EXPLORING THE MEANING AND IMPACT OF THE SUICIDES OF YOUNG RESIDENTIAL CARE-LEAVERS, FROM THE PERSPECTIVES OF THOSE WHO WORKED AND LIVED ALONGSIDE THEM IN RESIDENTIAL CHILD CARE

A thesis submitted in fulfilment of the Degree of Doctor of Philosophy

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Declaration

I declare that the work contained within this thesis has not been submitted for any other Degree at any other university. The content found within this thesis has been entirely composed by the candidate, Judith Madeline Ruth Furnivall.

Abstract

The suicide of care-experienced young people and its impact has only recently attracted public and academic concern. This qualitative study is the first to explore the meaning and impact of suicides of care-experienced young people from the perspective of those close to them.

Nineteen in-depth interviews were undertaken with people close to young care-leavers who died by suicide. My position as an 'insider' in the residential care system with personal experience of such a suicide required a rigorously reflexive approach.

Thematic analysis of the data suggested similarities and differences to other reported findings. Participants experienced overwhelming and enduring distress, but their grief was devalued and disenfranchised. This thesis argues that the intersection between a stigmatising death (suicide) and a stigmatised group (those with care experience) contributed to this. It also highlights how assumptions about appropriate professionalism and mistrust of relationships between young people negatively affected the recognition and expression of grief. Traditional mourning rituals rarely brought comfort to participants, and many expressed a desire for commemorations that acknowledged young people's care identities and relationships.

Although participants pointed to young people's difficult individual stories, they also identified problematic societal, systemic, and professional factors that they believed underlay the deaths. These included systematic disruption of relationships, failure to address trauma whilst children are in care, flawed decision making and inadequate support during and after transitions as well as the negative discourse around residential care that eroded hope and left young people feeling trapped. Most participants were committed to fighting for change in the system to help them find significance in the deaths.

Changes in policy and practice were suggested that might reduce the experience of disenfranchised grief as well as systemic and professional changes that could increase care-leavers' sense of belonging and contribute to safe and connected transitions from care.

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I also want to express my gratitude to my participants for sharing with me their memories and reflections about some of the most painful experiences of their lives. I am in awe at their courage and passion. Without their willingness to revisit their loss and pain and to reflect on their own experiences and those of the young people who died, this thesis would be much weaker. My only regret is that I was unable to include even more of the rich material they shared with me. I hope this work reassures them that neither they nor the young people who died have been forgotten.

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Chapter One: Introduction

The focus of this thesis is on the suicides of young people who had left or were about to leave a residential childcare setting. The purpose of this research is to begin to fill gaps in knowledge about the pathways to suicidal behaviour for care-leavers and the impact of suicide on those close to the young people who die. Although these issues could have been approached separately, they are interconnected and illuminate each other, as well as providing insights which may contribute to policy and practice development.

The research set out to explore the meaning and impact of the suicides of care-leavers through the reflections and memories of those close to them. Participants were family members of young people who died from suicide, care-experienced adults who had known them in residential care, or professionals who had worked closely with them. The original intention had been to interview adult care-leavers who had survived serious attempts to kill themselves and, in many cases, went on to lead successful lives. The intention was to provide a different perspective on the factors influencing young people's decisions to take their own lives after leaving care. It soon became clear, however, that this would be impossible to accomplish fully within the confines of a single PhD. Interestingly, however, many care-experienced participants referred to their own suicidal ideation and attempts to kill themselves. Whilst this was not the specific focus of the interviews, their openness certainly strengthened the findings of the research.

Although there is a rich and extensive research literature on suicidal behaviour and its impact on others, little focuses on children and young people with experience of residential care and those close to them. Similarly, despite a steady increase in academic and policy interest in children in care and care-leavers, a sustained attempt to quantify the level of any cause mortality among this group (Allik, et al. 2022) has only occurred very recently. The aim of this thesis is to highlight the gaps in our understanding suicide among care-leavers and how these affects those around them. Using in-depth interviews this research addresses two key questions:

- How do people who were close to young care-leavers who died by suicide, on the edge of after they left residential care, make sense of these deaths in relation to the care-leavers' life experiences and relationships?
- How do people who were close to young care-leavers who killed themselves on the edge of or after leaving residential care describe the impact of the deaths on them?

The intention in this research has been to listen to, hear and represent, as far as possible, the voices of participants who have suffered the loss through suicide of a young person they knew who lived in a residential care setting. The focus has been on making sense of, and interpreting, the lived experience of all participants.

The stories, reflections and pain participants shared with me, point clearly to some serious and continuing problems in the policy and practice framework governing the provision of care and support to vulnerable children and families that appear to have contributed to young people's deaths. They also, however, identified clear examples of good practice and policies that transformed children's lives and contributed to a positive trajectory into their adulthood. Their accounts provide a powerful insight into the experience and needs of those bereaved by the suicide of a care-experienced young person. They demonstrate consistent failings in recognition of the impact of deaths and poor provision of support to all those involved.

This chapter first provides a brief outline of the Scottish Childcare System to place this research in context. It then moves on to provide some background and a rationale for the research. Some definitional and language problems that confuse and complicate any research involving not only suicide and harm but also the care system are considered. Finally, the structure of this thesis is outlined.

The Scottish Childcare System

Most Scottish children spend their whole childhood within their own families although increasing diversity in family structures (Rees, 2017) means this may not conform to a traditional nuclear family. Nevertheless, however complex their family living arrangements may be, they are likely to be continuously cared for by familiar adults and key decisions about their development and welfare will be made by their parents (Osher, et al. 2020). If they have brothers and sisters, they will experience the normal joys and struggles of sibling relationships and develop a shared narrative that may support and sustain them throughout their lives (Osher, et al. 2020; Whiteman, et al. 2011). A small minority of children, however, will not live within their families either for their own protection or to ensure the safety of others. For them, however difficult their circumstances may be, coming into care is likely to involve the fracturing or, permanent loss of important relationships in their families, schools and communities (Ward, 2011).

The Children (Scotland) Act 1995 provides the legal framework for state intervention in families to ensure adequate care and protection for children. This Act uses the term ‘looked after children’ to refer to the small proportion of Scotland’s children who either receive state care outside their immediate family or to those who are subject to care and supervision in their homes. The commonest reasons for children living away from home are difficulties in their families that seriously interfere with their care and development. Some young people may be involved in serious or persistent offending that indicates an unmet need for care or control. In a few situations children may be received into care if their parents are unavailable, for example, if the young person is an unaccompanied asylum seeker. There are no statistics collected in Scotland, about the specific reasons children become looked after but, in both England and Wales, over 60% entered the system because of abuse or neglect (NSPCC, 2021). This focus on individual and family pathology disguises wider social factors that also influence admission to care. The Child Welfare Inequalities Project examined intervention patterns across the UK and found that the likelihood of being subject to a child protection intervention was related to families' socio-economic circumstances using neighbourhood deprivation as a measure.

> *A child in Scotland living in one of the most deprived 20% of UK neighbourhoods is 10 times more likely to be looked after away from parents, relatives or friends than a child in the least deprived 20% (Bywaters, et al. 2020a, pp. 203-204).*

Although most children in areas of high deprivation will be living at home with their families, the authors draw attention to the insidious impact of poverty on parenting and family life. There may be insufficient resources to cater for basic needs which may also mean that it is impossible to pay for childcare to take up employment or to provide a respite from the demands of parenting. They also point out how the emotional impact of anxiety, shame and stigma can affect parenting capacity (Bywaters, et al. 2020a and b).

Children usually become looked after away from home through formal proceedings in a Children's Hearing [1] or court or at the request of parents. Most children cared for in this way live with kinship carers (extended family members or close family connections), foster carers or prospective adopters. About ten percent of looked after children (1286 in 2021), however, are placed in some form of residential provision, including care homes, residential schools and secure care centres (Scottish Government, 2022a). The Children (Scotland) Act 1995 supports children remaining in their own families wherever possible and placement in a substitute family if children require out-of-home care. This underlying assumption that family care is best, combined with the costs of providing residential care (Audit Scotland, 2010), has meant that placement in residential settings is now largely restricted to children who have the greatest level of difficulties (Gilligan,

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[1] The Kilbrandon Report (1965) 'advocated a focus on needs not deeds; arguing that like children in need of protection from others, children involved in offending should be. responded to in the same way and by the same system'(Lightowler, 2022 p.236). This led to the creation of the Children's Hearing System (CHS) through the Social Work (Scotland) Act 1968. The CHS is the Scottish process for considering the needs of children where there are serious concerns about their safety, development or behaviour. Panels composed of lay people decide whether children need compulsory measures of care or supervision and if there is a need for a child to be removed from home for their own protection.

2014; Johnson and Steckley, 2023) or older children who find it difficult to accept the conflict of loyalties involved in living with another family (Kendrick, 2013). Moreover, many children enter residential care after a series of planned and unplanned foster placement moves and ‘the pattern of instability found in care frequently mirrors children and young people's experiences before and after the care episode’ (Ward, 2009, p. 1117). Despite the stated government aspiration ‘to make residential care the first and best placement of choice for those children whose needs it serves’ (Bayes, p.6) it is often viewed as a last resort (Johnson and Steckley, 2023; Smith, 2009).

The provision of care for looked after children has changed significantly since the1950s. Between 1945 and the early 21st century the percentage of children cared for away from home who live in residential settings has fallen from 55% to about 13% (Kendrick, 2014). Residential care has steadily shifted away from large institutions to much smaller houses or living groups (Connelly and Milligan, 2012; Milligan and Furnivall, 2011). Although these changes have been largely positive allowing for more individualised care for children in less institutional environments, they have had some unfortunate consequences. It is now much harder to look after sibling groups together or to respond flexibly and creatively to the needs of former residents. Changes in the environments where residential care is provided have been matched by changes in practice. Although there are few clearly articulated models of residential care in Scotland (Johnson and Steckley, 2023), there has been a move towards more consciously relational and therapeutic practice seeking to understand behaviour as communication rather than just a problem to manage (Emond, et al. 2016; Steckley, 2020). Risk-averse practices that inhibit children enjoying normal leisure pursuits or friendships are more frequently questioned and there is an increased emphasis on children developing risk competence (Milligan, 2011).

