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
4. Have you ever reached the point where your seriously considered taking your life, or perhaps made plans how you would go about doing it?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Tip!.
Please check your previous answers of part 4!

Please make sure that there are no conflicting answers between your answers in the first column and your answers for the same question in the following columns!

For example, if you have selected "No" for a question in the first column, then there is no need to answer the same question in the following columns (specifying the time).
If you have selected "Yes", you can answer the same question in the following two columns.

Q4.Corona. **How did the Coronavirus (COVID-19) crisis affect the following aspects for you compared to the time before?**

	positively	a bit positively	stayed the same	a bit negatively	negatively
Feeling of belongingness to others	◯	◯	◯	◯	◯
Feeling of being a burden for others	◯	◯	◯	◯	◯
Your attitude towards your life	◯	◯	◯	◯	◯

Q4.C_note.
If you feel upset and would like to get in touch with support services, here is a list of contact details provided by the NHS: https://www.nhs.uk/conditions/suicide/ or call directly Samaritans: 116 123.

Q4.5.
If you experienced suicidal thoughts: When did these suicidal thoughts appear first?
Please click on the age when you experienced this the first time. (If you never experienced suicidal thoughts, please go to question 5.1)

Q4.6.
Did something change at the time when you experienced these suicidal thoughts for the first time?

- No
- Yes. What did change?

Q4.7.
What do you think caused them? Can you describe what happened that might have influenced your suicidal thoughts to appear?
Please describe it in a few sentences (max. 400 characters)

Part 5: Reflection on care

Q5.1. **Part 5: Reflection on care**

How do you think your experience of being in care influenced your attitude towards life?
Please describe it in a few sentences (max. 400 characters)

Q5.2. **How would you wish social services and care to change to ensure that care leavers/care-experienced people have a satisfying (early) adulthood, particularly to prevent the experience of suicidal thoughts?**
Please write down one wish/recommendation which you think is most important. Please do not write more than 3 sentences (max. 400 characters).

Part 6: Empowerment and joy

Q6.1.
Part 6: Empowerment and joy

How do you deal with stress?
For example, what helps you to calm down when you feel stressed or upset?

Q6.2.
What are/were the situations or things that make you feel good and make you enjoy your life?

Q6.3. **What makes you feel strong?**

Q6.4.
What are your strengths that help you manage difficult situations?
Please try to write down 2 of your strengths.

- [ ] 1:
- [ ] 2:

Q6.5.
What can cheer you up?
Please describe it in a few sentences (max. 200 characters)

Part 7: General Information 2

Q7.
Part 6: General information 2

In the end, I would like to ask you a few more general information about you.

Q7.1. **Please specify your ethnicity!**

Q7.2.
Did you enter care as an unaccompanied/separated asylum seeking minor?

- No
- Yes
- I don't know/Prefer not to say

Q7.3.
What is your relationship status?

- Single
- In a relationship
- Married
- Same sex civil partnership / marriage
- Divorced
- Widowed
- Other:
- Prefer not to say

Q7.4. **What is your sexual orientation?**

- Heterosexual (straight)
- Homosexual (gay/lesbian)
- Bisexual
- Other:
- Prefer not to say

Q7.5. **How many children do you have?**

- 0
- 1
- 2
- 3
- 4
- 5 or more

Q7.5.1. **How many of your own children live with you?**

- 0
- 1
- 2
- 3
- 4
- 5 or more

Q7.6.
Do you class yourself as having a disability?

- No
- Yes. Please specify:
- Prefer not to say

Q7.7.
What is your highest level of education/qualification?

- No qualification
- GCSE
- A-Level or equivalent
- Diploma of higher education
- Degree of honours (BA, BSc)
- Masters (MSc, MA or PGCE)
- PhD or equivalent
- Other:
- Prefer not to say
- I don't know

Q7.8. **Are you currently...**

- Employed/self-employed
- Out of work and looking for work
- Out of work but not currently looking for work
- A homemaker
- A student
- Unable to work
- Other:

Debriefing

Ending

Thank you for taking part in the survey.
With your answers, you have helped those who work with young people leaving care to understand people with care experience better, and hopefully in the process develop guidelines and practices to empower future care leavers better, strengthen their mental health and life satisfaction.

Contact the research team
(questions, complaints or to request a summary of the final results of the study)

Email:
care-study@rhul.ac.uk

WhatsApp:
+447916401375

PhD Student:
Petra Göbbels-Koch

PhD supervisors:
Prof. Anna Gupta, *Anna.Gupta@rhul.ac.uk*
Dr Katrin Bain, *Katrin.Bain@rhul.ac.uk*

i PARTICIPATION IN INTERVIEWS

The survey is one part of a larger study. The other part will be interviews with care-experienced adults who experienced suicidal thoughts in the past and coped with such thoughts. I would like to hear about your experiences and opinions on how care and social services can help to prevent the experience of suicidal ideation
If you are interested in sharing your experience in order to help to identify factors influencing suicidal thoughts (like what helps to cope with such thoughts), you are welcome to contact me.

Taking part in the interviews is possible if you
- **Are between 18 and 40 years old**
- **Live in England or Germany**
- **Have care experience (residential care, foster care; in care on or after your 16th birthday)**
- **Experienced suicidal thoughts in the past but do not think of suicide anymore for at least several months**
- **Consider yourself as alright to talk about your experience.**

Interviews will take place online. It will be possible to take part until June 2021.
If you are interested in participating in the interviews, please send me an email or contact me by WhatsApp.
Then we will discuss further details about the interviews and also the option for reimbursement for your time.

SUPPORT SERVICES:

If you feel upset and would like to get in touch with support services, here is a list of contact details provided by the NHS: https://www.nhs.uk/conditions/suicide/.
If you're feeling like you want to die, it's important to tell someone. Help and support are available right now if you need it. You don't have to struggle with difficult feelings alone.
These free helplines are there to help when you're feeling down or desperate. Unless it says otherwise, they're open 24 hours a day, every day.

Samaritans – for everyone (24/7 available)
Call 116 123
Email *jo@samaritans.org*
https://www.samaritans.org/

Papyrus – for people under 35
Call 0800 068 41 41 – Monday to Friday 10am to 10pm, weekends 2pm to 10pm, bank holidays 2pm to 5pm
Text 07786 209697
Email *pat@papyrus-uk.org*

Talk to someone you trust. Let family or friends know what's going on for you. They may be able to offer support and help keep you safe. There's no right or wrong way to talk about suicidal feelings – starting the conversation is what's important.

Who else you can talk to?
If you find it difficult to talk to someone you know, you could:
call your GP ask for an emergency appointment call 111 out of hours (they will help you find the support and help you need) contact your mental health crisis team – if you have one.

Important:
Is your life in danger?
If you have seriously harmed yourself – for example, by taking a drug overdose – call 999 for an ambulance or go straight to A&E. Or ask someone else to call 999 or take you to A&E.

Tips for coping right now:
- try not to think about the future – just focus on getting through today
- stay away from drugs and alcohol
- get yourself to a safe place, like a friend's house
- be around other people
- do something you usually enjoy, such as spending time with a pet

See more tips from Rethink: https://www.rethink.org/diagnosis-treatment/symptoms/suicidal-thoughts

"Hub of Hope"
A national mental health database which brings together organisations and charities from across the country who offer mental health advice and support
https://hubofhope.co.uk/

SUPPORT SERVICES FOR CARE LEAVERS:
Care Leavers Association: https://www.careleavers.com/
Rees Foundation: http://www.reesfoundation.org/

Appendix 5: Shapiro-Wilk test results for normal distribution

Part 1

- Age
- Age entering care
- Duration in care
- Placement changes

	Shapiro-Wilk		
	Statistic	df	Sig.
How old are you?	,903	44	,001
At which age did you go into care?	,928	44	,009
How long did you spend in care?	,905	44	,002
How often did you change the placement during your time in care?	,358	44	,000

Country		Shapiro-Wilk		
		Statistic	df	Sig.
England	How old are you?	,934	15	,311
	At which age did you go into care?	,913	15	,150
	How long did you spend in care?	,915	16	,143
	How often did you change the placement during your time in care?	,511	16	,000
Germany	How old are you?	,886	29	,005
	At which age did you go into care?	,936	29	,080
	How long did you spend in care?	,885	28	,005
	How often did you change the placement during your time in care?	,834	28	,000

Part 2

- Life satisfaction
- Wellbeing
- Future perspective

	Shapiro-Wilk		
	Statistic	df	Sig.
On a scale from 1 (not positive at all) to 10 (extremely positive) how do you feel about your current life?	,947	45	,039
How would you describe your mental wellbeing recently?	,904	45	,001
How positive do you feel about the future? On a scale from 1 (not positive at all) to 10 (extremely positive):	,948	45	,043

Country		Shapiro-Wilk		
		Statistic	df	Sig.
England	On a scale from 1 (not positive at all) to 10 (extremely positive) how do you feel about your current life?	,943	16	,383
	How would you describe your mental wellbeing recently?	,911	16	,122
	How positive do you feel about the future? On a scale from 1 (not positive at all) to 10 (extremely positive):	,936	16	,303

Germany	On a scale from 1 (not positive at all) to 10 (extremely positive) how do you feel about your current life?	,925	29	,040
	How would you describe your mental wellbeing recently?	,890	29	,006
	How positive do you feel about the future? On a scale from 1 (not positive at all) to 10 (extremely positive):	,933	29	,064

Part 3

- Perceived Burdensomeness (INQ score) PB
- Thwarted Belongingness (INQ score) TB

	Shapiro-Wilk		
	Statistic	df	Sig.
INQ_PB	,916	43	,004
INQ_TB	,968	43	,269

		Shapiro-Wilk		
Country		Statistic	df	Sig.
England	INQ_PB	,915	16	,143
	INQ_TB	,947	16	,438
Germany	INQ_PB	,917	27	,034
	INQ_TB	,952	27	,246

Part 4

Paykel Suicide Scale (PSS):

- Lifetime
- Last month
- Last year
- Impact of the COVID-19 pandemic
- Age of first suicidal ideation

	Shapiro-Wilk		
	Statistic	df	Sig.
PSS lifetime	,591	34	,000
PSS year	,809	34	,000
PSS month	,777	34	,000

Country		Shapiro-Wilk Statistic	df	Sig.
England	PSS lifetime	,465	12	,000
	PSS year	,848	12	,034
	PSS month	,597	12	,000
Germany	PSS lifetime	,660	22	,000
	PSS year	,798	22	,000
	PSS month	,843	22	,003

How did the Coronavirus (COVID-19) crisis affect the following aspects for you compared to the time before?	Shapiro-Wilk Statistic	df	Sig.
Feeling of belongingness to others	,872	45	,000
Feeling of being a burden for others	,905	45	,001
Your attitude towards your life	,901	45	,001

How did the Coronavirus (COVID-19) crisis affect the following aspects for you compared to the time before?		Shapiro-Wilk Statistic	df	Sig.
England	Feeling of belongingness to others	,748	16	,001
	Feeling of being a burden for others	,842	16	,010
	Your attitude towards your life	,868	16	,025
Germany	Feeling of belongingness to others	,894	29	,007
	Feeling of being a burden for others	,911	29	,018
	Your attitude towards your life	,903	29	,012

	Shapiro-Wilk Statistic	df	Sig.
If you experienced suicidal thoughts: When did these suicidal thoughts appear first?	,837	39	,000

Country		Shapiro-Wilk Statistic	df	Sig.
England	If you experienced suicidal thoughts: When did these suicidal thoughts appear first?	,806	16	,003
Germany	If you experienced suicidal thoughts: When did these suicidal thoughts appear first?	,849	23	,003

Appendix 6: Overview of inclusion criteria for interviews

Inclusion criteria	**Exclusion criteria**
Age: 18–40 years old	Age: <18, >40
Usual residence: Germany or England	Usual residence is not in Germany/England
Care experience: Who had been in care (including supported accommodation) at least on or after their 16th birthday, in England or Germany	Care experience: - only spent a short time in care, - left the care system at an earlier age that they do not fit into the official criteria for leaving care support - No care experience at all.
Types of care placements: Residential care, Foster care, Supported/semi-independent living Further accommodation that qualifies for leaving care support	Types of care experience: Kinship care, Adoption, Ambulant family support service
Language: Good understanding/ speaking of German or English	Language: Lack of understanding German or English
Former suicidal ideation: Required to have experienced suicidal thoughts in their past, but last suicidal ideation was at least several months ago	Suicidal ideation was experienced recently (approximately within the last two months)
Emotional stability and reflectivity: The participant ensures that he/she is currently emotional stable and is able and willing to talk and reflect on the former personal experience of suicidal ideation without the risk of being emotionally distressed.	Emotional stability and reflectivity: The participant seems unsure about his/her ability and emotional capability to talk and reflect on their own suicidal ideation. The participant raises concerns about possible emotional distress.

Appendix 7: Checklist for pre-interview call

Checklist:

- How old are you?

  ____

- Did you live in out-of-home care (e.g. foster family, residential care placement/ children's home) on or after your 16th birthday?

  ____

- In Germany/England?

  ____

- Did you have ever suicidal thoughts like thinking about taking your own life?

  ____

  ____

- When was the last time you had suicidal thoughts?

  ____

  ____

- How do you feel when you talk about your experience?

  ____

  ____

- Do you have someone who can support you shortly after the interview in case some questions might remind you of distressing experiences and you feel upset?

  ____

  ____

Participation agreed:

Date of interview:

Online-platform:

Appendix 8: Interview guide informed by Wengraf's pyramid model

1: Care leavers' experience of suicidal ideation

TQ1: How did care leavers experience suicidal ideation?

IQ1a: Can you describe the time when you left care? How did you experience leaving care?

IQ1b: How do you think your experience of being in care influences your attitude towards life?

IQ1c: There was a time when you experienced thoughts of wishing your life would end soon/killing yourself. Can you describe this time?

IQ1d: When was the first time you experienced these thoughts?

IQ1e: Can you describe this time briefly? How would you describe this time?

IQ1f: How would you describe your social life during this time?

2: Factors which care leavers perceive as causative for the occurrence of suicidal ideation

TQ2: Which factors do care leavers perceive as causative for the occurrence of suicidal ideation? Specifically: Did they experience perceived burdensomeness and thwarted belongingness?

IQ2a: What do you think caused the suicidal thoughts in you when they occurred?

IQ2b: What role did your experience of the out-of-home care/Social Services play with the occurrence of suicidal thoughts?

IQ2c: How did you feel about people around you during the time the suicidal thoughts appeared first?

IQ2d: Did you miss something when you think about that time when you were among other people? What did you miss? What would you have liked to be different at that time that would prevent you experiencing such thoughts?

3: Factors which care leavers perceive as helpful for coping with suicidal ideation

TQ3: Which factors do care leavers perceive as helpful for coping with suicidal ideation?

IQ3a: What did help you during this difficult time to move on? What was most empowering for you to move on?

IQ3b: How did you develop during this time in order to move on?

IQ3c: How did you experience the time you spend with others when you have moved on? How did the interaction with others change/develop when you "have moved on"? How did your social life change?

IQ3d: What role did your social worker/Social Services/professionals play to cope with the suicidal thoughts?

IQ3e: How do you deal with stress?

IQ3f: What are your strengths that helped you manage with difficult situations?

IQ3g: What does make you enjoy life?

4: Care leavers' wishes of how to empower future care leavers to prevent suicidal ideation

TQ4: What are the care leavers' wishes and recommendations of how to empower future care leavers to prevent suicidal ideation?

IQ4a: What did you wish or hoped for most in such difficult times when you think about it now?

IQ4b: How was your social worker able to empower you?

IQ4c: What would you do different now if you could go back in time that would stop you getting the wish of dying?

IQ4d: What would you offer to someone who grew up in care, who is desperate about life and thinks about ending his or her life?

IQ4e: What is your wish what should change in the service which social workers provide to empower care experienced young people/young adults?

Appendix 9: Demographic data sheet for interview participants

1. How old are you in years?
   ____

2. What is your gender?
   - Female
   - Male
   - Trans
   - Other: ________________________
   - Prefer not to say

3. What country do you live in? __________________________________

4. What is your ethnicity?
   ____

5. What is your main occupation?
   - School student
   - College student
   - University student
   - Full-time employment
   - Part-time employment
   - Several jobs
   - Combining education and jobs
   - Housewife/-husband
   - Unemployed/job-seeking
   - Others:_____________
   - Prefer not to say

Information about your care experience:

6. Did you live in out-of-home care (e.g. foster family, residential care placement/ children's home) on or after your 16th birthday?
   - No
   - Yes

7. In which country did you live in care?
   - England
   - Germany
   - Other__________

8. What kind(s) of out-of-home care did you live in?
    1. Foster family
    2. Residential care home
    3. Both residential care and foster care
    4. Other:________

9. At which age did you go into care? For example, 11.

    ______

10. How long did you spend in care? For example, 4 years, 6 months.

    ______ *[years]*, _________ *[moths]*

11. How often did you change the placement during your time in care? For example, 2.

    ______

12. At which age did you leave care? For example, 18.

    ______

13. Are you still in touch with your social worker/personal advisor?
    - No
    - Yes.
      If yes, how often are you in touch with your social worker/personal advisor? For example, once every month.

      ____

Appendix 10: Transcription system

The transcription is informed by Powers (2005) and the ‘alternative abbreviated instructions for transcribers’ by Poland (2001, p. 641), with some aspects being simplified to fit the transcript's purpose better. The following signs for non-verbal components were implemented in the transcription (based on Powers, 2005, and Poland, 2001, p. 641):

Non-verbatim component	Description and signs
Anonymisation	All names and places are anonymised. If the speaker mentions a name or a place, the type of the rephrased expression is written in square brackets. For example, “*My friend [name]”* or “*I lived in [city]*”. If a person mentions several people or places, they will be distinguished with A, B, C etc. like “My friend [name A] told [name B].”
Pauses	Short pauses of 2-3 seconds are denoted with (.). All pauses equal to or longer than 4 seconds are denoted with (*pause).*
Laughing, deep breathing, etc.	Non-verbal, (possible) emotional reactions are denoted with the sound in parentheses like (*laughing)* and (*laughter)* if more than one person is laughing, (*deep breathing), (coughing)* and (*sighing).*
Interruptions	Interruptions or correction or break-up of a sentence while speaking are marked with a hyphen in parentheses *(-)*
Overlapping speech	If the interviewer and the interviewee speak at the same time, it is marked with *(overlapping)*
Fillers	Fillers without seeming to have a meaning or not even indicating the process of thinking are edited out, like starting every sentence with “*and*” or “*um*” (English) or “*ehm*” (German).
Assents	Non-verbal assent with a positive, agreeing meaning are written as “*Hm*” or “*hm hm*”.
Dissents	Non-verbal dissents with a negative, disagreeing meaning are written as “*uh uh*” (English) or “*eh-eh*” (German).
Inaudible/ guessed words	If a word or several words are inaudible, it is denoted with *[inaudible].* If the word is hard to understand and the transcriber guesses the word, it is denoted with the guessed word with a question mark in square brackets like *[castle?]*.
Emphasis	The person highlights a word with a prolonged pronunciation; the word is written with several highlighted vowels separated with hyphens like “*No-o-o-o*.” The person highlights something by saying it louder, the word or words in the louder tone are written with capital letters like “*WHAT*?”
Paraphrasing others	To indicate that the speaker imitates someone else, the part that is not the speakers' own words are placed between quotations marks. For example: *They came to me and said ‘Go away’.*
Addition	If anything is added to the original speech, it is indicated with square brackets [addition].
Cuts	Irrelevant comments which occurred due to disruption are cut out and indicated with square brackets with three dots like […]. For example, interruptions that did not concern the interview (e.g. comments on getting the charger for the computer/phone).

Appendix 11: Thematic framework

Code	*Description*
1. (Interpersonal) critical or traumatic events *Experiences that were described as traumatic or highly negative that directly were linked to the development of suicidal ideation (SI) or described as a cause or trigger of suicidal ideation.*	
1.1. Extra-familial abuse	Sexual, physical, emotional abuse by any kind of family member, including partner of a parent, extended family or kinship carers, including threats and psychological pressure due to mental illness of a family member
1.2. Intra-familial abuse	Sexual, physical, emotional abuse by a person not related to or as an internal of the family, e.g. teachers, friends or foster/residential carers
1.3. Harassment/bullying	Any kind of verbal harassment or bullying, mocking, e.g. by peers or colleagues, when not directly stated as emotional abuse
1.4. Loss of a beloved person	Death of a close person like family member, e.g. parent or grandparent
1.5. Witness/threat of suicidal behaviour	- Person witnessed suicide attempt - A person threats to die by suicide

2. Self-perception *Own perception of oneself influencing suicidal ideation.*	
2.1. Perceived burdensomeness	Feeling like a burden to others and causing others pain, stress or any kind of difficulties like a financial burden
2.2. Feeling of letting others down	The person feels like disappointing others, breaking promises or feeling like being a failure and failing to support others, particularly beloved persons like family or friends
2.3. Self-worth/self-esteem	- Feeling worthless - Feeling incapable
2.4. Self-blame/self-reproaches	The person blames oneself for a situation or event, e.g. the abuse that the person experienced or hiding a problem Contrast: ambivalence between blaming oneself or others as protective factors.
2.5. Identity & self-image	- The person has a negative self-image, e.g. regarding the person's body or physical appearance, including behaviour - The person struggles to find or accept identity, e.g. gender identity regarding transgender

	- The person has unrealistic self-expectations (identity) that cause an overwhelmed feeling and disappointment - Including recommendations for social work and care regarding identity building as prevention and support

3. Social connections *Relationships and social, relational factors relevant to the development, coping, or prevention of suicidal ideation.*	
3.1. (Not) feeling understood	The person does (not) feel understood, listened to or respected with respect to his/her wishes, expectations or expressed needs.
3.2. Loneliness and social company	The person feels alone and left alone to one's own devices, e.g. with no support; being alone like in an empty flat without company; social company present
3.3. Feeling of belongingness	Thwarted/lacking or unfulfilled belongingness - Relationships cease/break down - No social connections - Rejections or exclusion from a group - a strong feeling of belongingness to a group like to the person's family, but factors like physical distance affect the belongingness as he/she cannot be close to them, e.g. homesickness. - Rejection Positive feeling of belongingness that - The person has good social connections and the feeling of belongingness to a group like friendships e.g. feeling included and welcome by others - Others care for the young person - Others have a genuine interest in the young person - Feeling understood by others - Being there for someone e.g. not leaving a person alone when he/she doesn't feel well
3.4. Peer relationships	- Relationships with people who have similar experiences like other care leavers or young people in care - Friends If relevant to the experience or coping of SI
3.5. Love and caring for others	The person describes a strong relationship with others whom he/she cares for, e.g. does not want to hurt them by dying by suicide Different to belongingness as the person feels that others care while here the person cares for others as a kind of responsibility

3.6. Family relationships	- The person describes to positive effects of ongoing family contact - A relationship with a family member is described as supportive for coping and as a resource If relevant to the experience or coping of SI
3.7. Professional relationship	Description of the experienced relationship between the young person and - Social worker - Carers (residential or foster) - Mental health professionals/therapists - PA/leaving care workers Professionals take the young person seriously, show interest, emotional distance/closeness, empathy, trust, go the extra mile, have ongoing contact after formal support has ended etc.; If relevant to the experience or coping of SI
3.8. Alternative relationships/other	- Roommates, - Partners, - Colleagues If relevant to the experience or coping of SI
3.9. Achievements and development	- Being proud of oneself - Reflecting on own experiences and how successfully one dealt with them. - Reached goals and fulfilled wishes - Positive development due to learning from own experiences, e.g. how to deal with difficult situations - Development also with respect to getting older and more experienced

4. Self-care *Self-management skills to control a situation, emotions etc. relevant to suicidal ideation.*	
4.1. Self-management skills	This includes any self-management skills e.g. - educating oneself about how to deal with stress, anxiety etc. - therapeutic skill box that helps to deal with SI or self-harm, e.g. making use of physical resources like letters, photos to remind oneself of positive memories - creative activities like writing down thoughts or nightmares
4.2. Reflection on the situation	The person describes the ability to reflect on a stressful situation rather objectively and with the knowledge of the previous experience to judge emotions, further actions or options to control the situation.

4.3. Positive attitude and experiences	Having a positive perspective on situations and focusing on positive aspects in life or memories
4.4. Living in the moment	- Not thinking of the past or the future - Enjoying the current situation
4.5. Healthy relationships and boundaries	- The person has the ability to form healthy relationships and set boundaries to protect oneself from abusive relationships - The person describes relationships that he/she considers as healthy that helped to cope
4.6. Distraction and activity	- Any kind of distraction that helped to cope with SI like meeting friends, going out, games or enjoying nature. - Activities that helped the person to deal with SI like common activities with someone else or going outside for a walk.

5. Control *Gaining control over a situation/ feeling powerless/helpless/overwhelmed/psychological pressure*	
5.1. Control	The feeling that the person does (not) have any control over a situation, feels helpless, or feels powerful and in control of a situation or options of taking control and own influence
5.2. Psychological/emotional pressure	Pressure due to hiding something, stress, dealing with it by oneself, or may be also linked to threats by others and projected to oneself, e.g. threats to hide abuse. Therefore, this can be intrinsic or interpersonal.
5.3. Overwhelmed	Expression of being overwhelmed by one situation or multiple events/factors that may be related to the feeling of loss of control.

6. Motivation *All aspects related to intrinsic motivation concerning suicidal ideation either for the development and process of suicidal ideation or coping strategies.*	
6.1. Future perspective and hope	- Hopelessness: The person has a negative or no positive future perspective independent of any action the person could take. Thoughts include: • “This will never get better.” • “It will only get worse.” - Hope and a positive future perspective “Things will get better.”, “Positive experience will happen in the future.” - Hope regarding faith or religious belief

6.2. Achievements and development	- Being proud of oneself - Reflecting on own experiences and how successfully one dealt with them. - Reached goals and fulfilled wishes - Positive development due to learning from own experiences, e.g. how to deal with difficult situations - Development also with respect to getting older and more experienced
6.3. Mentors and role models	- Peer support and peer mentoring, like older care leavers mentoring young care leavers - Also related to relationships like people without care experience but have a supportive and kind of mentoring role and acting as a role model, e.g. inspiring lifestyles
6.4. Goals and taken actions	- Having clear goals set for oneself that may raise the person's motivation to achieve those - Referring to recommendations on support based on individual needs, capabilities and goals - Actions were taken to achieve wider goals like education and removing stigma
6.5. Intrinsic motivation to change	The person feels the desire and wish to change the state or situation he/she experiences and to improve the state/situation. Possibly to be referred as self-management if they take actions and apply changes to their life in general, e.g. being more active.
6.6. Motivational talk	Motivating oneself to "stay" (like not die by suicide) e.g. - Reminding oneself about achievements and having gone through difficult times in the past - Reminding oneself about goals - Reminding oneself about positive experiences
6.7. Purpose	Having a meaningful task or job that someone feels like being able to make a meaningful contribution to society and to make a change; responsibility for others, e.g. pets
6.8. Reward	Rewarding oneself, e.g. for working hard and creating an enjoyable lifestyle, treats like buying things, doing enjoyable things

7. Structural support *This includes the structural characteristics of support networks, both formal and informal, that seem relevant in the context of the development, coping, resources and prevention of suicidal ideation. The main focus is on professional support due to its' structural and systemic connection and relevance concerning the (leaving) care system. That includes social work, care practice and mental health support. Structural characteristics like the accessibility of support networks also include informal resources.*	
7.1. Access and availability of support	How accessible support is, particularly access to mental health support and suitable support to help cope with SI and mental health issues, e.g. required financial resources This support includes social workers, carers and mental health support. This includes: - Times of accessing support (outside regular working hours) - Support responding to messages
7.2. Assessment	- Assessment to figure out the suitable support needed, - Description of a time-wise, early support needed to, e.g., protect a young person or prevent SI and poor mental health
7.3. Awareness (generally)	This code refers to public and group-based awareness, like social workers in general, of a certain topic concerning mental health, suicide prevention etc.
7.4. Person-centred support	Formal support is based on individual needs that help to cope or would prevent SI
7.5. Professional qualification and skills	Qualification, training, professional interventions and abilities of - Social workers - Carers - Mental health practitioners
7.6. Social work and care practice	Description of experienced or wished professional practice, e.g. caseloads, bureaucracy, placements - Social work - Foster/residential care - Leaving care support If relevant to the experience or coping of SI
7.7. Therapy / mental health support	Descriptions of therapeutic, psychiatric, medical or mental health support that directly helped to cope with SI

8. Communication *All relevant aspects of communication that affected mental health and suicidal ideation, access to support or resources.*	
8.1. Stigma	Experiencing stigmatisations of - Care experience - Mental health issues