These changes have taken place within an evolving legal and policy framework. This has included the Regulation of Care (Scotland) Act 2001 which created a national inspection and regulatory body and the subsequent development of national standards of care (Scottish Government, 2002). Residential care workers became subject to minimum qualification requirements and were required to register with the Scottish Social Services Council. In 2000 the Scottish Executive funded a national centre, The Scottish Institute for Residential Childcare, to provide continuous professional development for practitioners as well as basic qualifying training and a Master’s level postgraduate qualification (Johnson and Steckley, 2023).

In 2015 a public inquiry began into historic abuse of children in residential care in Scotland. The inevitable public interest and widespread reporting of historic abuse has influenced the way residential care is perceived for many years (Johnson and Steckley, 2023) and continues to affect the morale of staff who work in residential care (Colton and Roberts, 2007). The consequent difficulties in recruiting and retaining staff have negative impacts on children and young people who may experience continual disruption of relationships even if they remain in the same placement (Colton and Roberts, 2007).

In 2016 Nicola Sturgeon also announced an independent ‘root and branch review’ of the current care system. This review was consciously constructed to privilege the voices of care-experienced people in every aspect of its operation. It heard from over 5,500 children, families and carers and their views formed the basis of the final report – The Promise (Independent Care Review, 2020) – which recommended a wholesale transformation of the care system. The Promise highlighted the importance of children in the care system experiencing love and the potential for lifelong relationships wherever they lived. It also recognised the need for carers and practitioners to be supported to understand the complex needs of young people who may have experienced severe loss and trauma. The Promise identified and challenged systemic and structural factors that prevented families receiving timely support to help them remain together, as well as those that inhibited the development of sustained and loving connections for children who had to be cared for away from their homes. There has been a positive response to the Promise from practitioners, policy makers and politicians and a strong commitment to the implementation of its recommendations.

The challenges in implementing such sweeping change are, however, considerable and as Johnson and Steckleyp. 62 (2023) state there is already a

> *'sometimes sizable gap between the evidence base for good practice and for policy aspirations on the one hand, and their implementation across the sector in everyday practice on the other … At a policy level, there is a similar implementation gap between rhetoric and the provision of resources to match those aspirations.'*

Since the mid-1990s evidence has been accumulating that when young people leave the care system to live more independently, they face a very difficult transition and are disproportionately represented in marginalised groups (Biehal, et al. 1994; Dixon and Stein, 2003). The Children (Scotland) Act 1995 set out the responsibilities of local authorities to provide aftercare support to young people leaving their care. These duties were extended by the Regulation of Care (Scotland) Act which required local authorities to carry out a formal assessment of young people's aftercare needs (their Pathway Plan). Although the 1995 Act created a presumption that children should remain in care until 18, Dixon and Stein (2003) found that most young people left care at 16 often to homeless or bed and breakfast accommodation. Sustained pressure from stakeholders, including young people themselves (Milligan, 2021), resulted in the Children and Young People (Scotland) Act 2014 amending the Children (Scotland) Act 1995 to extend the age care-leavers can continue to receive aftercare support from 21 to 26. It also introduced a new provision of 'continuing care' by which, when a young person ceases to be looked after, they can remain in their placement until 21 unless this would adversely affect their welfare. Other policy changes have eased the transition into independence such as removing the requirement for care experienced people to pay council tax until 26 and introducing a care bursary for students in higher education.

This brief account of the current Scottish childcare system and its recent history provides a context for the research reported in this thesis. It also helps to situate the experiences recounted by participants more accurately within the history of Scottish residential care. All but one care-experienced participant lived in residential childcare settings for some of their care journey as had two of the family members who talked about their siblings who died after leaving residential care. All professionals had worked closely with young people who had lived in residential care and later died by suicide. Many, however, whether care-experienced individuals, family members or professionals were first involved with the care system over twenty years ago, although all had some live connection with the sector at when interviewed. The perspectives of participants in this research were thus influenced not only by their personal histories of involvement in the care system but also by their current knowledge and awareness of recent developments and challenges.

Background and rationale for the research

Suicide is a common cause of death for young people aged 15 to 24. From the most recent data, almost a third (91) of the 303 young people of this age who died in Scotland in 2020 were deemed probable suicides (National Records of Scotland, 2022). This is not only a costly waste of potential, but every death affects those exposed to it. Young people removed from their families to keep them safe may be disproportionately represented among these figures (Cowan, 2008; Segal, et al. 2021). Anecdotal accounts from practitioners suggest many young people kill themselves shortly after leaving care. Their deaths affect those close to them, but they also challenge public and professional confidence in the care and support these young people have received from their 'corporate parents.'[2] Some authorities have reported findings that confirm this dismal picture at local level (Cowan, 2008; North Lanarkshire Council, 2009).

Until recently there were no published national statistics on care-leaver deaths in Scotland. Since the Children and Young People (Scotland) 2014 came into force in 2016, the Care Inspectorate records deaths of young people in receipt of leaving or continuing care services. Their first report (Care Inspectorate, 2020) identified 19 deaths in two years. This reporting mechanism, however, is undermined by lack of detail about the

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[2] Corporate parenting definition: "An organisation's performance of actions necessary to uphold the rights and safeguard the wellbeing of a looked after child or care leaver, and through which physical, emotional, spiritual, social and educational development is promoted." (Scottish Government, 2015). 24 organisations are now legally named as corporate parents which extends the responsibility of care well beyond local authorities (Children and Young People (Scotland) Act 2014 66(4))

circumstances of young people’s lives and deaths. Moreover, some vulnerable and isolated young people fail to engage with services and their deaths would not be included in these figures. A recent longitudinal study (Allik, et al. 2021) suggests that the rate of deaths from all causes amongst care-experienced children and young people in Scotland is at least five times higher than that of their peers in the wider population.

Research into Scottish care-leavers experiencing depression found that 23 out of 27 participants made at least one serious attempt to kill themselves (Amaral, 2014). A suicide attempt increases the risk of dying by suicide one hundredfold in the following year and the heightened risk persists for years (Jenkins, et al. 2002). The difficult experiences that many care-leavers endure, prior to and during their care journey, echo known risk factors for suicide in young people (McLean, et al. 2008). Perhaps it is, therefore, unsurprising that a disproportionate number of care-leavers kill themselves. It is unclear how this risk is translated into suicidal acts for care-leavers or, indeed, whether any deaths could have been prevented by changes in systems and policies or relationships and practice.

This gap in understanding of the lived experiences of young people is matched by an absence of research focusing on the aftermath of suicide for those close to them, not only family, but carers and peers who have shared their living space. There is some literature on the impact of death by suicide on close family members (Hvidkjær, et al. 2021; Jordan and McIntosh, 2011) but little focuses on those bereaved by the death of a care-experienced young person. For grieving relatives, it may be additionally painful to accept that those responsible for the care of their child could not keep them alive. They may also feel guilty that they could not care for their child and, indeed, may have contributed to the distress that led to their death. The stigma often associated with suicide of a family member or close friend (McIntosh and Jordan, 2011) can be intensified by the stigma that comes with being perceived as a “bad parent” who has had a child removed by the state (Schofield, et al. 2011; Scholte, et al. 1999). Siblings or friends may feel guilt or wish to copy the young person who has died (Cerel and Aldrich, 2011). For residential workers or foster carers who have had very close relationships with young people in their care, losing a young person through suicide may challenge both their emotional resilience and their professional competence and hopefulness (Gulfi, et al. 2010). In addition, they may experience blame and organisational investigation simultaneously with trying to deal with grief and shock (Weiner, 2004).

Language and definitions

This section explores terminology employed in both the UK child welfare system and the literature on suicide. It examines the power and impact of certain words within the literature and explains the choice of terms used in this research. It also describes my own journey as my clarities and certainties about language and definitions crumbled and I grappled with the nuanced and complex reality of the experiences I was exploring. From the outset it was clear that language I chose would have meaning, but my choices changed and evolved as I listened to my participants and recognised the challenges to professional language coming from the care-experienced community.

The Language of Care

Within the UK the term 'looked after children' is used to describe children subject to some form of compulsory care from the state. The only other country using this terminology is Australia. Within the UK the term is not used consistently: in Scotland it includes children in care living away from their birth family and those living at home but subject to compulsory involvement from social work; in the rest of the UK the term is reserved for children in care living away from home. It was introduced to address the perceived stigma of the phrase 'children in care,' but many children prefer this description to that of 'looked after children' (Barry, 2006). Moreover, the term itself is problematic. It can be confusing to the public and other professionals outside social work: most children are looked after well within their families, and the annexing of the term 'looked after,' to describe a group of children who have experienced periods of being very badly looked after, can be bewildering. In addition, assumptions built into the phrase 'looked after' institutionalise children's dependency on the adults around them and imply that the experience of care is inherently positive.