8.2. Option to talk to someone	Feeling of presence or absence of social support; (no) existing relationships as an option to talk about mental health issues and SI; (no) trustful relationship to disclose SI; no one or someone who offered a confidential conversation.
8.3. Fronting and masking	Hiding issues or own background due to fear of consequences
8.4. Young person's communication skills	The person discusses the ability or difficulties to: - Express own needs (like support) - Disclose/express traumatic experiences - Explain own behaviour or emotional state to others to connect with others If relevant to the experience or coping of SI
8.5. Building support network	Description of how to form a support network or difficulties if relevant to cope SI
8.6. Non-verbal signs	Behavioural characteristics or changes due to SI/depression, e.g. avoiding social contact, being more passive and quiet than usual, being more aggressive or shy
8.7. Communication with professionals	Description of how the young person has experienced the communication with professionals - Social workers - Foster/residential carers - Mental health workers/therapists If relevant to experiencing, preventing or coping with SI, this includes: - Lack of communication - Involvement/participation of the young person in decision-making processes - Listening to young person's wishes and needs

9. Transition *Category to group all aspects directly mentioned to the leaving care process, changes of placements, moving places or ceasing support. This includes the transition between places, systems, responsible teams/professionals, status (e.g. looked-after to independent, child to adult) and also caused effects (e.g. emotions) by this transition if not coded under a different category.*	
9.1. Transition	Description of the process of placement changes while in care and leaving care like: - Between foster/residential placements - Semi-independent living - Moving into own place - Moving to university - Related changes of support systems and responsibilities (e.g. transition from the care team to leaving care team) If relevant to the experience or coping with SI

9.2. Processing past	As an effect of leaving care, the person describes that he/she started processing the childhood or past experiences, mainly focusing on traumatic events.
9.3. Physical distance	Refers to moving away from the area the person lived before that e.g. - Affected social contacts - Having no local social contacts like knowing no one in the new area - Distance to family, friends etc. If relevant to the experience or coping of SI
9.4. Place and environment	- Feeling safe and comfortable in the place and area the person lives - In contrast to unsafe, lonely places and environments that contribute to SI and poor mental health. - Changes in environment and places regarding instability
9.5. Challenges and expectations	Refers to tasks related to the transition from care adulthood like bureaucracy when renting on own place, budgeting and daily structure If relevant to the developing or coping with SI

10. Suicidal ideation (SI) experiences *Description of the experience of suicidal ideation that includes types of ideation, development of suicidal thoughts such as trajectories of different types of suicidal thoughts or behaviour.*	
10.1. Active SI	- Desire to end oneself's life - Planning suicide attempt - Suicidal behaviour or attempt
10.2. Passive SI	- "Life is worthless." - Wishing to die without any clear plans, e.g. getting a terminal illness
10.3. First SI	Time/circumstances when SI appeared first
10.4. SI as background noise	Constant passive presence of SI
10.5. Self-harm	Self-harm as: - State before developing/experiencing SI (non-suicidal) - Suicidal behaviour like bringing oneself at risk by accepting that this may end deadly or as a suicide attempt - As a coping strategy to cope with SI or extreme stress without wanting to die
10.6. Ambivalence between life and death	- Wish to die vs fear of death simultaneously - Internal conflict between dying and living

Appendix 12: Interview information sheet including consent form and contact details of support services

Information sheet: interview

Department of Social Work, Royal Holloway, University of London

Progress and Coping:
Influencing Factors of Suicidal Thoughts among care-experienced adults

Researcher: Petra Göbbels-Koch, care-study@rhul.ac.uk, (+44)7916401375

Supervisor: Prof Anna Gupta, anna.gupta@rhul.ac.uk
Dr Katrin Bain, katrin.bain@rhul.ac.uk

My name is Petra Göbbels-Koch. I am a PhD student from the Royal Holloway, University of London. As part of my PhD project, I will look at the experience and influencing factors of suicidal thoughts (thoughts about ending your life) among young adults with care experience in England or Germany. The aim of the interviews is to collect care leavers' views about their past suicidal thoughts and recommendations for support to achieve a better understanding of the mental health of care-experienced young people. It's hoped that the results might have an impact on future supportive work for those still in care and care leavers.
You can participate if you are between 18 and 40 years old, care experienced (foster / residential care) and did not have suicidal thoughts recently. The interview will take about 60 minutes. I will offer you a reimbursement of £15 for your time. Questions about your experience of leaving care and suicidal thoughts will be asked as well as your views on how you coped with them.

Please note:

- Participation is entirely voluntary. You can withdraw from the study at any point during the interview and up to one month after the interview took place, without giving any reason. You will still get the reimbursement for your time.
- Your identity will remain confidential throughout the study and all names mentioned will be changed. You will not be identified as a participant.
- During the interview, you will be asked a number of questions. You do not have to answer any questions if you prefer not to.
- Some questions may seem to be sensitive and may cause distress as they might remind you on unpleasant experiences. At any time, you can take a break, skip questions or stop the interview. If you feel upset and you would like to contact support services, please do so. Contact details for support services are attached (see below). Please identify a person of your trust (e.g. a friend) who you will call after the interview to support you afterwards. If you mention that you or someone else is at risk of harm, I may have to report this to the relevant authorities.
- The interview will be audio-recorded. The audio recording will be listened to by myself, my supervisors and a transcriber.
- Your written or recorded consent will be stored separately from the responses during the interview which you provide.
- We will have a debriefing at the end of the interview and schedule a short follow-up phone call on one of the following days after the interview.
- The results will be used for my PhD dissertation, reports and publications.
- If you would like a copy of the final results of the study, please inform me.

Consent form

Progress and Coping:
Influencing Factors of Suicidal Thoughts among care-experienced adults

Please tick the following to provide consent for your participation in this study (not necessary if the interview takes place online):

I have read the information sheet about this study.	☐
The purpose of the study has been explained to me in writing and I have also been briefed before participation and will also be offered debriefing after the interview.	☐
I have had the opportunity to ask questions.	☐
I have received satisfactory answers to any questions.	☐
I understand that even if I consent to participate now, I am free to withdraw from the interview within one month after it took place, without any consequences or without giving a reason.	☐
I understand that participation will involve me participating in interviews that will be recorded.	☐
I understand that the data collected from the interview will be used for the researcher's PhD dissertation, reports and publications.	☐
I understand that all the information I provide for this study will be treated confidentially and my identity will remain anonymous throughout.	☐
I understand that if I inform the researcher that I or someone else is at risk of harm they may have to report this to the relevant authorities and need to disclose my identity.	☐
I understand that I am free to contact the researcher to seek further clarification and information.	☐
I agree to participate in this study.	☐

I ______________________________ voluntary agree to participate in this research study.

______________________________ ____________

Signature of research participant *Date*

Alternatively (filled out by the researcher): consent recorded on ____________

Date

I would like a copy of the final result of the research to send to the following email:

____

SUPPORT SERVICES:

If you're feeling like you want to die, it's important to tell someone. Help and support are available right now if you need it.

Talk to someone you trust. Let family or friends know what's going on for you. They may be able to offer support and help keep you safe. There's no right or wrong way to talk about suicidal feelings – starting the conversation is what's important.

Who else you can talk to?
If you find it difficult to talk to someone you know, you could:

- call your GP
- ask for an emergency appointment call 111 out of hours (they will help you find the support and help you need)
- contact your mental health crisis team – if you have one.
- If you have seriously harmed yourself – for example, by taking a drug overdose – call 999 for an ambulance or go straight to A&E. Or ask someone else to call 999 or take you to A&E.

These **free helplines** are there to help when you're feeling down or desperate:

Samaritans – for everyone (24/7 available)
Call 116 123
Email *jo@samaritans.org*
https://www.samaritans.org/

Papyrus – for people under 35
Call 0800 068 41 41 – Monday to Friday 10am to 10pm, weekends 2pm to 10pm, bank holidays 2pm to 5pm
Text 07786 209697
Email *pat@papyrus-uk.org*

for more services: **"Hub of Hope"**
A national mental health database which brings together organisations and charities from across the country who offer mental health advice and support
https://hubofhope.co.uk/

Support services for care leavers:

Care Leavers Association
https://www.careleavers.com/

Rees Foundation
http://www.reesfoundation.org/

Appendix 13: Ethics Committee's approval notifications

Royal Holloway
University of London
Egham, Surrey
TW20 0EX

Professor Katie Normington
Deputy Principal (Research)

Principal's Office
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31st January 2020

Dear Ms Gobbels,

I can confirm that project ID number 1806, entitled 'The occurrence and influencing factors of suicidal ideation among care leavers: a cross-national comparison in England and Germany' has been approved by the Research Ethics Committee via the full ethical review process.

Yours sincerely,

Professor Katie Normington
Deputy Principal (Research)

Ethical approval confirmation for amendment request in June 2020:

Result of your application to the Research Ethics Committee (application ID 1806)

Ethics Application System <ethics@rhul.ac.uk>
Wed 24/06/2020 10:49
To: Gobbels, Petra (2017) <Petra.Gobbels.2017@live.rhul.ac.uk>; Gupta, Anna <Anna.Gupta@rhul.ac.uk>; ethics@rhul.ac.uk <ethics@rhul.ac.uk>

PI: Anna Gupta, Katrin Bain
Project title: The occurrence and influecing factors of suicidal ideation among care leavers: a cross-national comparison in England and Germany

REC ProjectID: 1806

Your application has been approved by the Research Ethics Committee.
Please report any subsequent changes that affect the ethics of the project to the University Research Ethics Committee ethics@rhul.ac.uk

Appendix 14: Detailed survey results of quantitative analysis

14.1 Comparing distributions of age entering care, length of care and number of placement changes: Mann–Whitney test and t-test

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of At which age did you go into care? is the same across categories of What country do you live in? - Selected Choice.	Independent-Samples Mann-Whitney U Test	,872	Retain the null hypothesis.
2	The distribution of How long did you spend in care? is the same across categories of What country do you live in? - Selected Choice.	Independent-Samples Mann-Whitney U Test	,961	Retain the null hypothesis.
3	The distribution of How often did you change the placement during your time in care? - Selected Choice is the same across categories of What country do you live in? - Selected Choice.	Independent-Samples Mann-Whitney U Test	,001	Reject the null hypothesis.

Asymptotic significances are displayed. The significance level is ,05.

Group Statistics

	Country	N	Mean	Std. Deviation	Std. Error Mean
Age entering care	England	15	11,00	5,169	1,335
	Germany	29	11,62	4,305	,799

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Age entering care	Equal variances assumed	1,483	,230	-,423	42	,674	-,621	1,466	-3,580	2,339
	Equal variances not assumed			-,399	24,285	,693	-,621	1,556	-3,829	2,588

14.2 Age leaving care: a comparison of the distribution from England and Germany

Group Statistics

	Country	N	Mean	Std. Deviation	Std. Error Mean
Age leaving care	England	16	18,00	1,461	,365
	Germany	24	18,42	1,530	,312

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of Age leaving care is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,557[1]	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is ,05.

[1] Exact significance is displayed for this test.

14.3 Distribution of participation who were still receiving support from Social Services at the time of participation

At which age did you stop receiving support for care leavers from the local authority?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	still receiving support for care leavers from the local authority	10	22,2	22,2	22,2
	16	1	2,2	2,2	24,4
	17	3	6,7	6,7	31,1
	18	12	26,7	26,7	57,8
	19	5	11,1	11,1	68,9
	20	3	6,7	6,7	75,6
	21	6	13,3	13,3	88,9
	23	2	4,4	4,4	93,3
	24	2	4,4	4,4	97,8
	25	1	2,2	2,2	100,0
	Total	45	100,0	100,0	

At which age did you stop receiving support for care leavers from the local authority?

Country		Frequency	Percent	Valid Percent	Cumulative Percent
England	still receiving support for care leavers from the local authority	4	25,0	25,0	25,0
	16	1	6,3	6,3	31,3
	18	1	6,3	6,3	37,5
	19	2	12,5	12,5	50,0
	21	4	25,0	25,0	75,0
	23	1	6,3	6,3	81,3
	24	2	12,5	12,5	93,8
	25	1	6,3	6,3	100,0
	Total	16	100,0	100,0	
Germany	still receiving support for care leavers from the local authority	6	20,7	20,7	20,7
	17	3	10,3	10,3	31,0
	18	11	37,9	37,9	69,0
	19	3	10,3	10,3	79,3
	20	3	10,3	10,3	89,7
	21	2	6,9	6,9	96,6
	23	1	3,4	3,4	100,0
	Total	29	100,0	100,0	

14.4 Family relationships and contact with family members

Have you been in touch with your birth family after you have left care?

Country			Frequency	Percent	Valid Percent	Cumulative Percent
England	Valid	No	6	37,5	37,5	37,5
		Yes	10	62,5	62,5	100,0
		Total	16	100,0	100,0	
Germany	Valid	No	3	10,3	11,1	11,1
		Yes	24	82,8	88,9	100,0
		Total	27	93,1	100,0	
	Missing	System	2	6,9		
	Total		29	100,0		

Distribution of multiple-choice answers

"To whom of your family members do you have regular contact after you have left care?"

	Total N		Country: England N		Country: Germany N	
	Valid	Missing	Valid	Missing	Valid	Missing
Mother	21	24	6	10	15	14
Father	10	35	2	14	8	21
Sibling(s)	28	17	10	6	18	11
Grandparent(s)	10	35	3	13	7	22
Uncle(s)/aunt(s)	11	34	5	11	6	23
Cousin(s)	6	39	3	13	3	26
Others	3	42	1	15	2	27
Foster family	4	41	0	16	4	25
None	2	43	2	14	0	29

14.5 Paykel Suicide Scale (PSS or PAYKELscore)

		Samples					
		England		Germany		Total	
		Count	Column N %	Count	Column N %	Count	Column N %
PSS lifetime	,00	0	0,0%	2	6,9%	2	4,4%
	1,00	0	0,0%	3	10,3%	3	6,7%
	2,00	0	0,0%	2	6,9%	2	4,4%
	3,00	2	12,5%	4	13,8%	6	13,3%
	4,00	14	87,5%	18	62,1%	32	71,1%
	Total	16	100,0%	29	100,0%	45	100,0%
PSS year	,00	4	33,3%	8	36,4%	12	35,3%
	1,00	1	8,3%	1	4,5%	2	5,9%
	2,00	2	16,7%	2	9,1%	4	11,8%
	3,00	2	16,7%	5	22,7%	7	20,6%
	4,00	3	25,0%	6	27,3%	9	26,5%
	Total	12	100,0%	22	100,0%	34	100,0%
PSS month	,00	8	66,7%	9	40,9%	17	50,0%
	1,00	2	16,7%	4	18,2%	6	17,6%
	2,00	0	0,0%	4	18,2%	4	11,8%
	3,00	0	0,0%	4	18,2%	4	11,8%
	4,00	2	16,7%	1	4,5%	3	8,8%
	Total	12	100,0%	22	100,0%	34	100,0%

Mann–Whitney Test: country comparison

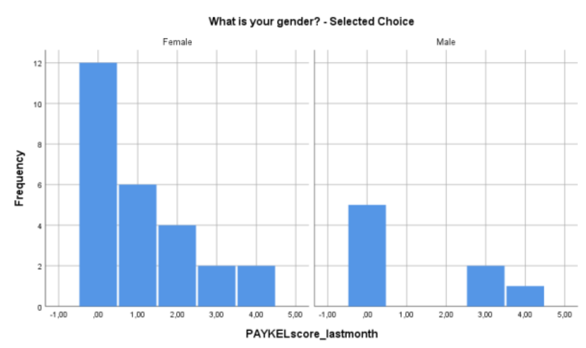
Hypothesis Test Summary

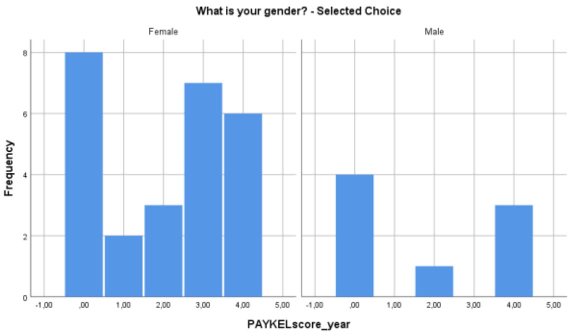
	Null Hypothesis	Test	Sig.	Decision
1	The distribution of PAYKELscore_lifetime is the same across categories of What country do you live in? - Selected Choice.	Independent-Samples Mann-Whitney U Test	,050	Retain the null hypothesis.
2	The distribution of PAYKELscore_year is the same across categories of What country do you live in? - Selected Choice.	Independent-Samples Mann-Whitney U Test	,901[1]	Retain the null hypothesis.
3	The distribution of PAYKELscore_lastmonth is the same across categories of What country do you live in? - Selected Choice.	Independent-Samples Mann-Whitney U Test	,276[1]	Retain the null hypothesis.

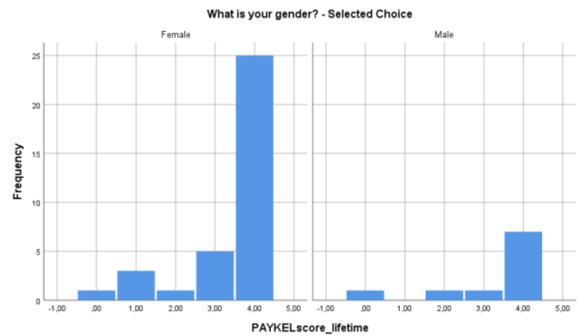
Asymptotic significances are displayed. The significance level is ,05.

[1]Exact significance is displayed for this test.

14.6PSS: Testing gender differences in the distribution of PSS scores







Mann–Whitney Test

Ranks

	Gender	N	Mean Rank	Sum of Ranks
PSS month	Female	26	17,62	458,00
	Male	8	17,13	137,00
	Total	34		
PSS year	Female	26	17,79	462,50
	Male	8	16,56	132,50
	Total	34		
PSS lifetime	Female	35	23,14	810,00
	Male	10	22,50	225,00
	Total	45		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	101,000	96,500	170,000
Wilcoxon W	137,000	132,500	225,000
Z	-,131	-,316	-,171
Asymp. Sig. (2-tailed)	,896	,752	,864
Exact Sig. [2*(1-tailed Sig.)]	,921[b]	,765[b]	,904[b]

a. Grouping Variable: gender

b. Not corrected for ties.

14.7 Age of first suicidal ideation

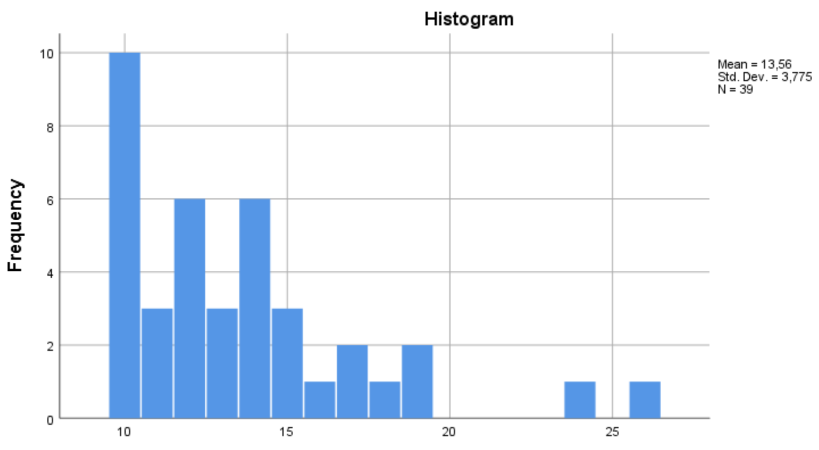
Statistics

If you experienced suicidal thoughts: When did these suicidal thoughts appear first?

N	Valid	39
	Missing	6
Mean		13,56
Std. Deviation		3,775
Minimum		10
Maximum		26

If you experienced suicidal thoughts: When did these suicidal thoughts appear first?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	10 or younger	10	22,2	25,6	25,6
	11	3	6,7	7,7	33,3
	12	6	13,3	15,4	48,7
	13	3	6,7	7,7	56,4
	14	6	13,3	15,4	71,8
	15	3	6,7	7,7	79,5
	16	1	2,2	2,6	82,1
	17	2	4,4	5,1	87,2
	18	1	2,2	2,6	89,7
	19	2	4,4	5,1	94,9
	24	1	2,2	2,6	97,4
	26	1	2,2	2,6	100,0
	Total	39	86,7	100,0	
Missing	System	6	13,3		
Total		45	100,0		



Statistics

If you experienced suicidal thoughts: When did these suicidal thoughts appear first?

England	N	Valid	16
		Missing	0
	Mean		13,69
	Std. Deviation		4,143
Germany	N	Valid	23
		Missing	6
	Mean		13,48
	Std. Deviation		3,591

If you experienced suicidal thoughts: When did these suicidal thoughts appear first?

Country			Frequency	Percent	Valid Percent	Cumulative Percent
England	Valid	10 or younger	5	31,3	31,3	31,3
		12	3	18,8	18,8	50,0
		14	3	18,8	18,8	68,8
		15	1	6,3	6,3	75,0
		16	1	6,3	6,3	81,3
		17	2	12,5	12,5	93,8
		26	1	6,3	6,3	100,0
		Total	16	100,0	100,0	
Germany	Valid	10 or younger	5	17,2	21,7	21,7
		11	3	10,3	13,0	34,8
		12	3	10,3	13,0	47,8
		13	3	10,3	13,0	60,9
		14	3	10,3	13,0	73,9
		15	2	6,9	8,7	82,6
		18	1	3,4	4,3	87,0
		19	2	6,9	8,7	95,7
		24	1	3,4	4,3	100,0
		Total	23	79,3	100,0	
	Missing	System	6	20,7		
	Total		29	100,0		

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of Age of first suicidal thoughts is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,966[1]	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is ,05.

[1]Exact significance is displayed for this test.

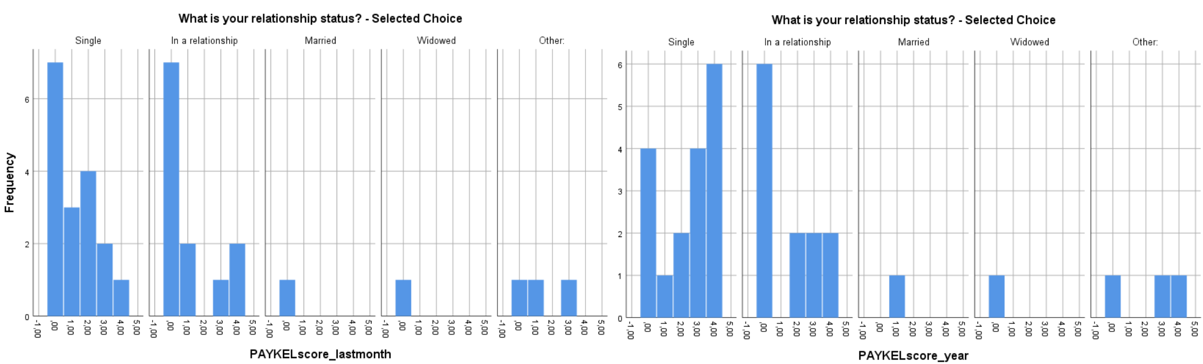
14.8 Kendall's tau: Correlations between PSS scores and PB and TB

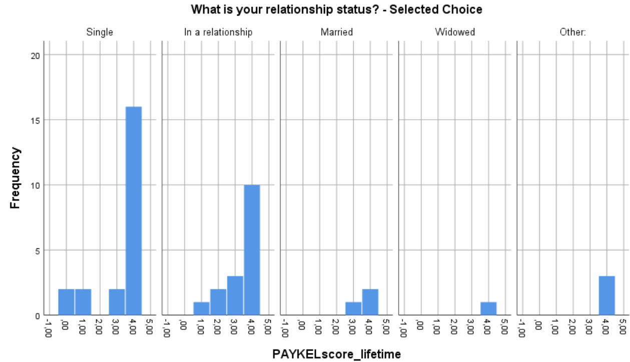
Kendall's tau_b			PSS score month	PSS score year
Total	INQ_PB	Correlation Coefficient	,426**	,421**
		Sig. (2-tailed)	0,002	0,002
		N	34	34
	INQ_TB	Correlation Coefficient	0,078	0,155
		Sig. (2-tailed)	0,575	0,262
		N	32	32
England	INQ_PB	Correlation Coefficient	,542*	,775**
		Sig. (2-tailed)	0,03	0,001
		N	12	12
	INQ_TB	Correlation Coefficient	0,479	0,287
		Sig. (2-tailed)	0,055	0,225
		N	12	12
Germany	INQ_PB	Correlation Coefficient	,432*	0,284
		Sig. (2-tailed)	0,011	0,096
		N	22	22
	INQ_TB	Correlation Coefficient	-0,055	0,037
		Sig. (2-tailed)	0,758	0,837
		N	20	20

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

14.9 Comparing distributions of PSS scores regarding relationship status/sexuality





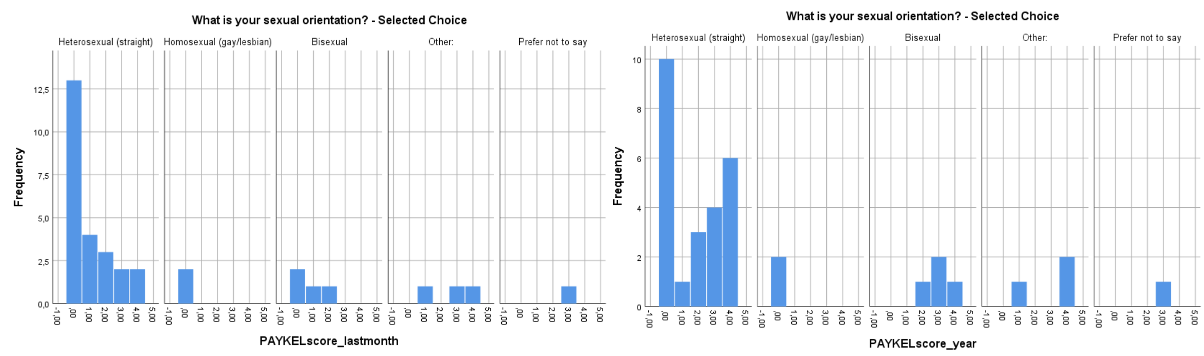
Ranks

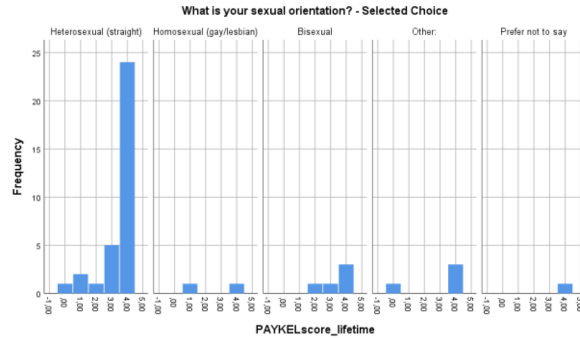
	What is your relationship status?	N	Mean Rank
PSS month	Single	17	17,32
	In a relationship	12	15,38
	Married	1	8,50
	Widowed	1	8,50
	Total	31	
PSS year	Single	17	18,50
	In a relationship	12	13,58
	Married	1	12,50
	Widowed	1	6,00
	Total	31	
PSS lifetime	Single	22	21,82
	In a relationship	16	20,53
	Married	3	22,17
	Widowed	1	28,00
	Total	42	

Test Statistics[a,b]

	PSS month	PSS year	PSS lifetime
Kruskal-Wallis H	2,079	3,756	,605
df	3	3	3
Asymp. Sig.	,556	,289	,895

a. Kruskal Wallis Test
b. Grouping Variable: What is your relationship status? - Selected Choice





Kruskal–Wallis Test

Ranks

	sexual orientation	N	Mean Rank
PSS month	Heterosexual (straight)	24	16,56
	Homosexual (gay/lesbian)	2	9,00
	Bisexual	4	16,00
	Other:	3	27,17
	Total	33	
PSS year	Heterosexual (straight)	24	16,17
	Homosexual (gay/lesbian)	2	6,50
	Bisexual	4	22,13
	Other:	3	23,83
	Total	33	
PSS lifetime	Heterosexual (straight)	33	23,17
	Homosexual (gay/lesbian)	2	16,50
	Bisexual	5	20,80
	Other:	4	22,13
	Total	44	

Test Statistics[a,b]

	PSS month	PSS year	PSS lifetime
Kruskal-Wallis H	5,589	5,580	,952
df	3	3	3
Asymp. Sig.	,133	,134	,813

a. Kruskal Wallis Test
b. Grouping Variable: sexual orientation

14.10 Correlation tests between suicidal ideation (PSS) and care-related variables

			PSS month	PSS year	PSS lifetime	Age entering care	Time in care	No. placem. changes	Age ceasing support
Kendall's tau_b	PSS month	Correlation Coefficient	1,000	,737**	,262	,163	-,136	-,274	-,127
		Sig. (2-tailed)	.	,000	,089	,241	,320	,054	,363
		N	34	34	34	33	33	34	34
	PSS year	Correlation Coefficient	,737**	1,000	,366*	,079	-,103	-,136	-,061
		Sig. (2-tailed)	,000	.	,017	,570	,447	,335	,660
		N	34	34	34	33	33	34	34
	PSS lifetime	Correlation Coefficient	,262	,366*	1,000	,228	-,188	,057	,134
		Sig. (2-tailed)	,089	,017	.	,064	,123	,652	,287
		N	34	34	45	44	44	45	45
	Age entering care	Correlation Coefficient	,163	,079	,228	1,000	-,834**	-,234*	-,099
		Sig. (2-tailed)	,241	,570	,064	.	,000	,040	,385
		N	33	33	44	44	43	44	44
	Time in care	Correlation Coefficient	-,136	-,103	-,188	-,834**	1,000	,233*	,127
		Sig. (2-tailed)	,320	,447	,123	,000	.	,038	,257
		N	33	33	44	43	44	44	44
	Number of placement changes	Correlation Coefficient	-,274	-,136	,057	-,234*	,233*	1,000	,161
		Sig. (2-tailed)	,054	,335	,652	,040	,038	.	,167
		N	34	34	45	44	44	45	45
	Age ceasing support	Correlation Coefficient	-,127	-,061	,134	-,099	,127	,161	1,000
		Sig. (2-tailed)	,363	,660	,287	,385	,257	,167	.
		N	34	34	45	44	44	45	45