‘Looked after child’ is frequently abbreviated to LAC and indeed children are sometimes referred to as ‘LAC children.’ This unfortunately has sometimes led to children being seen as somehow “lacking.” McLaughlin (2009) examined changing terminology within social work and emphasised that every term is built on particular assumptions and signifies different relationships. He argues the importance of using terms people in receipt of services prefer and may actively claim. Moreover, he states that ‘*…the language we use is imbued with meaning and power*’ (McLaughlin, 2009, p. 1115) and that it is important to critically reflect on how terminology constructs relationships with people and their position within society. Originally, I had planned to use the term ‘children in care,’ which, although it has its own difficulties, was often preferred by children themselves. It is less confusing and does not confine them to a singular dependent identity that is defined in relation to those caring for them. Over the last few years, however, the term ‘care-experienced’ has been claimed by many children, young people and adults who share a care background of any kind. This is seen as maximising inclusiveness and developing the possibility of a community of identity. It is the terminology adopted by The Promise (Independent Care Review, 2020) in an explicit attempt to reduce stigmatising and cold language. Wherever appropriate this is the language I use within this research.

The term ‘care-experienced’ describes anyone who has been in the care system for whatever length of time. While this helpfully recognises a shared identity and commonality of experience it can lead to confusion when focusing on specific groups of young people such as those leaving care to move towards independence. Since the Children (Scotland) Act 1995 a statutory requirement has existed to provide guidance and support to young people leaving the care system in this way. Although the positive or negative consequences of a care background can be life-long (Duncalf, 2011), the identity of care-leaver is largely confined to the period after leaving care, when entitlement to services exists. Most policy, practice and research focus on this group of young people (Parry and Weatherhead, 2014; Stein, 2006b). More recently, however, there has been interest in the later experiences of adults with a care background. These adults have been described with a variety of terms, some of which are extremely stigmatising – 'former care inmates' (Coldrey, 2001; Penglase, 2007) – or restrict identity to childhood experiences – 'former boys and girls' (Magnusson, 2006). A more widely used term, however, which has been claimed by researchers with a care background is 'adult care-leavers' (Duncalf, 2011). Within this research when the use of 'care-experienced' is insufficiently precise, the term 'care-leaver' is applied to individuals younger than 26, when entitlement to leaving care support ends, and 'adult care-leaver' to those above this age.

The language of suicide and self-harm

Research into suicide and self-harm is riddled with imprecise definitions and inconsistent uses of terminology (National Collaborating Centre for Mental Health, 2011). This may reflect the inherent messiness of the acts and the motivations and intentions associated with them. Even the apparently clearest act – actual suicide, which involves death with deliberate intent – defies easy definition. Establishing intent retrospectively is difficult, even if the deceased leaves a note (which only occurs in a minority of cases), as it can only be inferred by witness accounts of the event or the emotional state of the deceased (Fincham, et al. 2011). The standard of proof required in England for a finding in an inquest of a death by suicide has recently shifted from that required in criminal courts – 'beyond all reasonable doubt' - to that required in civil courts – 'the balance of probabilities' (Appleby, et al. 2019). In Scotland, the Procurator Fiscal investigates all unexpected deaths. The decision to categorise a death as suicide is made by the Crown Office, using the Fiscal's report, unless a Fatal Accident Inquiry (FAI) is required. If an FAI takes place the presiding sheriff determines cause of death. Atkinson (1978) suggests that categorising a death as a suicide is not a simple fact-finding exercise that identifies 'real' suicides. Instead, legal officials use evidence provided by professionals, witnesses, and families to make decisions based on a set of common-sense assumptions – such as mode of death, life experiences, mental health difficulties – about what characterises a suicide. Thus, suicide figures based on the formal recording of a death as a suicide are likely to over-include certain types of death and exclude others (Gosney and Hawton, 2007; O'Donnell and Farmer, 1995). There is some formal recognition of this: deaths of undetermined intent are included in suicide statistics to improve accuracy. Since 2011 death from acute drug intoxication is routinely included within official suicide figures, unless National Records of Scotland are explicitly informed that the death is accidental.

Language around non-fatal self-harm is inconsistently used in research and practice. ‘Parasuicidal behaviour,’ ‘deliberate self-harm,’ ‘non-suicidal self-injury’ and ‘self-mutilation’ have all been used to describe the same act. Both the Royal College of Psychiatrists (2010) and the National Institute for Health and Care Excellence (2011) now define non-fatal self-harm as an intentional act of self-poisoning or self-injury, irrespective of the motivation or degree of suicidal intent. Although this now provides an inclusive definition covering all types of non-fatal self-harm, it explicitly excludes consideration of intent. Most people who self-harm deny that their actions are intended to lead to death (Bywaters and Rolfe, 2002). This does not, however, preclude them also experiencing suicidal ideation at other times in their daily lives (Kidger, et al. 2012). The term ‘intent’ is itself unclear, as some people describe hurting themselves while not caring whether they live or die.

Initially I had hoped to use intent as the defining criterion for inclusion in the research. I had assumed that, despite the complexity within the legal process of identifying a death as suicide, those close to the care-leavers who died would have a sense of whether they deliberately engaged in self-harming behaviour with some intent to die, even if no legal finding of suicide occurred. The reality was that many participants wrestled with the lack of certainty about the deaths they were describing. There was often a hope that the young people did not really mean to die, even where there was a clear finding of suicide, and the method was irreversible. In their reflections, however, participants often commented that young people placed themselves at such consistent and serious risk that their deaths were effectively self-inflicted even if there was no obvious intent to die. It was clear that many participants knew several care-leavers who had died prematurely, not necessarily through suicide, but often in circumstances of poverty, isolation, and continuing trauma. The focus in the interviews remained on those where a strong possibility existed that deliberate intent to die was involved.

There are other aspects of language within the suicide literature that pose difficulties. Within Scotland, suicide was never an offence, but suicide remained a crime in England and Wales until 1961 (Suicide Act 1961) and in Northern Ireland until 1966 (Criminal Justice Act (Northern Ireland) 1966). Individuals were prosecuted and, in some cases, imprisoned, until shortly before the offence was removed. The perception of suicide as a crime remains enshrined in the phrase ‘to commit suicide’ which implies an offence has taken place. As an alternative to this pejorative language, many professionals, including me, used the term to ‘complete suicide.’ For many people bereaved by suicide this was not neutral, however, as they felt it had connotations of achievement or success rather than recognising the distressing impact and meaning of such deaths. A survey conducted with people affected by suicide (Padmanathan, 2019) identified the alternative term ‘died by suicide’ as one that was seen as acceptable by most respondents. Although it may be criticised as a rather blunt phrase, and also one that fails to recognise individual agency, it appears to have a high rate of acceptance and is used throughout this research.

Suicidal acts are often discussed in terms of success or failure, which frames the understanding of their meaning by people other than the actors themselves. Actual death may be seen as the only evidence of true intent to die and attempted suicide becomes diminished in meaning as a gesture or ‘cry for help,’ intended to elicit a specific response from others (Saunders, et al. 2012). This has particular importance in the way that suicide and gender are represented (Jaworski, 2014). Many more men die by suicide than women, yet far more women seek to kill themselves (Hawton, 2000). Jaworski (2014) argues convincingly that the production of knowledge about suicide is imbued with gendered assumptions about agency, that render completed suicide as a male, active act, in contrast to attempted suicide, which is perceived as female and passive. This affects the way suicidal acts are responded to by other people and the meaning of being alive for those whose acts did not result in death. This research explores choice and agency as key aspects of understanding suicide, without imposing constraints following from the gendered use of the language of success and failure.

In the language of suicidology the term ‘survivor’ is not used to denote a person who has lived after a suicidal act, instead it usually refers to someone who has been affected by the death through suicide of another person (Webb, 2002). This contrasts with other situations in which a person avoids death and is described as a ‘survivor,’ such as overcoming life-threatening conditions or recovering from potentially fatal injuries incurred through accident or assault. The term is also used to refer to people affected by deliberate damage afflicted by others, for example ‘abuse survivors’ (Philips and Daniluk, 2004).

In examining the implicit assumptions of this use of language, it is difficult not to question whether, in the first instance, it reflects a denial of the meaning and importance of attempted suicide and, in the second, an assumption that suicidal acts are always intended to affect others. Most acts of self-harm are usually undertaken with no intent to die or, at most, with ambivalence about living, but many people undertake suicidal acts expecting to die, even if there is no fatal outcome (Beautrais, et al. 1996). Similarly, although some people who die by suicide demonstrate, either through their manner of death or some active communication, that their death is intended to have a specific effect on someone else, others make strenuous attempts to minimise the impact on people in their relationship network or on unknown professionals who may have to deal with the aftermath of their death (Fincham, et al. 2011). Certainly, those bereaved by suicide may experience additional and complicated emotions beyond those who are dealing with the loss evoked by other forms of death. The language of survivorship, however, imports assumptions that may be unwarranted into the relationship between the living and the dead. Moreover, this use of language makes those who have attempted suicide invisible. David Webb (2002) who analysed his own suicidal experience in his PhD, described his experience of exclusion and invisibility when he entered the term ‘suicide survivor’ in an internet search and could only find references to those bereaved by suicide.

> *What do I call myself? How can I reach out to my fellow survivors without a name for us? I still don’t know. And I still can’t find many of my soul mates despite the many thousands of us that we know are “out there”. We are hidden behind labels of depression and other mental “illnesses” where discussion of suicide is generally*

> *avoided. Language is important and I need a word or phrase to identify this role in my life (Webb, 2002, p. 2).*

There has been some recent challenge to this terminology and the phrase 'bereaved by suicide' is now gaining currency, particularly outside the US. Within some literature, however, the terminology is entrenched and difficult to avoid. As a result, within this thesis the term 'survivor' is used when referencing studies where this is the author's terminology to denote those affected by the suicide of another, whilst retaining an awareness of the problematic nature of its use. In exploring, reflecting on and analysing the experiences of participants I have tried to maintain a respect for their agency and a belief in the importance and meaning of suicidal acts whatever their outcome.

Structure of the Thesis

Following this introductory chapter there are six additional chapters.