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

14.11 Correlation test: care-related variables and INQ factors

Correlations

			INQ_PB	INQ_TB	age entering care	Time in care	Number of placement changes	Age ceasing support
Kendall's tau_b	INQ_PB	Correlation Coefficient	1,000	,360**	,088	-,128	-,003	-,019
		Sig.	.	,001	,425	,240	,976	,864
		N	45	43	44	44	45	45
	INQ_TB	Correlation Coefficient	,360**	1,000	-,053	-,050	,092	,024
		Sig.	,001	.	,631	,648	,417	,831
		N	43	43	42	42	43	43
	Age entering care	Correlation Coefficient	,088	-,053	1,000	-,834**	-,234*	-,099
		Sig.	,425	,631	.	,000	,040	,385
		N	44	42	44	43	44	44
	Time in care	Correlation Coefficient	-,128	-,050	-,834**	1,000	,233*	,127
		Sig.	,240	,648	,000	.	,038	,257
		N	44	42	43	44	44	44
	Number of placement changes	Correlation Coefficient	-,003	,092	-,234*	,233*	1,000	,161
		Sig.	,976	,417	,040	,038	.	,167
		N	45	43	44	44	45	45
	Age ceasing support	Correlation Coefficient	-,019	,024	-,099	,127	,161	1,000
		Sig.	,864	,831	,385	,257	,167	.
		N	45	43	44	44	45	45

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

14.12 Mann–Whitney test: groups regarding siblings in care and PSS

Kruskal–Wallis Test

Ranks

	Sibling(s) in care at the same time	N	Mean Rank
PSS month	Yes, all of my siblings were in care at the same time as I was	5	8,50
	Yes, one/some of my siblings was/were in care at the same time as I was	4	8,50
	No, my sibling(s) lived with our family while I was in care	16	20,78
	No, because of other reasons	5	18,20
	Other	2	14,00
	Total	32	
PSS year	Yes, all of my siblings were in care at the same time as I was	5	11,10
	Yes, one/some of my siblings was/were in care at the same time as I was	4	8,38
	No, my sibling(s) lived with our family while I was in care	16	20,53
	No, because of other reasons	5	16,70
	Other	2	13,50
	Total	32	
PSS lifetime	Yes, all of my siblings were in care at the same time as I was	8	17,75
	Yes, one/some of my siblings was/were in care at the same time as I was	5	17,90
	No, my sibling(s) lived with our family while I was in care	20	21,55
	No, because of other reasons	6	24,08
	Other	2	27,00
	Total	41	

Test Statistics[a,b]

	PSS month	PSS year	PSS lifetime
Kruskal-Wallis H	11,765	8,390	2,901
df	4	4	4
Asymp. Sig.	**,019**	,078	,574
Exact Sig.	**,008**	,061	,596
Point Probability	,000	,000	,000

a. Kruskal Wallis Test

b. Grouping Variable: Sibling(s) in care at the same time

Mann–Whitney Test

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, all of my siblings were in care at the same time as I was	5	5,00	25,00
	Yes, one/some of my siblings was/were in care at the same time as I was	4	5,00	20,00
	Total	9		
PSS year	Yes, all of my siblings were in care at the same time as I was	5	5,60	28,00
	Yes, one/some of my siblings was/were in care at the same time as I was	4	4,25	17,00
	Total	9		
PSS lifetime	Yes, all of my siblings were in care at the same time as I was	8	7,19	57,50
	Yes, one/some of my siblings was/were in care at the same time as I was	5	6,70	33,50
	Total	13		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	10,000	7,000	18,500
Wilcoxon W	20,000	17,000	33,500
Z	,000	-,822	-,241
Asymp. Sig. (2-tailed)	1,000	,411	,810
Exact Sig. [2*(1-tailed Sig.)]	1,000[b]	,556[b]	,833[b]
Exact Sig. (2-tailed)	1,000	,524	,875
Exact Sig. (1-tailed)	1,000	,357	,451
Point Probability	1,000	,238	,054

a. Grouping Variable: Sibling(s) in care at the same time

b. Not corrected for ties.

Mann–Whitney Test

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, all of my siblings were in care at the same time as I was	5	5,50	27,50
	No, my sibling(s) lived with our family while I was in care	16	12,72	203,50
	Total	21		
PSS year	Yes, all of my siblings were in care at the same time as I was	5	6,20	31,00
	No, my sibling(s) lived with our family while I was in care	16	12,50	200,00
	Total	21		
PSS lifetime	Yes, all of my siblings were in care at the same time as I was	8	12,63	101,00
	No, my sibling(s) lived with our family while I was in care	20	15,25	305,00
	Total	28		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	12,500	16,000	65,000
Wilcoxon W	27,500	31,000	101,000
Z	-2,417	-2,058	-,924
Asymp. Sig. (2-tailed)	**,016**	**,040**	,356
Exact Sig. [2*(1-tailed Sig.)]	,019[b]	,050[b]	,469[b]
Exact Sig. (2-tailed)	**,020**	**,039**	,369
Exact Sig. (1-tailed)	,012	,025	,199
Point Probability	,012	,011	,016

a. Grouping Variable: Sibling(s) in care at the same time
b. Not corrected for ties.

Mann–Whitney Test

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, all of my siblings were in care at the same time as I was	5	3,50	17,50
	No, because of other reasons	5	7,50	37,50
	Total	10		
PSS year	Yes, all of my siblings were in care at the same time as I was	5	4,50	22,50
	No, because of other reasons	5	6,50	32,50
	Total	10		
PSS lifetime	Yes, all of my siblings were in care at the same time as I was	8	6,44	51,50
	No, because of other reasons	6	8,92	53,50
	Total	14		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	2,500	7,500	15,500
Wilcoxon W	17,500	22,500	51,500
Z	-2,390	-1,074	-1,298
Asymp. Sig. (2-tailed)	**,017**	,283	,194
Exact Sig. [2*(1-tailed Sig.)]	,032[b]	,310[b]	,282[b]
Exact Sig. (2-tailed)	**,048**	,373	,259
Exact Sig. (1-tailed)	,024	,187	,196
Point Probability	,024	,071	,168

a. Grouping Variable: Sibling(s) in care at the same time
b. Not corrected for ties.

Mann–Whitney Test

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, one/some of my siblings was/were in care at the same time as I was	4	3,00	12,00
	No, because of other reasons	5	6,60	33,00
	Total	9		
PSS year	Yes, one/some of my siblings was/were in care at the same time as I was	4	3,50	14,00
	No, because of other reasons	5	6,20	31,00
	Total	9		
PSS lifetime	Yes, one/some of my siblings was/were in care at the same time as I was	5	5,10	25,50
	No, because of other reasons	6	6,75	40,50
	Total	11		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	2,000	4,000	10,500
Wilcoxon W	12,000	14,000	25,500
Z	-2,191	-1,542	-1,045
Asymp. Sig. (2-tailed)	**,028**	,123	,296
Exact Sig. [2*(1-tailed Sig.)]	,063[b]	,190[b]	,429[b]
Exact Sig. (2-tailed)	**,048**	,206	,303
Exact Sig. (1-tailed)	,040	,103	,182
Point Probability	,040	,063	,121

a. Grouping Variable: Sibling(s) in care at the same time
b. Not corrected for ties.

Mann–Whitney Test

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, one/some of my siblings was/were in care at the same time as I was	4	5,00	20,00
	No, my sibling(s) lived with our family while I was in care	16	11,88	190,00
	Total	20		
PSS year	Yes, one/some of my siblings was/were in care at the same time as I was	4	5,00	20,00
	No, my sibling(s) lived with our family while I was in care	16	11,88	190,00
	Total	20		
PSS lifetime	Yes, one/some of my siblings was/were in care at the same time as I was	5	11,50	57,50
	No, my sibling(s) lived with our family while I was in care	20	13,38	267,50
	Total	25		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	10,000	10,000	42,500
Wilcoxon W	20,000	20,000	57,500
Z	-2,194	-2,190	-,644
Asymp. Sig. (2-tailed)	**,028**	**,028**	,519
Exact Sig. [2*(1-tailed Sig.)]	,039[b]	,039[b]	,621[b]
Exact Sig. (2-tailed)	**,044**	**,022**	,574
Exact Sig. (1-tailed)	,026	,014	,297
Point Probability	,026	,007	,046

a. Grouping Variable: Sibling(s) in care at the same time
b. Not corrected for ties.

Kruskal–Wallis Test

Ranks

	Siblings together at the same place while in care	N	Mean Rank
PSS month	Yes	1	3,50
	Partly	5	3,50
	Total	6	
PSS year	Yes	1	2,50
	Partly	5	3,70
	Total	6	
PSS lifetime	Yes	2	8,00
	Partly	8	4,88
	Total	10	

Test Statistics[a,b]

	PSS month	PSS year	PSS lifetime
Kruskal-Wallis H	,000	,480	1,967
df	1	1	1
Asymp. Sig.	1,000	,488	,161
Exact Sig.	1,000	1,000	,333
Point Probability	1,000	,667	,222

a. Kruskal Wallis Test
b. Grouping Variable: Siblings together at the same place while in care

14.13 Impact of the coronavirus pandemic

Statistics

How did the Coronavirus (COVID-19) crisis affect the following aspects for you compared to the time before?

		Feeling of belongingness to others	Feeling of being a burden for others	Your attitude towards your life
N	Valid	45	45	45
	Missing	0	0	0
Mean		3,64	3,11	3,09
Std. Deviation		1,151	1,229	1,203

How did the Coronavirus (COVID-19) crisis affect the following aspects for you compared to the time before?

Feeling of belongingness to others

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	positively	2	4,4	4,4	4,4
	a bit positively	4	8,9	8,9	13,3
	stayed the same	16	35,6	35,6	48,9
	a bit negatively	9	20,0	20,0	68,9
	negatively	14	31,1	31,1	100,0
	Total	45	100,0	100,0	

How did the Coronavirus (COVID-19) crisis affect the following aspects for you compared to the time before?

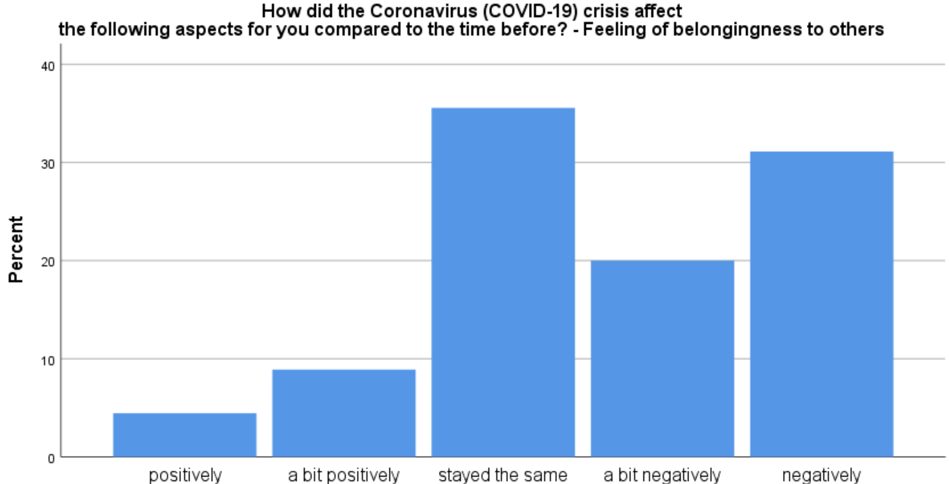
Feeling of being a burden for others

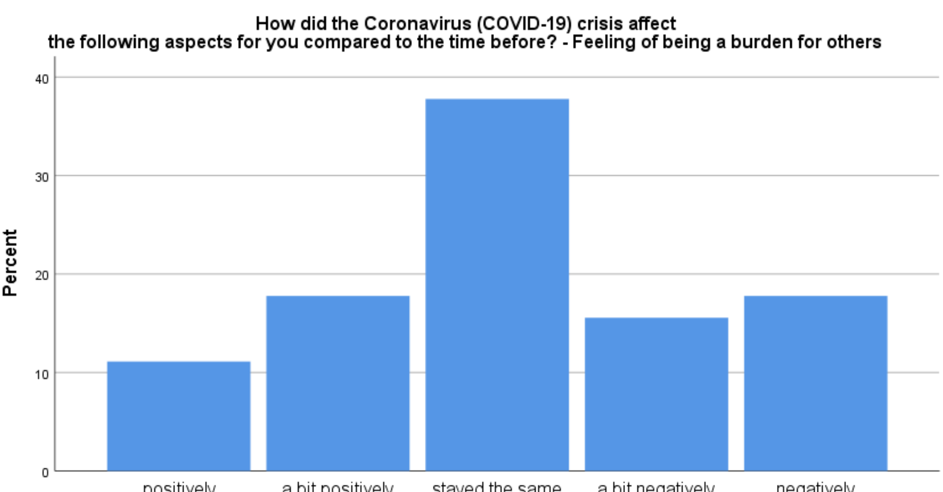
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	positively	5	11,1	11,1	11,1
	a bit positively	8	17,8	17,8	28,9
	stayed the same	17	37,8	37,8	66,7
	a bit negatively	7	15,6	15,6	82,2
	negatively	8	17,8	17,8	100,0
	Total	45	100,0	100,0	

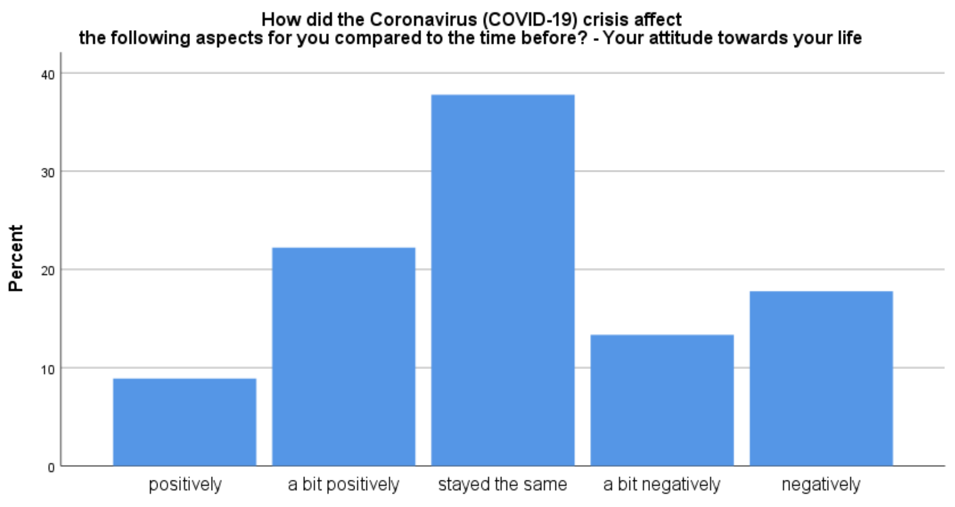
How did the Coronavirus (COVID-19) crisis affect the following aspects for you compared to the time before?