Chapter Two is a literature review divided into two main sections. This chapter explores the literature and theoretical developments around suicide and the care sector. In examining the core literature in each of these areas I identify research and literature that crosses over and highlight gaps in knowledge.

Chapter Three situates the methodological and ethical foundations of this research. The aims, objectives, research questions and ethical dilemmas are explored in more depth. Decisions made about the final methodology are explained. The process of gathering and analysing the data is described. It also has a section introducing the data chapters.

Chapter Four is the first of three data chapters. This chapter explores the direct impact of the deaths. It focuses first on emotional responses evoked by the deaths and explores similarities and differences between groups. This is followed by an examination of the impact of the deaths on participants' personal and professional engagement with and capacity to trust others.

Chapter Five explores the more indirect impact on participants created by the responses of others. It firstly outlines the concept of disenfranchised grief, then identifies and explores how participants experienced their grief to be disenfranchised.

Chapter Six is the final data chapter. This chapter identifies and discusses the key themes that were generated across the data set that participants used to explain and make meaning from young people's deaths.

Chapter Seven brings together the central discussions and conclusions of this thesis. The key findings from the research are highlighted and implications for practice and policy identified. It then explores strengths and weaknesses in the research as well as identifying possible areas for future research. This chapter summarises and outlines my contribution to this field.

Chapter Two: Literature Review

Young people with a care background have had experiences that contrast starkly to their peers. Concern about their poor outcomes has generated a substantial body of research literature (Jackson and Cameron, 2012; Jones, et al. 2011). Much draws on publicly available statistics or large, quantitative studies (Matheson and Connelly, 2012; Viner and Taylor, 2005; Zlotnick, et al. 2012) comparing the outcomes of care-experienced people with those of their peers. This research reflects the general anxiety that exists about state care and clearly aims to influence policy and practice (Connelly, et al. 2008; Jackson, et al. 2003). While this approach has been helpful in highlighting the continuing disadvantages faced by care-experienced people, it hides the diversity of experiences and outcomes for young people and loses sight of the other narratives of care-leavers which often demonstrate strength, resilience and agency in the face of overwhelming adversity (Brady and Gilligan, 2019; Tefaeli, 2017). Arguably this repetitive message of hopelessness and failure can contribute to the stigma, both personal and public, that children in care and care-leavers experience. Some authors, however, explore the experience and meaning of their care journey directly with young people (Chambers, 2014; Pinkerton and Rooney, 2014). They attempt to identify which in-care and post-care experiences lead to positive outcomes for care-leavers, including a reduced risk of suicidal behaviour. They involve detailed interviews with care-experienced people, and researchers strive to engage with their participants in a joint endeavour to create coherence out of complex, and often difficult, care pathways.

While there is considerable research focused on the care system, the research literature relating to suicide is vast. Perhaps this reflects our shared interest in this question posed by Camus (1975 [1942], p. 11), questioning the value of life:

> *There is but one truly serious philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy.*

Confronted by suicide we are both fascinated and frightened by the choices others make and are moved to reflect on the meaning of our existence (Clark, 1984). Few people are unaffected by the self-chosen death of another, and this is amplified in individuals most directly touched by suicide (Jordan and McIntosh, 2011). The debate about the causes and impact of suicide draws on psychological (Joiner, 2005; O'Connor, 2011; Shneidmann, 1993; Williams, 2001) and sociological (Atkinson, 1978; Cavan, 1928; Douglas, 1967; Durkheim, 1951 [1897]; Fincham, et al. 2011) explanations of the phenomenon. Moreover, professionals strive to prevent suicide by identifying factors associated with it to inform policy and improve practice. These are important academic and professional endeavours, but less research has taken place that allows the voices of those who attempt suicide, or those most intimately affected by the suicide of others, to be properly heard.

An analysis of papers published in three leading suicidology journals between 2005 and 2007 showed that only 3% were qualitative rather than quantitative (Hjelmeland and Knizek, 2017). The authors argue for a more qualitative focus within suicide research that seeks understanding and meaning rather than causal explanation. They point to the danger that aggregation of data loses the richness of individual experience and obscures both the process by which people decide to kill themselves and the impact of their actions on those around them.

This literature review is, by necessity, selective. It begins by placing suicide in the UK in a historical and cultural context. It then highlights existing gaps in knowledge and understanding that this research begins to fill. Although the wider landscape of both suicide and care research is outlined, the chapter focuses on research that illuminates meaning in the suicidal acts of care-leavers. The literature relating to risk and protective factors in suicide relating to young people is reviewed. This is linked to relevant research on the experiences of young people as they move into, through and out of the care system. Some key theoretical explanations of the pathways from risks to suicidal thoughts or acts are then introduced. Finally, research on the impact of bereavement by suicide is presented and gaps in the literature, particularly relevant to this study, are identified.

Search Strategy

The international literature was searched from 2000 to 2023 using electronic databases SOCARXIV, PsycINFO, Social Sciences Citation Index, Scopus, ProQuest and PubMed but with a primary focus on research most relevant to the UK context. The 2000 start date was selected because targeted legislation to support care-leavers in England was enacted (Children (Leaving Care) Act 2000) followed in Scotland by amendments to the Children (Scotland) Act 1995 in 2001. A search strategy was developed using key words, and boolean and proximity operators were used to adapt the search strategy for each database. Several searches were undertaken. The initial search used key terms for care-leavers and combined them with those associated with suicide. Thereafter searches were undertaken combining key terms for care-leavers with a range of factors associated with suicide. Searches were also undertaken combining key terms for suicide bereavement with those for specific groups of people including family, friends, and professionals. These were refined by adding key terms for children's social care and care-leaving. Grey literature was searched using Google Scholar and key websites such as the Centre for Excellence for Looked After Children in Scotland (CELCIS), the Care Inspectorate and the Scottish Government. Relevant references in identified papers were also retrieved.

Suicide - a cultural and historical background

Attitudes and explanations about suicide vary across different cultures and have shifted dramatically across time (Minois, 1995). This research will be framed by ideas and attitudes drawn from a cultural context with its roots predominantly in Western European thought. Although these have changed over time, we all carry with us the legacy of language, assumptions and prejudices created in societies that are connected to us through our shared histories, but which espoused values and priorities different from those most common today. For these reasons this chapter will provide a brief historical account of how suicide has been understood in Europe and particularly within Britain.

In classical times there were mixed views about suicide. Some philosophers such as Seneca believed that a good suicide could mean '*an escape from the danger of living ill'* (Seneca, 2004, C70). Many others, including Plato, however, saw it as a cowardly crime against both gods and the state except in very circumscribed situations (Plato, 2009). Initially, the spread of Christianity inadvertently encouraged suicide, often through the indirect means of martyrdom as it promised a rapid route to paradise (Bremmer, 2004). This desperate seeking out of martyrdom, however, alarmed early church fathers and in *The City of God (Book 1 Chapter 20)* St Augustine made an unequivocal denunciation of suicide as unacceptable for Christians. In Dante's Inferno (Alighieri, 2006 [1321]) the souls of those who killed themselves were assigned to a lower circle of hell than murderers. This total condemnation remained the church's position for more than a millennium and the bodies of those who killed themselves were often exposed to ritualized humiliation and barred from Christian burial while their families could be stripped of their assets and forced into penury (Cvinar, 2005).

In contrast during the early Middle Ages a very different tradition remained alive in Scandinavian countries – in Norse mythology a violent death was a requirement for entry to Valhalla. Whilst death in battle was the most strongly celebrated, death by suicide was also highly honoured (Alvarez, 1972). As Christianity consolidated its grip on European law and philosophy, however, this perspective of suicide as a courageous act was silenced.

Although renaissance writers, notably Shakespeare, explored suicidal acts and thoughts in their work, John Donne was the first British thinker to challenge explicitly, from a Christian perspective, the belief that suicide could never be condoned (Donne, 1982 [1608]). He was so concerned about the potentially negative reaction to his ideas, however, that he refused to allow his thesis that '*selfe-homicide is not so naturally Sinne,* *that it may never be Otherwise'* (Donne, 1982 [1608]) to be published while he was alive. By the Enlightenment an alternative view of suicide as a rational choice was more openly proposed and the church's attitude frequently questioned. When Montesquieu (1973 [1721], p. 153) asks: '*When I am overcome by anguish, poverty, or humiliation, why must I be prevented from putting an end to my troubles, and harshly deprived of a remedy which lies in my power*?' he poses a question that echoes contemporary concerns about people's right to choose death if life is insufferable.

Some contradictory views about suicide that now exist – courageous or cowardly; a right or a sin – may be rooted in the different cultural traditions and complex history that have contributed to the way suicide has been understood and responded to for over 2000 years. Arguably, the continuing stigma associated with suicide is connected to the disgrace and shame that both Church and State imposed on the act over hundreds of years. It is also, however, clear that suicide remains dangerously seductive if it is portrayed as a pathway to a better imagined place whether that is through jihadist martyrdom (Belanger, et al. 2014) or joining lost family, friends, or celebrity heroes (Kentor and Kaplow, 2020; Keyes, et al. 2021). The development of responsible guidelines on media reporting recognises the potential for glorifying the deaths of those who have killed themselves and encouraging imitation (Sisask and Varnik, 2012).

Outlining the problem -mortality and suicide among care-leavers

The specific literature on rates of attempted and completed suicide among both adult and young care-leavers has been sparse, confusing, and contradictory. Most UK literature refers to suicide attempts, rather than actual deaths, and is often incidental information in research focused on a more general examination of the experience and outcomes of care (Dixon, 2008; Saunders and Broad, 1997). Although there may be some systematic differences between individuals who self-harm or attempt suicide and those who die by suicide, there is clear evidence that both self-harm and suicide attempts are significant risk factors for suicide (McLean, et al. 2008). There is evidence that children in care have elevated risk of suicide attempts and are also much more likely to engage in entrenched self-harm than their peers (Cousins, et al. 2008). Despite these heightened risks, it has, until recently, been difficult to establish whether there is an increased incidence of suicide in the care population, as the numbers involved are so low.