Your attitude towards your life

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	positively	4	8,9	8,9	8,9
	a bit positively	10	22,2	22,2	31,1
	stayed the same	17	37,8	37,8	68,9
	a bit negatively	6	13,3	13,3	82,2
	negatively	8	17,8	17,8	100,0
	Total	45	100,0	100,0	


How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Feeling of belongingness to others
Percent
0
10
20
30
40
positively
a bit positively
stayed the same
a bit negatively
negatively


How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Feeling of being a burden for others
Percent
0
10
20
30
40
positively
a bit positively
stayed the same
a bit negatively
negatively


How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Your attitude towards your life
Percent
0
10
20
30
40
positively
a bit positively
stayed the same
a bit negatively
negatively

14.14 Coronavirus pandemic impact: England and Germany

Statistics

How did the Coronavirus (COVID-19) crisis affect the following aspects for you compared to the time before?

What country do you live in?			Feeling of belongingness to others	Feeling of being a burden for others	Your attitude towards your life
England	N	Valid	16	16	16
		Missing	0	0	0
	Mean		3,94	3,56	3,50
	Std. Deviation		,929	1,153	1,095
	Minimum		3	2	2
	Maximum		5	5	5
Germany	N	Valid	29	29	29
		Missing	0	0	0
	Mean		3,48	2,86	2,86
	Std. Deviation		1,243	1,217	1,217
	Minimum		1	1	1
	Maximum		5	5	5

How did the Coronavirus (COVID-19) crisis affect the following aspects for you compared to the time before?

Feeling of belongingness to others

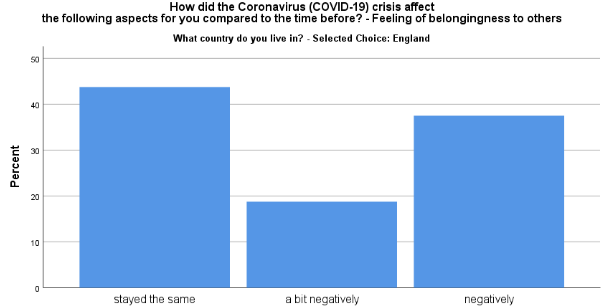
What country do you live in?			Frequency	Percent	Valid Percent	Cumulative Percent
England	Valid	positively				
		a bit positively				
		stayed the same	7	43,8	43,8	43,8
		a bit negatively	3	18,8	18,8	62,5
		negatively	6	37,5	37,5	100,0
		Total	16	100,0	100,0	
Germany	Valid	positively	2	6,9	6,9	6,9
		a bit positively	4	13,8	13,8	20,7
		stayed the same	9	31,0	31,0	51,7
		a bit negatively	6	20,7	20,7	72,4
		negatively	8	27,6	27,6	100,0
		Total	29	100,0	100,0	

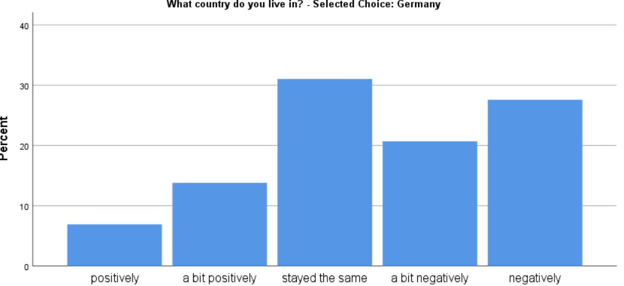
How did the Coronavirus (COVID-19) crisis affect the following aspects for you compared to the time before? Feeling of being a burden for others

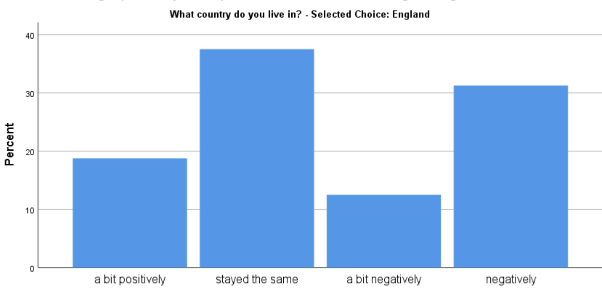
What country do you live in?			Frequency	Percent	Valid Percent	Cumulative Percent
England	Valid	positively				
		a bit positively	3	18,8	18,8	18,8
		stayed the same	6	37,5	37,5	56,3
		a bit negatively	2	12,5	12,5	68,8
		negatively	5	31,3	31,3	100,0
		Total	16	100,0	100,0	
Germany	Valid	positively	5	17,2	17,2	17,2
		a bit positively	5	17,2	17,2	34,5
		stayed the same	11	37,9	37,9	72,4
		a bit negatively	5	17,2	17,2	89,7
		negatively	3	10,3	10,3	100,0
		Total	29	100,0	100,0	

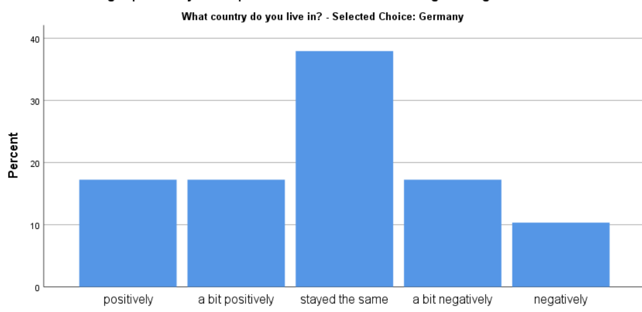
How did the Coronavirus (COVID-19) crisis affect the following aspects for you compared to the time before? Your attitude towards your life

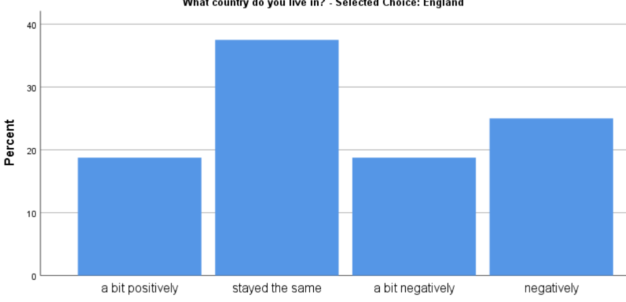
What country do you live in? - Selected Choice			Frequency	Percent	Valid Percent	Cumulative Percent
England	Valid	positively				
		a bit positively	3	18,8	18,8	18,8
		stayed the same	6	37,5	37,5	56,3
		a bit negatively	3	18,8	18,8	75,0
		negatively	4	25,0	25,0	100,0
		Total	16	100,0	100,0	
Germany	Valid	positively	4	13,8	13,8	13,8
		a bit positively	7	24,1	24,1	37,9
		stayed the same	11	37,9	37,9	75,9
		a bit negatively	3	10,3	10,3	86,2
		negatively	4	13,8	13,8	100,0
		Total	29	100,0	100,0	

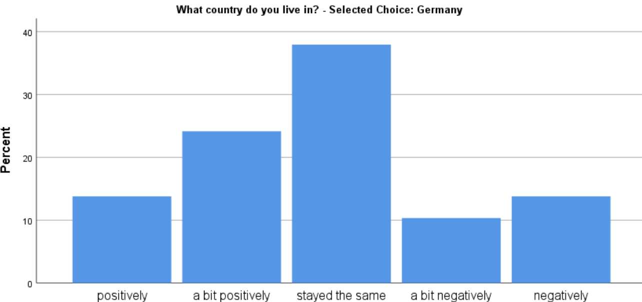

How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Feeling of belongingness to others
What country do you live in? - Selected Choice: England
Percent
stayed the same
a bit negatively
negatively
How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Feeling of belongingness to others


How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Feeling of belongingness to others
What country do you live in? - Selected Choice: Germany
Percent
positively
a bit positively
stayed the same
a bit negatively
negatively
How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Feeling of belongingness to others


How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Feeling of being a burden for others
What country do you live in? - Selected Choice: England
Percent
a bit positively
stayed the same
a bit negatively
negatively
How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Feeling of being a burden for others


How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Feeling of being a burden for others
What country do you live in? - Selected Choice: Germany
Percent
positively
a bit positively
stayed the same
a bit negatively
negatively
How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Feeling of being a burden for others


How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Your attitude towards your life
What country do you live in? - Selected Choice: England
Percent
a bit positively
stayed the same
a bit negatively
negatively
How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Your attitude towards your life


How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Your attitude towards your life
What country do you live in? - Selected Choice: Germany
Percent
positively
a bit positively
stayed the same
a bit negatively
negatively
How did the Coronavirus (COVID-19) crisis affect
the following aspects for you compared to the time before? - Your attitude towards your life

14.15 Country comparison of coronavirus impact (Mann–Whitney test)

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of How did the Coronavirus (COVID-19) crisis affect the following aspects for you compared to the time before? - Feeling of belongingness to others is the same across categories of What country do you live in? - Selected Choice.	Independent-Samples Mann-Whitney U Test	,260	Retain the null hypothesis.
2	The distribution of How did the Coronavirus (COVID-19) crisis affect the following aspects for you compared to the time before? - Feeling of being a burden for others is the same across categories of What country do you live in? - Selected Choice.	Independent-Samples Mann-Whitney U Test	,095	Retain the null hypothesis.
3	The distribution of How did the Coronavirus (COVID-19) crisis affect the following aspects for you compared to the time before? - Your attitude towards your life is the same across categories of What country do you live in? - Selected Choice.	Independent-Samples Mann-Whitney U Test	,094	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is ,05.

Appendix 15: Tests regarding possible double-response

15.1 Mann–Whitney tests: England – Germany comparison

(A) n = 44 (excluding the response from December 2020)

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of How often did you change the placement during your time in care? is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,002	Reject the null hypothesis.
2	The distribution of PAYKELscore_lifetime is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,063	Retain the null hypothesis.
3	The distribution of PAYKELscore_year is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,665[1]	Retain the null hypothesis.
4	The distribution of PAYKELscore_lastmonth is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,114[1]	Retain the null hypothesis.
5	The distribution of Age of first suicidal thoughts is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,768[1]	Retain the null hypothesis.
6	The distribution of Coronavirus (COVID-19) - Feeling of belongingness to others is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,366	Retain the null hypothesis.
7	The distribution of Coronavirus (COVID-19) - Feeling of being a burden for others is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,157	Retain the null hypothesis.
8	The distribution of Coronavirus (COVID-19) - Your attitude towards your life is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,153	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is ,05.

[1] Exact significance is displayed for this test.

(B) n = 44 (excluding the recent response from May 2021)

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of How often did you change the placement during your time in care? - Selected Choice is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,002	Reject the null hypothesis.
2	The distribution of PAYKELscore_lifetime is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,063	Retain the null hypothesis.
3	The distribution of PAYKELscore_year is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,665[1]	Retain the null hypothesis.
4	The distribution of PAYKELscore_lastmonth is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,355[1]	Retain the null hypothesis.
5	The distribution of Age of first suicidal thoughts is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,953[1]	Retain the null hypothesis.
6	The distribution of Coronavirus (COVID-19) - Feeling of belongingness to others is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,366	Retain the null hypothesis.
7	The distribution of Coronavirus (COVID-19) - Feeling of being a burden for others is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,157	Retain the null hypothesis.
8	The distribution of Coronavirus (COVID-19) - Your attitude towards your life is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,153	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is ,05.

[1] Exact significance is displayed for this test.

(C) n = 43 (excluding both presumed double-responses)

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of How often did you change the placement during your time in care? is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,004	Reject the null hypothesis.
2	The distribution of PAYKELscore_lifetime is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,079	Retain the null hypothesis.
3	The distribution of PAYKELscore_year is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,434[1]	Retain the null hypothesis.
4	The distribution of PAYKELscore_lastmonth is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,163[1]	Retain the null hypothesis.
5	The distribution of Age of first suicidal thoughts is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,841[1]	Retain the null hypothesis.
6	The distribution of Coronavirus (COVID-19) - Feeling of belongingness to others is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,507	Retain the null hypothesis.
7	The distribution of Coronavirus (COVID-19) - Feeling of being a burden for others is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,257	Retain the null hypothesis.
8	The distribution of Coronavirus (COVID-19) - Your attitude towards your life is the same across categories of Country.	Independent-Samples Mann-Whitney U Test	,245	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is ,05.

[1] Exact significance is displayed for this test.

15.2 Kruskal–Wallis and post hoc Mann–Whitney tests: siblings in care and PSS

(A) n = 44 (excluding the response from December 2020)

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of PAYKELscore_lastmonth is the same across categories of Sibling (s) in care at the same time.	Independent-Samples Kruskal-Wallis Test	,025	Reject the null hypothesis.
2	The distribution of PAYKELscore_year is the same across categories of Sibling(s) in care at the same time.	Independent-Samples Kruskal-Wallis Test	,108	Retain the null hypothesis.
3	The distribution of PAYKELscore_lifetime is the same across categories of Sibling(s) in care at the same time.	Independent-Samples Kruskal-Wallis Test	,594	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is ,05.

Mann–Whitney Test

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, all of my siblings were in care at the same time as I was	5	5.50	27.50
	No, my sibling(s) lived with our family while I was in care	15	12.17	182.50
	Total	20		
PSS year	Yes, all of my siblings were in care at the same time as I was	5	6.20	31.00
	No, my sibling(s) lived with our family while I was in care	15	11.93	179.00
	Total	20		
PSS lifetime	Yes, all of my siblings were in care at the same time as I was	8	12.38	99.00
	No, my sibling(s) lived with our family while I was in care	19	14.68	279.00
	Total	27		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	12.500	16.000	63.000
Wilcoxon W	27.500	31.000	99.000
Z	-2.345	-1.944	-.826
Asymp. Sig. (2-tailed)	**.019**	.052	.409
Exact Sig. [2*(1-tailed Sig.)]	.025[b]	.066[b]	.515[b]
Exact Sig. (2-tailed)	**.030**	.053	.455
Exact Sig. (1-tailed)	.016	.032	.223
Point Probability	.016	.014	.014

a. Grouping Variable: Sibling(s) in care at the same time
b. Not corrected for ties.