A follow-on study from research conducted in the early 1980s demonstrated a small increase in risk of mortality for adults with long-term care experience as children but the authors acknowledged that with such a small sample it was difficult to draw authoritative conclusions (Bullock and Gaehl, 2012). Of the recorded deaths (7) in a sample of 152 adult care-leavers, only one was a known suicide but another had died of a drug overdose which might now be categorised as suicide.

There is evidence that the mental health of many care-leavers is at risk of deteriorating after leaving their last placement. Dixon (2008) found that within fifteen months of leaving care the percentage of young people reporting mental health problems had doubled. Among another sample of care-leavers, 60% had considered suicide and 40% had attempted to kill themselves (Saunders and Broad, 1997).

Young people die unexpectedly in other ways than suicide, such as murder, road traffic deaths or substance misuse. It can at times be difficult to distinguish between risk-taking or reckless behaviours that end in death and suicides (Gosney and Hawton, 2007; O'Donnell and Farmer, 1995). Until recently no reliable assessment of the premature death rate among care-experienced people existed. Anecdotal accounts suggest that premature death is a serious risk for care-experienced people and that the years following the transition to independence are particularly dangerous. In the absence of more rigorous research there have been attempts to estimate how many deaths of care-experienced people occur compared to their peers. One frequently quoted figure claims the risk of premature death in Scotland is twenty times greater for care-experienced individuals (Dugdale, 2018, p. 10). This figure emerged from Who Cares? Scotland, an advocacy and campaigning organisation for the care-experienced community. Unsurprisingly workers and members in this organisation are more frequently exposed to the deaths of care-experienced people and, perhaps, understandably attempts to use this anecdotal data to estimate comparative risk led to an inflated figure.

There have also been attempts to establish rates of death through Freedom of Information (FOI) requests (Goodwin, 2021; Greenwood, 2017). The figures for deaths of care-leavers obtained for Scotland are shown in Figure 1. The numbers are simply drawn from the deaths reported to the Care Inspectorate. There has always been a requirement to report deaths of looked after children but the legal duty to report deaths of those young people in continuing care or in receipt of after care services was only established by the Children and Young People (Scotland) Act 2014 (Sections 66 and 67). The Act only came into effect in April 2015 and the requirement to report on deaths in either category was only relevant for young people who reached their 16th birthday after that date. Moreover, the reporting mechanism only exists for those young people who are in receipt of a service and some vulnerable young people refuse to engage with social work after they have left care. It will be some years before a more accurate report will be available on the young people who have died before their 26th birthday.

Type of Notification	2014 Jan-Dec	2015 Jan-Dec	2016 Jan-Dec	2017 Jan-Dec	2018 Jan-Dec	2019 Jan-Dec	2020 Jan-Dec	2021 Jan-Sept	Grand Total
Deaths of looked after children	8	3	5	8	9	6	7	4	50
Deaths in continuing care	0	0	0	0	1	3	2	2	8
Deaths in throughcare and aftercare	0	1	6	7	4	12	15	8	53
TOTAL	**8**	**4**	**11**	**15**	**14**	**21**	**24**	**14**	**111**

Figure 1 Deaths of looked after children and care-leavers.

Some local authorities have undertaken reviews of deaths of care-leavers known to them (Glasgow City Council, 2006; North Lanarkshire Council, 2009) which confirmed that the number of deaths was greater than the local average for their peers. Cowan (2008) examined the deaths of 12 Glasgow care-leavers (aged 16-22 at the point of death) which were believed to be suicide. High levels of both substance misuse and self-harm were noted and most young people were neither in employment nor education when they died. Only five young people had received support for mental health difficulties.

There have been other more systematic attempts to measure mortality in the care-experienced population. Two studies using data from the Office of National Statistics Longitudinal Study (Meltzer, et al. 2008; Murray, et al. 2020) identified an elevated risk of mortality that continued well into adulthood. Meltzer, at al. (2008) focused on people who had experienced residential care as children and found they had a three-fold greater all-cause mortality risk than the general population. Similarly, Murray, et al. (2020) reported elevated rates of mortality for young people in all forms of care but emphasised that those in residential care were most at risk. These excess deaths were largely attributable to 'unnatural' deaths such as violence, suicide, accidents, or poisoning. Interestingly, despite the reduction in mortality for the general population since the 1980s, this has not been replicated in the care-experienced population.

Recently there has been important progress in moving to a population-based analysis of deaths in the care-experienced population. Practical and ethical difficulties in linking data held by care and health agencies have been overcome in Scotland through the Children's Health in Care Study (CHiCS) (Allik, et al. 2021; Allik, et al. 2022). All publicly funded school-aged children in Scotland included in the 2009 pupil census were followed up from birth to 2016. Those with care-experience were identified through the Children Looked After Statistics (CLAS) compiled annually. This study has reported on comparative mortality between those with and without care experience. The raw figures suggest that care-experienced young people are five times more likely to die than their peers. When these figures are adjusted for sex, age, deprivation and disability, death rates remained 2.7 times as high for care-experienced children. The largest group of disabilities identified among the care-experienced group was 'social emotional and behavioural difficulties' (SEBD). It is not clear from the report whether there was any distinction made between type of disability in adjusting the relative risks. Arguably, children with SEBD are more at risk of dangerous and self-destructive behaviour which increases the risk of mortality so the adjusted figure quoted for risk in the care-experienced population may be an under-estimate. Three quarters of care-experienced young people were no longer in a care placement when they died, and more than half died after the age of 18. Most deaths in the care-experienced group (68%) were from preventable external causes and almost a third (29%) were suicides. The crude figures suggest that care-experienced young people were 8.1 times more likely to die from external causes than their non-care-experienced peers, and even when this was adjusted for age, sex, deprivation, and disability the risk ratio remained at 6.8 (Personal communication).

Preliminary results of a study exploring mortality among care-experienced people using linked data sets in Northern Ireland also suggest an inflated risk of mortality that persists into middle adulthood - up to age 45 (Maguire, 2020). A cohort of over 1.5 million people born between 1970 and 2015 were followed up between 2015 and 2019. Those who had been in care were more at risk of all-cause mortality than those who had other types of contact or no contact with social services. They were also over six times more likely to die by suicide than those who had no contact with social services. Of the care-experienced almost a third (30%) died of suicide.

Some studies in countries outside the UK have also looked specifically at mortality among those who experienced state care in their childhood (Hjern, et al. 2004; Maguire, et al. 2019). Whilst interesting these findings cannot be easily generalised. Rates of suicide differ dramatically across countries and these differences are even more pronounced in the age groups between 15 and 24 which are the focus of this research. This makes it difficult to identify suicide risks that are specific to the care experience rather than the country of residence. Moreover, systems of care vary between countries so that the groups of young people in the various research studies are not directly comparable. The research does, however, add weight to the proposition that young people who have been in care have an increased risk of attempted and completed suicide.

Some disturbing findings of elevated risk for suicide in care-leavers come from Scandinavia. Hjern, et al. (2004) using a national cohort in Sweden, found that experience of state care was associated with a threefold increase in suicide risk compared with the general population. Although the relative risks reduced when children were compared with children from similar psychosocial backgrounds their risk of suicide remained significantly higher. This work is compelling as the study group includes all Swedish residents born between 1972–1981, according to the Total Population Register, who were also present in the Population and Housing Census of 1975, 1980, 1985 or 1990. There is also a comparative cross-national study currently taking place in Northern Ireland and Finland exploring social services interventions, mental health, and mortality in care-leavers. Preliminary results from Finland suggest that anyone with a care experience is three times more likely to die from suicide than those with no history of care (Maguire, et al. 2019).

These recent population-based studies are expanding the findings from earlier smaller scale cohort studies and are beginning to provide compelling evidence that not only are care-experienced people more at risk of premature death but also that a high proportion of these deaths are suicides. This demonstrates that the concerns of care-experienced people and professionals based on their anecdotal experiences have a basis in objective reality. Despite a substantial research literature on suicide, however, that examines risk factors, protective factors and the experiences and reflections of those engaged in or affected by suicidal behaviour, there is almost no such research that focuses on the suicides of care-experienced individuals. It is therefore necessary to make links between what is known about the experience and pathways of care- experienced people and the broader suicide literature.

Risks and protective factors for suicide

Much research on suicide has been epidemiological – devoted to identifying which factors are associated with a greater vulnerability to completed or attempted suicide and which factors seem to provide some protection (McLean, et al. 2008; Rodway, et al.

2020a and b). By its very nature, however, the approach taken to such enquiry has been a nomothetic one, built on positivist principles, that seeks to find an explanatory model that can be generally applied. This has been undeniably helpful in emphasising the importance of recognising the impact of adverse experiences (Geoffroy, et al. 2014; Wanner, et al. 2012) the significance of previous self-harm or suicide attempts (Cooper, et al. 2005) and the relevance of mental health difficulties in assessing suicide risk (Fleischmann, et al. 2005). In addition, the identification of protective factors such as connectedness to others through family, school, employment, and leisure interests (Flouri and Buchanan, 2002) as well as individual factors, such as problem-solving skills and reasons for living (Everall, et al. 2006), point to potential ways of intervening effectively with people at risk of suicide. This section examines the research which contributes most powerfully to our picture of which factors might be relevant in understanding the suicidal acts of care-leavers.

Adverse childhood experiences (ACES)

Adverse childhood experiences have been linked to premature mortality from many causes. The ACE study (Felitti, et al. 1998) identified a relationship between ten categories of child abuse and household dysfunction and adult deaths from a range of causes, including suicide. This study has become very influential in guiding public policy in Scotland where the government supports the vision for Scotland to become the first ACE-aware nation (2018 The Vision - ACE Aware Scotland). The original study's findings, however, must be approached with caution. It was conducted retrospectively by a large Health Maintenance Organisation on a predominantly middle-class population. Reliance on memories of events and experiences in childhood means the data may overrepresent or underrepresent adversities. In addition, the demographics of this population largely precluded the identification of adversities associated with structural inequality and oppression. The researchers also simply asked about the presence or absence of specific adversities which failed to recognise the impact of the severity of an experience. There is a significant difference, for example, between witnessing the murder of a relative, as happened to three young people whose suicides were the focus of this study and being exposed to a single incident of domestic violence where no severe injury was sustained, yet within the ACE framework they would be reported as equivalent. Moreover, the model fails to identify the factors that protect individuals who have experienced multiple childhood adversities but go on to live healthy and productive lives.

Despite these criticisms the ACE model has been helpful in identifying the link between childhood experiences and later health difficulties and when used for its original purpose in epidemiological research can be useful. The simplistic misapplication of its findings in policy development, however, risks diverting attention away from the social determinants of health and contributing to the discourse of individual and family failure (Walsh, 2020). Most research into the links between childhood adversities and suicide focuses on the individual and their childhood family environment which fails to recognise the wider structural distribution of power and resources that affect all families. Care-experienced people are likely to have experienced childhood maltreatment and family disruption but there is clear evidence that this is likely to have occurred in the stressful context of poverty and inequality (Bywaters, et al. 2015).

Although there is a considerable amount of research that links adversity in childhood to elevated risk of suicide and attempted suicide (Enns, et al. 2006; Geoffroy, et al. 2014; Johnson, et al. 2002), including cross-national surveys and data from longitudinal cohorts, many studies only focus on suicide ideation and suicide attempts, as it is difficult to establish the history of adversity or trauma after individuals have died by suicide. Beautrais, et al. (1996) addressed the difficult problem that the characteristics of people who attempt suicide may differ in important ways from those who die by suicide. She compared a group of young people who made serious suicide attempts with a randomly selected group of controls. Results suggested that the 129 young people making serious suicide attempts were more likely to have experienced childhood adversity, current social disadvantage and psychiatric morbidity than 153 community controls. These factors were associated with severe suicide attempts, both independently and jointly. Although a care background was included as a childhood adversity it was not significantly associated with severe suicide attempt in this group when all childhood adversities were correlated.

This link was further confirmed by a meta-analysis of seven longitudinal studies that identified that all forms of childhood abuse and physical neglect were associated with increased risks of suicidality in adulthood (Zatti, et al. 2017). A later systematic review reiterated this connection though the authors, however, commented on the dearth of literature examining the mechanisms underlying these finding (Angelakis, et al. 2019).

Using data from the British Birth Cohort, 1958, researchers identified prenatal and early childhood experiences associated with suicides up to 2009 (Geoffroy, et al. 2014). Suicide risk was associated with several factors recorded in the first seven years of life. These included prenatal factors (low birth weight, higher birth order, and younger age of mother), higher numbers of emotional adversities (particularly bullying and parental death but also including residential care) and in boys, higher rates of externalising behaviours.

Researchers analysing data from the World Mental Health surveys, across 21 countries with over 55,000 respondents also identified a clear association between childhood adversities and suicide attempts and ideation (Bruffaerts, et al. 2010). Sexual and physical abuse were the strongest risk factors for both onset of suicidal behaviour and its persistence across the life course. Despite most previous research identifying mental ill health as a separate risk for suicide, the association between childhood adversities and suicidal behaviour remained similar even when results were adjusted for lifetime mental health status.

There has also been research examining links between specific childhood adversities and later death by suicide. For example, an historical cohort linkage study of suicide and accidental drug-induced death among medically ascertained victims of child sexual abuse (CSA) found a highly elevated risk of both suicide and accidental death by overdose for individuals with a history of CSA (Cutajar, et al. 2010). Women were more likely to die than men despite the risk of death by suicide or accidental overdose being greater among males in the comparison group. The authors recognised that it was impossible to isolate CSA as the specific cause of later deaths. A long time had passed since the abuse and other childhood adversities may also have been associated with these deaths. Individuals in this study may also have been exposed to particularly severe abuse as most CSA is not reported and is extremely difficult to ascertain through medical examination (Gifford, 2019). Other studies highlight the risks associated with CSA but also identify the risks of all forms of abuse and neglect for later suicidality (de Mattos Souza, et al. 2016; Marshall, et al. 2013). A systematic review of the literature suggested that exposure to the death by suicide of a parent or a sibling during adolescence also increased the risk of subsequent suicide. This risk increased with the exposure to more than one such suicide (Del Carpio, et al. 2021).

Whilst there is general agreement among researchers that child maltreatment increases the risk for all forms of suicidality including death, there is less clarity about the mechanisms by which this occurs. A few studies have explored different pathways from adversity to suicidal ideation and behaviour. For example, Makhija and Sher (2007) explored the links between childhood maltreatment, persistent alcohol misuse and suicidal behaviour. They suggested that alcohol misuse might be implicated in suicidal behaviour in several ways. A family history of alcoholism presents both social and biological threats to children – increasing the risk of maltreatment but also a potential genetic propensity for disinhibited behaviour. Childhood maltreatment can create continuing psychological distress which may increase the likelihood of misusing alcohol to numb emotional pain. Finally, the consumption of alcohol reduces inhibition and makes it easier to contemplate and enact self-destructive behaviours. Alcohol use featured in other studies including one which argued that early onset of heavy drinking led to a four-fold increase in the risk of suicide attempts compared to those whose alcohol misuse began in adulthood (Langeland, et al. 2004).

Researchers have also examined the impact of sustained child abuse on biological and cognitive development and functioning. O'Connor, et al. (2020) identified disturbances in the cortisol release patterns in individuals with childhood trauma who reported suicidal ideation or suicide attempts. They suggest that the prolonged activation of the stress response in childhood might lead to a depletion in the cortisol response which is associated with an increased risk of suicidal behaviour and ideation. The authors, however, also state that the causal mechanism underlying this association remains unclear. Child maltreatment has also been linked to difficulties in developing self-regulatory capacities particularly the capacity to manage impulsivity. In a systematic review exploring the association between childhood maltreatment and suicide through impulsivity, the authors found impulsivity acted as a mediating factor between child abuse and later suicidality (Perez-Balaguer, et al. 2022). More recently a cross-sectional survey of individuals reporting suicidal ideation also found significant indirect effects of childhood abuse on suicidal ideation and well-being through impulsivity and executive function (Rogerson, et al. 2022).

Simkiss (2019) argues for the adoption of an ACES lens with children in the care system as they are likely to have experienced some form of childhood adversity. She acknowledges, however, that there is limited research which explicitly explores the intersection between ACES and care experience. There have, however, been a few studies focusing on single agencies or providers. A retrospective review of all children in one local authority referred for an initial looked after child health assessment between April 2019 and March 2020 found an average of five risks from intrauterine experiences to child and family difficulties (Ogundele and Zaidi, 2020). One study exploring the prevalence of adverse childhood experiences among admissions to a single secure children's home found that residents were more than five times more likely to have over 4 ACES than the general population (Martin, et al. 2021). Similar findings were presented from a study of a large secure and residential care provider in Scotland (Johnson, 2017) which also identified high rates among their residents of all the ACEs identified in the original ACE study (Felitti, et al. 1998). These studies are all small scale, but their findings to some extent strengthen the case made by Simkiss (2019) for the adoption of an ACEs lens in making sense of outcomes for care-experienced people including suicide. There is, however, a danger that focusing too much on identifying ACEs may contribute to a deterministic view, not only among professionals but in children themselves, that children are condemned to fail because of their ACEs. All these studies focus on the adversity experienced by children in their families before admission to care but there is a dearth of studies focusing on the adversities experienced by children within the care system which may also contribute to mortality after leaving the care system.

Self-harm

Research suggests that previous incidents of self-harm and attempted suicide are among the most significant risk factors for suicide (Bostwick, et al. 2016; Yoshimasu, et al. 2008). A prospective multi-centre study in England collected data on all young people presenting with self-harm to the hospitals included in the study (n=5025). At the follow up they found 51 deaths of which almost half were judged to be suicides (Hawton, et al. 2012). Repeated self-harm was significantly associated with increased risk of suicide and self-cutting was more associated with suicide than self-poisoning. The association between self-harm and suicide also appears to exist in the care-leaver population. For example, in their analysis of care-leaver deaths in Glasgow, Cowan (2008) found that most young people who killed themselves had a history of severe and repeated self-harm.

Most people who self-harm or attempt suicide, however, do not go on to die. Indeed, self-harm is an extremely common phenomenon among the adolescent population with community-based self-report studies finding that as many as 10% of young people hurt themselves (Hawton, et al. 2002; Madge, et al. 2008; O’ Connor, et al. 2009). Many young people deny undertaking self-harm with any intent to die. They described a complicated relationship between their reasons for self-harm and the level of their suicidal intent. For many, self-harm was used to relieve intensely painful emotions or to punish themselves, but several young people also said they wanted to die. Many described suicidal thoughts but did not usually hurt themselves intending to die. In contrast, others experienced suicidal ideation, and had even developed a suicide plan, without ever having self-harmed (Kidger, et al. 2012).