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, all of my siblings were in care at the same time as I was	5	3.50	17.50
	No, because of other reasons	5	7.50	37.50
	Total	10		
PSS year	Yes, all of my siblings were in care at the same time as I was	5	4.50	22.50
	No, because of other reasons	5	6.50	32.50
	Total	10		
PSS lifetime	Yes, all of my siblings were in care at the same time as I was	8	6.44	51.50
	No, because of other reasons	6	8.92	53.50
	Total	14		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	2.500	7.500	15.500
Wilcoxon W	17.500	22.500	51.500
Z	-2.390	-1.074	-1.298
Asymp. Sig. (2-tailed)	**.017**	.283	.194
Exact Sig. [2*(1-tailed Sig.)]	.032[b]	.310[b]	.282[b]
Exact Sig. (2-tailed)	**.048**	.373	.259
Exact Sig. (1-tailed)	.024	.187	.196
Point Probability	.024	.071	.168

a. Grouping Variable: Sibling(s) in care at the same time
b. Not corrected for ties.

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, all of my siblings were in care at the same time as I was	5	5.00	25.00
	Yes, one/some of my siblings was/were in care at the same time as I was	4	5.00	20.00
	Total	9		
PSS year	Yes, all of my siblings were in care at the same time as I was	5	5.60	28.00
	Yes, one/some of my siblings was/were in care at the same time as I was	4	4.25	17.00
	Total	9		
PSS lifetime	Yes, all of my siblings were in care at the same time as I was	8	7.19	57.50
	Yes, one/some of my siblings was/were in care at the same time as I was	5	6.70	33.50
	Total	13		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	10.000	7.000	18.500
Wilcoxon W	20.000	17.000	33.500
Z	.000	-.822	-.241
Asymp. Sig. (2-tailed)	1.000	.411	.810
Exact Sig. [2*(1-tailed Sig.)]	1.000[b]	.556[b]	.833[b]

a. Grouping Variable: Sibling(s) in care at the same time
b. Not corrected for ties.

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, one/some of my siblings was/were in care at the same time as I was	4	5.00	20.00
	No, my sibling(s) lived with our family while I was in care	15	11.33	170.00
	Total	19		
PSS year	Yes, one/some of my siblings was/were in care at the same time as I was	4	5.00	20.00
	No, my sibling(s) lived with our family while I was in care	15	11.33	170.00
	Total	19		
PSS lifetime	Yes, one/some of my siblings was/were in care at the same time as I was	5	11.20	56.00
	No, my sibling(s) lived with our family while I was in care	19	12.84	244.00
	Total	24		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	10.000	10.000	41.000
Wilcoxon W	20.000	20.000	56.000
Z	-2.128	-2.105	-.576
Asymp. Sig. (2-tailed)	**.033**	**.035**	.564
Exact Sig. [2*(1-tailed Sig.)]	.049[b]	.049[b]	.679[b]
Exact Sig. (2-tailed)	.054	**.048**	.632
Exact Sig. (1-tailed)	.033	.018	.318
Point Probability	.033	.009	.048

a. Grouping Variable: Sibling(s) in care at the same time
b. Not corrected for ties.

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, one/some of my siblings was/were in care at the same time as I was	4	3.00	12.00
	No, because of other reasons	5	6.60	33.00
	Total	9		
PSS year	Yes, one/some of my siblings was/were in care at the same time as I was	4	3.50	14.00
	No, because of other reasons	5	6.20	31.00
	Total	9		
PSS lifetime	Yes, one/some of my siblings was/were in care at the same time as I was	5	5.10	25.50
	No, because of other reasons	6	6.75	40.50
	Total	11		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	2.000	4.000	10.500
Wilcoxon W	12.000	14.000	25.500
Z	-2.191	-1.542	-1.045
Asymp. Sig. (2-tailed)	**.028**	.123	.296
Exact Sig. [2*(1-tailed Sig.)]	.063[b]	.190[b]	.429[b]
Exact Sig. (2-tailed)	**.048**	.206	.303
Exact Sig. (1-tailed)	.040	.103	.182
Point Probability	.040	.063	.121

a. Grouping Variable: Sibling(s) in care at the same time
b. Not corrected for ties.

(B) n = 44 (excluding the recent response from May 2021)

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of PAYKELscore_lastmonth is the same across categories of Sibling (s) in care.	Independent-Samples Kruskal-Wallis Test	,012	Reject the null hypothesis.
2	The distribution of PAYKELscore_year is the same across categories of Sibling(s) in care.	Independent-Samples Kruskal-Wallis Test	,108	Retain the null hypothesis.
3	The distribution of PAYKELscore_lifetime is the same across categories of Sibling(s) in care.	Independent-Samples Kruskal-Wallis Test	,594	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is ,05.

Mann–Whitney Test

Ranks

	Sibling(s) in care	N	Mean Rank	Sum of Ranks
PSS month	Yes, all of my siblings were in care at the same time as I was	5	5,00	25,00
	No, my sibling(s) lived with our family while I was in care	15	12,33	185,00
	Total	20		
PSS year	Yes, all of my siblings were in care at the same time as I was	5	6,20	31,00
	No, my sibling(s) lived with our family while I was in care	15	11,93	179,00
	Total	20		
PSS lifetime	Yes, all of my siblings were in care at the same time as I was	8	12,38	99,00
	No, my sibling(s) lived with our family while I was in care	19	14,68	279,00
	Total	27		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	10,000	16,000	63,000
Wilcoxon W	25,000	31,000	99,000
Z	-2,533	-1,944	-,826
Asymp. Sig. (2-tailed)	**,011**	,052	,409
Exact Sig. [2*(1-tailed Sig.)]	,015[b]	,066[b]	,515[b]
Exact Sig. (2-tailed)	**,013**	,053	,455
Exact Sig. (1-tailed)	,008	,032	,223
Point Probability	,008	,014	,014

a. Grouping Variable: Sibling(s) in care
b. Not corrected for ties.

Ranks

	Sibling(s) in care	N	Mean Rank	Sum of Ranks
PSS month	Yes, all of my siblings were in care at the same time as I was	5	3,50	17,50
	No, because of other reasons	5	7,50	37,50
	Total	10		
PSS year	Yes, all of my siblings were in care at the same time as I was	5	4,50	22,50
	No, because of other reasons	5	6,50	32,50
	Total	10		
PSS lifetime	Yes, all of my siblings were in care at the same time as I was	8	6,44	51,50
	No, because of other reasons	6	8,92	53,50
	Total	14		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	2,500	7,500	15,500
Wilcoxon W	17,500	22,500	51,500
Z	-2,390	-1,074	-1,298
Asymp. Sig. (2-tailed)	**,017**	,283	,194
Exact Sig. [2*(1-tailed Sig.)]	,032[b]	,310[b]	,282[b]
Exact Sig. (2-tailed)	**,048**	,373	,259
Exact Sig. (1-tailed)	,024	,187	,196
Point Probability	,024	,071	,168

a. Grouping Variable: Sibling(s) in care
b. Not corrected for ties.

Ranks

	Sibling(s) in care	N	Mean Rank	Sum of Ranks
PSS month	Yes, all of my siblings were in care at the same time as I was	5	5.00	25.00
	Yes, one/some of my siblings was/were in care at the same time as I was	4	5.00	20.00
	Total	9		
PSS year	Yes, all of my siblings were in care at the same time as I was	5	5.60	28.00
	Yes, one/some of my siblings was/were in care at the same time as I was	4	4.25	17.00
	Total	9		
PSS lifetime	Yes, all of my siblings were in care at the same time as I was	8	7.19	57.50
	Yes, one/some of my siblings was/were in care at the same time as I was	5	6.70	33.50
	Total	13		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	10.000	7.000	18.500
Wilcoxon W	20.000	17.000	33.500
Z	.000	-.822	-.241
Asymp. Sig. (2-tailed)	1.000	.411	.810
Exact Sig. [2*(1-tailed Sig.)]	1.000[b]	.556[b]	.833[b]
Exact Sig. (2-tailed)	1.000	.524	.875
Exact Sig. (1-tailed)	1.000	.357	.451
Point Probability	1.000	.238	.054

a. Grouping Variable: Sibling(s) in care
b. Not corrected for ties.

Ranks

	Sibling(s) in care	N	Mean Rank	Sum of Ranks
PSS month	Yes, one/some of my siblings was/were in care at the same time as I was	4	4,50	18,00
	No, my sibling(s) lived with our family while I was in care	15	11,47	172,00
	Total	19		
PSS year	Yes, one/some of my siblings was/were in care at the same time as I was	4	5,00	20,00
	No, my sibling(s) lived with our family while I was in care	15	11,33	170,00
	Total	19		
PSS lifetime	Yes, one/some of my siblings was/were in care at the same time as I was	5	11,20	56,00
	No, my sibling(s) lived with our family while I was in care	19	12,84	244,00
	Total	24		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	8,000	10,000	41,000
Wilcoxon W	18,000	20,000	56,000
Z	-2,303	-2,105	-,576
Asymp. Sig. (2-tailed)	**,021**	**,035**	,564
Exact Sig. [2*(1-tailed Sig.)]	,027[b]	,049[b]	,679[b]
Exact Sig. (2-tailed)	**,031**	**,048**	,632
Exact Sig. (1-tailed)	,018	,018	,318
Point Probability	,018	,009	,048

a. Grouping Variable: Sibling(s) in care
b. Not corrected for ties.

Ranks

	Sibling(s) in care	N	Mean Rank	Sum of Ranks
PSS month	Yes, one/some of my siblings was/were in care at the same time as I was	4	3,00	12,00
	No, because of other reasons	5	6,60	33,00
	Total	9		
PSS year	Yes, one/some of my siblings was/were in care at the same time as I was	4	3,50	14,00
	No, because of other reasons	5	6,20	31,00
	Total	9		
PSS lifetime	Yes, one/some of my siblings was/were in care at the same time as I was	5	5,10	25,50
	No, because of other reasons	6	6,75	40,50
	Total	11		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	2,000	4,000	10,500
Wilcoxon W	12,000	14,000	25,500
Z	-2,191	-1,542	-1,045
Asymp. Sig. (2-tailed)	**,028**	,123	,296
Exact Sig. [2*(1-tailed Sig.)]	,063[b]	,190[b]	,429[b]
Exact Sig. (2-tailed)	**,048**	,206	,303
Exact Sig. (1-tailed)	,040	,103	,182
Point Probability	,040	,063	,121

a. Grouping Variable: Sibling(s) in care

b. Not corrected for ties.

(C) n = 43 (excluding both presumed double-responses)

Hypothesis Test Summary

	Null Hypothesis	Test	Sig.	Decision
1	The distribution of PAYKELscore_lastmonth is the same across categories of Sibling (s) in care at the same time.	Independent-Samples Kruskal-Wallis Test	,016	Reject the null hypothesis.
2	The distribution of PAYKELscore_year is the same across categories of Sibling(s) in care at the same time.	Independent-Samples Kruskal-Wallis Test	,148	Retain the null hypothesis.
3	The distribution of PAYKELscore_lifetime is the same across categories of Sibling(s) in care at the same time.	Independent-Samples Kruskal-Wallis Test	,609	Retain the null hypothesis.

Asymptotic significances are displayed. The significance level is ,05.

Mann–Whitney Test

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, all of my siblings were in care at the same time as I was	5	5,00	25,00
	No, my sibling(s) lived with our family while I was in care	14	11,79	165,00
	Total	19		
PSS year	Yes, all of my siblings were in care at the same time as I was	5	6,20	31,00
	No, my sibling(s) lived with our family while I was in care	14	11,36	159,00
	Total	19		
PSS lifetime	Yes, all of my siblings were in care at the same time as I was	8	12,13	97,00
	No, my sibling(s) lived with our family while I was in care	18	14,11	254,00
	Total	26		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	10,000	16,000	61,000
Wilcoxon W	25,000	31,000	97,000
Z	-2,463	-1,821	-,723
Asymp. Sig. (2-tailed)	,014	,069	,469
Exact Sig. [2*(1-tailed Sig.)]	,019[b]	,087[b]	,567[b]
Exact Sig. (2-tailed)	,018	,086	,497
Exact Sig. (1-tailed)	,011	,050	,251
Point Probability	,011	,025	,015

a. Grouping Variable: Sibling(s) in care at the same time
b. Not corrected for ties.

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, all of my siblings were in care at the same time as I was	5	3,50	17,50
	No, because of other reasons	5	7,50	37,50
	Total	10		
PSS year	Yes, all of my siblings were in care at the same time as I was	5	4,50	22,50
	No, because of other reasons	5	6,50	32,50
	Total	10		
PSS lifetime	Yes, all of my siblings were in care at the same time as I was	8	6,44	51,50
	No, because of other reasons	6	8,92	53,50
	Total	14		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	2,500	7,500	15,500
Wilcoxon W	17,500	22,500	51,500
Z	-2,390	-1,074	-1,298
Asymp. Sig. (2-tailed)	**,017**	,283	,194
Exact Sig. [2*(1-tailed Sig.)]	,032[b]	,310[b]	,282[b]
Exact Sig. (2-tailed)	**,048**	,373	,259
Exact Sig. (1-tailed)	,024	,187	,196
Point Probability	,024	,071	,168

a. Grouping Variable: Sibling(s) in care at the same time
b. Not corrected for ties.

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, all of my siblings were in care at the same time as I was	5	5.00	25.00
	Yes, one/some of my siblings was/were in care at the same time as I was	4	5.00	20.00
	Total	9		
PSS year	Yes, all of my siblings were in care at the same time as I was	5	5.60	28.00
	Yes, one/some of my siblings was/were in care at the same time as I was	4	4.25	17.00
	Total	9		
PSS lifetime	Yes, all of my siblings were in care at the same time as I was	8	7.19	57.50
	Yes, one/some of my siblings was/were in care at the same time as I was	5	6.70	33.50
	Total	13		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	10.000	7.000	18.500
Wilcoxon W	20.000	17.000	33.500
Z	.000	-.822	-.241
Asymp. Sig. (2-tailed)	1.000	.411	.810
Exact Sig. [2*(1-tailed Sig.)]	1.000[b]	.556[b]	.833[b]
Exact Sig. (2-tailed)	1.000	.524	.875
Exact Sig. (1-tailed)	1.000	.357	.451
Point Probability	1.000	.238	.054

a. Grouping Variable: Sibling(s) in care at the same time
b. Not corrected for ties.