The difficult, and sometimes traumatising, backgrounds of children in care places them at greater risk of harming themselves than other young people. Piggot, et al. (2004) found that almost half the children in residential settings in Glasgow had harmed themselves deliberately. Evans, et al. (2017) in a systematic analysis of studies on suicide attempts among children in care suggested that this population was at least three times more at risk of attempting suicide than the general child population whilst Saunders and Broad (1997) found that a third of the 48 care-leavers they interviewed had self-harmed between the ages of 15 and 16. Care-experienced young people are also disproportionately represented among those attending hospital for self-harm (Hurry and Storey, 2000; Storey, et al. 2005). Children in care may be taken for treatment more frequently than their peers but these studies suggest that, despite this potentially confounding factor, they are over-represented in the numbers of young people harming themselves.

Although these studies suggest a high level of self-harming behaviour in the residential childcare population, they fail to illuminate the reasons they hurt themselves. Some researchers, however, have explored the reasons young people give for their self-harm. For example, in an anonymous self-report study, conducted with Scottish children in care, those who self-harmed reported fewer reasons for living and displayed a more self-critical and self-hating view of themselves (Harkness-Murphy, et al. 2013). In another study young people in care described changes of placement as a trigger for self-harm. They explained their self-harm as a coping mechanism for overwhelming anger and a way of gaining some sense of control over their lives. Some also shared their reluctance to seek help because of previous experiences of patronising responses or anxiety that disclosure would lead to restrictive interventions (Wadman, et al. 2017). These studies suggest that self-harm is an indicator of inner turmoil and may in part be a reaction to the lack of control young people have experienced in their lives. Arguably, imposing unnegotiated protective measures may heighten young people's distress and confirm their sense of powerlessness when the risk of death is very low (Furnivall, 2013). Zahl and Hawton (2004) whilst confirming previous findings that repeated self-harm substantially increases the risk of subsequent suicide, also drew attention to the very low numbers of actual deaths and made clear that repeated self-harm in isolation was a poor predictor of suicide.

Suicide and mental health difficulties

As there are numerous studies that link attempted and completed suicide in young people with psychiatric disorders (Flesichmann, et al. 2005; Luoma, et al. 2002), this section will provide a critical examination of this literature before considering research about the mental health of children in care and care-leavers.

A systematic review and meta-analysis of longitudinal and population-based studies suggested that young people with any psychiatric disorder were over ten times more likely to die of suicide (Gili, et al. 2019). Some studies have used psychological autopsy to examine, in depth, the social experiences and psychiatric history of young people who have died by suicide. Houston, et al. (2001), for example, analysed medical records and interviewed key informants to study the suicides of 27 young people aged 15 -24. Retrospective evidence of diagnosable psychiatric disorders was found in 70% of the young people. Some had their diagnosis recorded in their medical history but for others, it was constructed from evidence provided by informants close to the young person. Fleischmann, et al. (2005) approached the problem in a different way by synthesising evidence from 13 studies in seven countries which included information on 894 young people who had killed themselves. Nearly 90% had a psychiatric diagnosis which is much higher than the 10% rate reported in the general population of young people (McGinnity, et al. 2005). The rates reported in both these studies, however, may not be completely accurate as the researchers had to assess the mental state of young people without access to clear information, as a psychiatric diagnosis was not recorded for all those who died. Whilst the processes they described were clear and rigorous they were dependent on secondary information that could obviously not be checked with the person who died.

Many more people attempt suicide than die by suicide (World Health Organisation, 2021) so most studies linking mental health difficulties to suicide focus on attempted, rather than completed, suicide which may not be representative of the experiences of those who kill themselves. Fleischmann, et al. (2005) also reviewed studies focusing on suicidal ideation and suicide attempts. These studies showed similar levels of psychiatric morbidity as those among young people who died by suicide. Similarly, Hawton, et al. (2012) suggest that, while mental disorders may be risk factors for suicide, the rate of psychiatric morbidity is similar between young people who self-harm and those who die by suicide. It is, however, important to consider whether these are distinct populations of young people, and, how far findings for one group are relevant to the other. One study examining the differences between serious suicide attempts and death by suicide in young people, found that one factor that discriminated between attempted and completed suicide was that those who killed themselves were less likely to be suffering from a mood disorder (Beautrais, 2003). She acknowledged this might be an inaccurate finding because of the difficulty in establishing mental health status in those who have died. She also wondered whether depressed mood may limit people's effectiveness in carrying out their wish to die. There were some indications in these studies that the authors recognised that mental illness was only a partial explanation for suicide and other factors were also important.

There is often a complex interaction between the effects of structural issues such as poverty or discrimination, the immediate social and relational context and the individual's internal world and genetic heritage which contribute to the development of mental health problems. Indeed, the rate of suicide differs so dramatically across cultures and societies that de Leo (2002, p. 27) argues that '*social phenomena may have a formidable influence on suicidal behaviours, far more than any other type of event.'* Although this complexity is recognised in some suicidology research literature, there is often a focus on the diagnosis itself rather than the context in which that diagnosis emerged. Implicit within some literature is the belief that increased medical assessment and intervention are the most reliable ways to prevent suicide rather than changes in the relational, social, and structural contexts of people's lives. Schmitz, et al. (2012, p. 301) argue that *'Improving the training and competence of mental health professionals is one of the most logical ways to prevent suicide and save lives.'* In contrast Johannessen, et al. (2011) found that a substantial increase in mental health services in Norway over a ten-year period had no significant impact on suicide rates. There is also evidence from a population-based case control study in Australia that socio- economic status contributed a similar level of population attributable suicide risk as psychiatric diagnoses (Page, et al. 2014). They point out that this suggests that structural and policy changes that affect social conditions may be an important focus of suicide prevention work as well as ensuring easier and earlier access to mental health services.

Although there is a considerable body of research linking psychiatric disorder to suicidal behaviour, it is also important to consider the potentially tautological nature of this evidence Many psychiatric disorders associated with suicidal behaviour include suicidal ideation or self-harm in their diagnostic criteria. When suicidal ideation, attempted suicide or self-harm are symptoms of psychiatric disorder, then psychiatric disorder inevitably becomes correlated with suicidal behaviour. García-Haro, et al. (2020) provided a detailed critique of the over-focus on psychiatric disorder arguing that this confuses a risk factor with psychiatric causality and results in suicide being seen as a symptom or a mental disorder in itself. They also argued that the current medicalisation of suicidal behaviour undermines the essential nature of suicide as an intentional act of an individual in the context of their own life. This is not to suggest that there is no connection between mental health difficulties and suicidal acts, but the medicalisation of distress may mask the importance of relational and societal contributors to attempted and completed suicide (Fincham, et al. 2011). Shneidman (1993, p. 145), who coined the term ‘psychache’ to express the despair underlying suicidal acts, was highly critical of the process he described as the conversion of suicide into depression. He argued that:

> *the multi-billion-dollar drug industry …in one of the most successful philosophic distortions the world has ever seen, has convinced vast numbers of the population that human suffering and thoughts of death are physiological products of a defective organ to be treated by their tailor-made prescriptions’ (Shneidman, 2005, p. 7).*

Hjelmeland and Knizek (2017) claim that the preoccupation with psychiatric diagnosis in the suicidology literature silenced critical voices, especially those of individuals who have themselves attempted suicide. They question the assumption that mental illness is the cause of most suicides, arguing that contextual factors may cause both the wish to die and the mental disorder. Emphasising the link between mental illness and suicide may also prevent some people with suicidal ideation from seeking help (Rasmussen, et al. 2014; Shahtahmasebi, 2015). By locating explanations of suicidal behaviour in individual psychopathology, we may fail to recognise the meaning of interpersonal connections or the power of societal factors in contributing to suicide. For marginalised young people such as care-leavers this can only add to the stigma they already experience.

Despite these criticisms of the intense focus on mental disorder in explanations of suicide, mental health difficulties do seem to pose a risk for engaging in suicidal behaviour. It is therefore important to establish what is known about the mental health of children in care and care-leavers. Mental health problems might emerge at various points in an individual's care journey. The first systematic study in the UK investigating the prevalence of psychiatric disorders among adolescents in care found they had a higher rate of diagnosable mental health problems than a comparison group (McCann, et.al. 1996). Compared to a rate of 15% in the comparison group, adolescents in residential care had a 96% rate of psychiatric disorder. The study was conducted in a single local authority and focused on adolescents aged 13 – 17. The psychiatrists conducting the research noted that many difficulties were previously undetected and that there was a high level of comorbidity. Meltzer and colleagues (Meltzer, et al. 2003; Meltzer, et al. 2004a; Meltzer, et al. 2004b) conducted several studies across the UK that found high levels of mental disorders in children in care though not at such an elevated rate as the McCann study.

A critical review of literature undertaken by Steels and Simpson (2017) suggested that residential childcare can have both positive and negative impacts on children's mental health. The safety and containment of predictable rhythms and routines as well as the availability of several adult role models and potential attachment figures can provide a positive space for emotional recovery and development. These advantages can be undermined, however, if practitioners are insufficiently trained and supported or if policies and procedures prevent the development of deep relationships between adults and children. Moreover, the structures of residential childcare create a continual micro-disruption of relationships through the constant changes imposed by shift working.

There are also risks in bringing together a group of very distressed young people who may adversely affect each other's emotional wellbeing. Mental health difficulties are also exacerbated by frequent placement moves.