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, one/some of my siblings was/were in care at the same time as I was	4	4,50	18,00
	No, my sibling(s) lived with our family while I was in care	14	10,93	153,00
	Total	18		
PSS year	Yes, one/some of my siblings was/were in care at the same time as I was	4	5,00	20,00
	No, my sibling(s) lived with our family while I was in care	14	10,79	151,00
	Total	18		
PSS lifetime	Yes, one/some of my siblings was/were in care at the same time as I was	5	10,90	54,50
	No, my sibling(s) lived with our family while I was in care	18	12,31	221,50
	Total	23		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	8,000	10,000	39,500
Wilcoxon W	18,000	20,000	54,500
Z	-2,239	-2,014	-,504
Asymp. Sig. (2-tailed)	**,025**	**,044**	,614
Exact Sig. [2*(1-tailed Sig.)]	,035[b]	,061[b]	,691[b]
Exact Sig. (2-tailed)	**,041**	**,044**	,634
Exact Sig. (1-tailed)	,023	,023	,342
Point Probability	,023	,011	,050

a. Grouping Variable: Sibling(s) in care at the same time
b. Not corrected for ties.

Ranks

	Sibling(s) in care at the same time	N	Mean Rank	Sum of Ranks
PSS month	Yes, one/some of my siblings was/were in care at the same time as I was	4	3,00	12,00
	No, because of other reasons	5	6,60	33,00
	Total	9		
PSS year	Yes, one/some of my siblings was/were in care at the same time as I was	4	3,50	14,00
	No, because of other reasons	5	6,20	31,00
	Total	9		
PSS lifetime	Yes, one/some of my siblings was/were in care at the same time as I was	5	5,10	25,50
	No, because of other reasons	6	6,75	40,50
	Total	11		

Test Statistics[a]

	PSS month	PSS year	PSS lifetime
Mann-Whitney U	2,000	4,000	10,500
Wilcoxon W	12,000	14,000	25,500
Z	-2,191	-1,542	-1,045
Asymp. Sig. (2-tailed)	**,028**	,123	,296
Exact Sig. [2*(1-tailed Sig.)]	,063[b]	,190[b]	,429[b]
Exact Sig. (2-tailed)	**,048**	,206	,303
Exact Sig. (1-tailed)	,040	,103	,182
Point Probability	,040	,063	,121

a. Grouping Variable: Sibling(s) in care at the same time
b. Not corrected for ties.

15.3 Correlation tests

PSS scores (month, year) and INQ: total sample

(A) n = 44 (excluding the response from December 2020)

			PSS month	PSS year	INQ_PB	INQ_TB
Kendall's tau_b	PSS month	Correlation Coefficient	1,000	,726**	,386**	,005
		Sig. (2-tailed)	.	,000	,005	,970
		N	33	33	33	31
	PSS year	Correlation Coefficient	,726**	1,000	**,392****	,105
		Sig. (2-tailed)	,000	.	**,004**	,454
		N	33	33	33	31
	INQ_PB	Correlation Coefficient	**,386****	**,392****	1,000	,330**
		Sig. (2-tailed)	**,005**	**,004**	.	,003
		N	33	33	44	42
	INQ_TB	Correlation Coefficient	,005	,105	,330**	1,000
		Sig. (2-tailed)	,970	,454	,003	.
		N	31	31	42	42

(B) n = 44 (excluding the recent response from May 2021)

			PSS month	PSS year	INQ_PB	INQ_TB
Kendall's tau_b	PSS month	Correlation Coefficient	1,000	,799**	**,480****	,077
		Sig. (2-tailed)	.	,000	**,000**	,584
		N	33	33	33	31
	PSS year	Correlation Coefficient	,799**	1,000	**,392****	,165
		Sig. (2-tailed)	,000	.	**,004**	,239
		N	33	33	33	31
	INQ_PB	Correlation Coefficient	**,480****	**,392****	1,000	,374**
		Sig. (2-tailed)	**,000**	**,004**	.	,001
		N	33	33	44	42
	INQ_TB	Correlation Coefficient	,077	,165	,374**	1,000
		Sig. (2-tailed)	,584	,239	,001	.
		N	31	31	42	42

(C) n = 43 (excluding both presumed double-responses)

			PSS month	PSS year	INQ_PB	INQ_TB
Kendall's tau_b	PSS month	Correlation Coefficient	1,000	,791**	**,442****	,003
		Sig. (2-tailed)	.	,000	**,002**	,985
		N	32	32	32	30
	PSS year	Correlation Coefficient	,791**	1,000	**,359****	,113
		Sig. (2-tailed)	,000	.	**,010**	,431
		N	32	32	32	30
	INQ_PB	Correlation Coefficient	**,442****	**,359****	1,000	,344**
		Sig. (2-tailed)	**,002**	**,010**	.	,002
		N	32	32	43	41
	INQ_TB	Correlation Coefficient	,003	,113	,344**	1,000
		Sig. (2-tailed)	,985	,431	,002	.
		N	30	30	41	41

PSS scores (month, year) and INQ: country comparison

(A) n = 44 (excluding the response from December 2020)

	Country			PSS month	PSS year	PSS lifetime	INQ_PB	INQ_TB
Kendall's tau_b	England	PSS month	Correlation Coefficient	1,000	,607*	,277	,431	,350
			Sig. (2-tailed)	.	,029	,367	,106	,188
			N	11	11	11	11	11
		PSS year	Correlation Coefficient	,607*	1,000	,035	,749**	,162
			Sig. (2-tailed)	,029	.	,903	,003	,516
			N	11	11	11	11	11
		PSS lifetime	Correlation Coefficient	,277	,035	1,000	-,119	-,098
			Sig. (2-tailed)	,367	,903	.	,607	,669
			N	11	11	15	15	15
		INQ_PB	Correlation Coefficient	,431	,749**	-,119	1,000	,437*
			Sig. (2-tailed)	,106	,003	,607	.	,030
			N	11	11	15	15	15
		INQ_TB	Correlation Coefficient	,350	,162	-,098	,437*	1,000
			Sig. (2-tailed)	,188	,516	,669	,030	.
			N	11	11	15	15	15
	Germany	PSS month	Correlation Coefficient	1,000	,774**	,348	,432*	-,055
			Sig. (2-tailed)	.	,000	,066	,011	,758
			N	22	22	22	22	20
		PSS year	Correlation Coefficient	,774**	1,000	,486*	,284	,037
			Sig. (2-tailed)	,000	.	,011	,096	,837
			N	22	22	22	22	20
		PSS lifetime	Correlation Coefficient	,348	,486*	1,000	,308*	,179
			Sig. (2-tailed)	,066	,011	.	,041	,246
			N	22	22	29	29	27
		INQ_PB	Correlation Coefficient	,432*	,284	,308*	1,000	,278*
			Sig. (2-tailed)	,011	,096	,041	.	,048
			N	22	22	29	29	27
		INQ_TB	Correlation Coefficient	-,055	,037	,179	,278*	1,000
			Sig. (2-tailed)	,758	,837	,246	,048	.
			N	20	20	27	27	27

(B) n = 44 (excluding the recent response from May 2021)

	Country			PSS month	PSS year	PSS lifetime	INQ_PB	INQ_TB
Kendall's tau_b	England	PSS month	Correlation Coefficient	1,000	,834**	,333	**,680****	,461
			Sig. (2-tailed)	.	,002	,272	**,010**	,080
			N	11	11	11	11	11
		PSS year	Correlation Coefficient	,834**	1,000	,035	**,749****	,405
			Sig. (2-tailed)	,002	.	,903	**,003**	,104
			N	11	11	11	11	11
		PSS lifetime	Correlation Coefficient	,333	,035	1,000	-,119	-,059
			Sig. (2-tailed)	,272	,903	.	,607	,798
			N	11	11	15	15	15
		INQ_PB	Correlation Coefficient	**,680****	**,749****	-,119	1,000	,579**
			Sig. (2-tailed)	**,010**	**,003**	,607	.	,004
			N	11	11	15	15	15
		INQ_TB	Correlation Coefficient	,461	,405	-,059	,579**	1,000
			Sig. (2-tailed)	,080	,104	,798	,004	.
			N	11	11	15	15	15
	Germany	PSS month	Correlation Coefficient	1,000	,774**	,348	**,432***	-,055
			Sig. (2-tailed)	.	,000	,066	**,011**	,758
			N	22	22	22	22	20
		PSS year	Correlation Coefficient	,774**	1,000	,486*	,284	,037
			Sig. (2-tailed)	,000	.	,011	,096	,837
			N	22	22	22	22	20
		PSS lifetime	Correlation Coefficient	,348	,486*	1,000	**,308***	,179
			Sig. (2-tailed)	,066	,011	.	**,041**	,246
			N	22	22	29	29	27
		INQ_PB	Correlation Coefficient	**,432***	,284	**,308***	1,000	,278*
			Sig. (2-tailed)	**,011**	,096	**,041**	.	,048
			N	22	22	29	29	27
		INQ_TB	Correlation Coefficient	-,055	,037	,179	,278*	1,000
			Sig. (2-tailed)	,758	,837	,246	,048	.
			N	20	20	27	27	27

(C) n = 43 (excluding both presumed double-responses)

	Country			PSS month	PSS year	PSS lifetime	INQ_PB	INQ_TB
Kendall's tau_b	England	PSS month	Correlation Coefficient	1,000	,788**	,313	**,604***	,318
			Sig. (2-tailed)	.	,007	,333	**,032**	,259
			N	10	10	10	10	10
		PSS year	Correlation Coefficient	,788**	1,000	-,041	**,702****	,276
			Sig. (2-tailed)	,007	.	,892	**,008**	,300
			N	10	10	10	10	10
		PSS lifetime	Correlation Coefficient	,313	-,041	1,000	-,179	-,110
			Sig. (2-tailed)	,333	,892	.	,459	,646
			N	10	10	14	14	14
		INQ_PB	Correlation Coefficient	**,604***	**,702****	-,179	1,000	,533*
			Sig. (2-tailed)	**,032**	**,008**	,459	.	,012
			N	10	10	14	14	14
		INQ_TB	Correlation Coefficient	,318	,276	-,110	,533*	1,000
			Sig. (2-tailed)	,259	,300	,646	,012	.
			N	10	10	14	14	14
	Germany	PSS month	Correlation Coefficient	1,000	,774**	,348	**,432***	-,055
			Sig. (2-tailed)	.	,000	,066	**,011**	,758
			N	22	22	22	22	20
		PSS year	Correlation Coefficient	,774**	1,000	,486*	,284	,037
			Sig. (2-tailed)	,000	.	,011	,096	,837
			N	22	22	22	22	20
		PSS lifetime	Correlation Coefficient	,348	,486*	1,000	**,308***	,179
			Sig. (2-tailed)	,066	,011	.	**,041**	,246
			N	22	22	29	29	27
		INQ_PB	Correlation Coefficient	**,432***	,284	**,308***	1,000	,278*
			Sig. (2-tailed)	**,011**	,096	**,041**	.	,048
			N	22	22	29	29	27
		INQ_TB	Correlation Coefficient	-,055	,037	,179	,278*	1,000
			Sig. (2-tailed)	,758	,837	,246	,048	.
			N	20	20	27	27	27

PSS scores (month, year) and future perspective: country comparison

(A) n = 44 (excluding the response from December 2020)

Correlations

	Country			How positive do you feel about the future?	PSS month	PSS year
Kendall's tau_b	England	How positive do you feel about the future?	Correlation Coefficient	1,000	**-,544***	**-,710****
			Sig. (2-tailed)	.	**,049**	**,006**
			N	15	11	11
		PSS month	Correlation Coefficient	**-,544***	1,000	,607*
			Sig. (2-tailed)	**,049**	.	,029
			N	11	11	11
		PSS year	Correlation Coefficient	**-,710****	,607*	1,000
			Sig. (2-tailed)	**,006**	,029	.
			N	11	11	11
	Germany	How positive do you feel about the future?	Correlation Coefficient	1,000	-,302	-,240
			Sig. (2-tailed)	.	,082	,170
			N	29	22	22
		PSS month	Correlation Coefficient	-,302	1,000	,774**
			Sig. (2-tailed)	,082	.	,000
			N	22	22	22
		PSS year	Correlation Coefficient	-,240	,774**	1,000
			Sig. (2-tailed)	,170	,000	.
			N	22	22	22

*. Correlation is significant at the 0.05 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

(B) n = 44 (excluding the recent response from May 2021)

Correlations

	Country			How positive do you feel about the future?	PSS month	PSS year
Kendall's tau_b	England	How positive do you feel about the future?	Correlation Coefficient	1,000	**-,791****	**-,703****
			Sig. (2-tailed)	.	**,004**	**,007**
			N	15	11	11
		PSS month	Correlation Coefficient	**-,791****	1,000	,834**
			Sig. (2-tailed)	**,004**	.	,002
			N	11	11	11
		PSS year	Correlation Coefficient	**-,703****	,834**	1,000
			Sig. (2-tailed)	**,007**	,002	.
			N	11	11	11
	Germany	How positive do you feel about the future?	Correlation Coefficient	1,000	-,302	-,240
			Sig. (2-tailed)	.	,082	,170
			N	29	22	22
		PSS month	Correlation Coefficient	-,302	1,000	,774**
			Sig. (2-tailed)	,082	.	,000
			N	22	22	22
		PSS year	Correlation Coefficient	-,240	,774**	1,000
			Sig. (2-tailed)	,170	,000	.
			N	22	22	22

**. Correlation is significant at the 0.01 level (2-tailed).

(C) n = 43 (excluding both presumed double-responses)

Correlations

	Country			How positive do you feel about the future?	PSS month	PSS year
Kendall's tau_b	England	How positive do you feel about the future?	Correlation Coefficient	1,000	**-,754***	**-,649***
			Sig. (2-tailed)	.	**,010**	**,019**
			N	14	10	10
		PSS month	Correlation Coefficient	**-,754***	1,000	,788**
			Sig. (2-tailed)	**,010**	.	,007
			N	10	10	10
		PSS year	Correlation Coefficient	**-,649***	,788**	1,000
			Sig. (2-tailed)	**,019**	,007	.
			N	10	10	10
	Germany	How positive do you feel about the future?	Correlation Coefficient	1,000	-,302	-,240
			Sig. (2-tailed)	.	,082	,170
			N	29	22	22
		PSS month	Correlation Coefficient	-,302	1,000	,774**
			Sig. (2-tailed)	,082	.	,000
			N	22	22	22
		PSS year	Correlation Coefficient	-,240	,774**	1,000
			Sig. (2-tailed)	,170	,000	.
			N	22	22	22

*. Correlation is significant at the 0.05 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).