Although their care experience may have contributed to some young people's mental health difficulties, studies conducted as children entered the care system point to pre-existing difficulties. For example, Dimigen, et al. (1999) surveyed the mental health of children between ages of 5 and 12 as they entered the care system in Glasgow and found that they experienced a higher-than-expected level of mental disorders. Using a different approach Ogundele (2020) in a retrospective review of health assessments in one local authority found that 70% of children had at least one neurodevelopmental, emotional, behavioural or intellectual problems (average two). Although pre-care experiences may contribute strongly to the mental health difficulties experienced by children in the care system, the assessment and treatment criteria of Child and Adolescent Mental Health Services (CAMHS) often preclude these children from accessing help once they are in care. Children's difficulties may be dismissed as behavioural or too complex for CAMHS as children often meet the criteria for several conditions (Coulter, et al. 2022; Hiller, et al. 2022; Tarren-Sweeney, 2017). Children may also be excluded from a service until they are in a settled placement, despite the reality that their distress and pain can often result in behaviour that continually disrupts relationships and placements (Hiller, et al. 2022; Tarren-Sweeney, 2017). When children are offered a service, they may be offered treatment for their acute presenting problems rather than receiving a holistic service that recognises the complexity of their social and relational context. These difficulties have been noted by several child mental health practitioners who have argued for specialist training for practitioners and the development of dedicated services for this group that can provide an ongoing service that recognises the complexity and enduring nature of their difficulties (Hiller, et al. 2022; Tarren-Sweeney, 2017).

Several studies have highlighted that although high levels of mental disorder have been consistently identified among children in the care system there is insufficient focus on mental health and emotional wellbeing in the move out of care (Barnardos, 2017; Butterworth, et al. 2017; Munro, 2011). There is evidence that the stress of leaving care can exacerbate existing mental health difficulties or trigger new problems. Memarzia, et al. (2015) in a study of adolescents discharged from mental health or care services found that those who felt ill-prepared for their transition were more likely to have a current diagnosis and to have developed a new disorder when they were followed up 12 months after leaving the service. Among the care-leaver group increased General Health Questionnaire (GHQ) scores showed a worsening of psychological distress. No care-leavers had been referred to adult mental health services despite over half having a diagnosable mental disorder.

A more in-depth study of a group of Scottish care-leavers diagnosed with depression during their transition from residential care was undertaken by Amaral (2014). She identified that there was insufficient focus by professionals on mental health in the pathway planning process for those leaving care and that priority was given to practical skills and obtaining accommodation and employment, education or training. Young people, themselves, often conceptualised independence in ways that echoed these priorities – 'material independence' was understood as having a tenancy and an income; 'practical independence' was understood as having the practical skills to look after themselves and 'organisational independence' meant that they had freedom to manage their lives as they wished. Most care-leavers in this study had initially anticipated that their mental health would have little impact on their transition, but they found that their depression often affected their capacity to manage every area of their lives in a negative way. Although the development of depression preceded their move out of care, they experienced a critical deterioration in their mental health when they moved into independent living. A complex interaction between their depression and their social context meant that they found it hard to keep jobs or educational placements, struggled to manage their accommodation, frequently faced poverty and eviction and some responded to their distress in ways that brought them into conflict with the law and a few were imprisoned. The despair they experienced was such that 23 of the 27 young people in the study had self-harmed repeatedly and 22 had experienced suicidal ideation and/or attempted suicide. Excessive use of alcohol or other drugs was also frequently mentioned as a method of coping with their pain.

These findings echo Dixon's (2008) earlier study which also identified the move to independence as constituting a risk for a deterioration in mental wellbeing and noted the potentially negative interplay between mental ill health and difficult and deteriorating social and emotional circumstances. She also, however, identified some care-leavers whose wellbeing was enhanced by a successful and well-supported move and expressed optimism that changes in policy and legislation would increase the systematic focus on mental health in planning processes. By 2019, however, Atkinson and Hyde (2019) in their review of literature on care-leavers' views on their transition, found that many experienced the pathway planning process as a bureaucratic exercise that was inadequate in addressing their needs and for some it was only initiated as they were about to leave care. They also found that many care-leavers felt emotionally and psychologically ill-prepared for independence and that the stress of the move led to a deterioration in their mental wellbeing. Many care-leavers also identified loneliness and the sudden rupture of relationships resulting from their move as contributing to their distress. Sulimani-Aidan, et al. (2022) studied the experience of psychological distress in Israeli care-leavers using a life course perspective. This highlighted the importance of social support from adults and peers, both whilst they were in care and after they left. Lower psychological distress was predicted by the acquisition of skills whilst in care and success in post-secondary education. The experience of deprivation and financial and employment insecurity were associated with greater psychological distress. The authors emphasise that care-leavers' psychological wellbeing was affected both by their subjective experiences and the objective conditions of their lives.

The experiences and mental health history of care-leavers before, during and after their time in care can contribute to high levels of distress as they face the challenges of emerging adulthood (Amaral, 2014). Although there is clear evidence of elevated mental health difficulties including suicidal behaviour in the care-experienced population, these must be understood as intricately intertwined with the social and relational contexts they have endured. Whilst individual care-leavers should be supported to access appropriate mental health support and treatment, it is also important to address the social and emotional context that can contribute to their difficulties. Devaney, et al. (2023) undertook a series of consultative workshops with researchers, practitioners and policy makers, informed by work with a group of care-experienced young people, exploring areas for future research on the mental health of care-leavers. The key message from young people was that

> *mental health is not an isolated aspect of people's lives, or something that impacts a section of people's brains. It is deeply interwoven with individual's whole life experiences, of the past, the present and with anticipations, hopes and worries about the future (Devaney, et al. 2023, p. 4).*

Transitions

Life-course research points out that although life transitions are important opportunities for growth, they are also times of vulnerability. Hutchison (2019, p. 361) identifies:

> *the possibility of at least temporary dysfunction in relationships at times of major transition and suggests that targeted interventions may help to avoid communication breakdowns and stress pileup in times of pronounced change.*

Children removed from their families and taken into care experience a major transition that affects their developmental and social trajectory profoundly. For some that is only the first of many childhood transitions that have a cumulative negative impact on their developmental trajectory and mental health.

The negative impact of multiple moves in childhood was identified by Qin, et al. (2009). They examined medical records for all children born between 1978 and 1995 in Denmark and identified those who had attempted (4160) or completed (79) suicide between the ages of 11 and 17. Compared with a matched sample, these children were significantly more likely to have moved home several times during childhood and/or adolescence. This difference remained significant even when adjustments were made for confounding variables at birth or during upbringing. As the number of changes of residence increased so did the level of risk of both attempted and completed suicide. They suggest that the unrecognised losses of friends and well-known spaces create considerable distress for children. This risk may be even more pronounced for children in care. Most children who move several times accompany their parents and their possessions move with them. Multiple placement changes, often involving a change of school, are common for children in care (Rock, et al. 2015; Ward, 2009). They frequently lose relationships with adult carers as well as with children they have lived with. They are moved from places they know well and can also lose treasured possessions, either by accident or in a punitive withholding by their carers (Ward, 2011). Cashmore and Paxman (2006), however, pointed out that whilst young people's stability in their care journeys was important for care-leavers, other aspects of felt security, continuity and social support were more significant to a successful transition.

A systematic review and meta-analysis also found that major stressful life events are associated with an increased risk of suicide particularly among young adults (Howarth, et al. 2020). The enhanced risk of suicide for individuals moving into or out of a variety of institutional experiences has also been noted in several reports and research studies. Many suicides in prison occur in the early months of incarceration, some within the first 24 hours (Bogue and Power, 1995; Frottier, et al. 2009; Radeloff, et al. 2021) and the increased risk of unnatural death, particularly suicide, among newly released prisoners is significantly higher than for the general population (Phillips, et al. 2017; Phillips and Roberts, 2019). Admission to (Crawford, 2004) and discharge from (Hunt, et al. 2013) in-patient psychiatric care is also associated with a higher rate of suicide than at other points in patients' hospital journeys. Another group that has been identified as having an elevated risk of mental health difficulties and suicide are veterans post discharge from military service (Brenner and Barnes, 2012). Loss of relationships, both personal and professional, as well as difficulties adjusting to a different social environment were implicated in these studies. Brenner and Barnes (2012) noted that proactive engagement seemed to be helpful in mitigating suicide risk. For veterans a program of psychoeducation and preparation for civilian life, as well as clear delineation of routes for seeking support helped to ease the transition. When professionals deliberately reached out to contact patients in the period immediately after leaving psychiatric hospital, expressing concern for their well-being, and reminding them of support that was available, the risk of suicide appeared to be lessened.

The rupture of relationships and abrupt change or role and place that these studies describe are characteristic of care-leavers' transition from care and can have catastrophic consequences. Several studies identify negative outcomes for many, though not all, care-leavers across a range of important aspects of adult functioning such as continuing education or training (Brady and Gilligan, 2019; Mallon, 2005), employment (Furey and Harris-Evans, 2021), mental health (Barnardos, 2017) and family relationships (Biehal and Wade, 1996). Other reports highlight the over-representation of care-experienced people in marginalised groups such as homeless people (CELCIS, 2019), prisoners (Gooch, et al. 2022) and people who misuse substances (Scottish Government, 2021). Care-leavers experience a transition to independence that compared to their peers is typically '*premature, compressed and accelerated'* (Ward, 2011 p. 2512) which along with other childhood adversities may contribute to these negative outcomes. Noting the steady increase in age of young people in the general population finally leaving home as well as the safety net provided by continuing family relationships, Turner and Percy-Smith (2020, p. 1768) comment that '*…care-leavers may therefore be one of the few groups in society subjected to an institutional requirement of independence.'*

Mann-Feder and Goyette (2019) use the theory of emerging adulthood (Arnett, 2000) to explore the challenges faced by care-leavers. This theory suggests that identity consolidation emerges relatively late and that for most people their 20s is a developmental period full of exploration and instability. Achieving an autonomous lifestyle is a gradual, non-linear process that is made possible by a space free from responsibility where affective focus moves to friends and romantic relationships but usually parents are available to provide emotional and practical support when needed. This is in stark contrast to the experience of most care-leavers who are subjected to instant adulthood and who '*miss out on the critical preparation stage, the transition itself, that gives people an opportunity to space out, providing a time for freedom,* *exploration, reflection and identity search'* (Stein, 2006b, p. 274). Hiles, et al. (2013) highlighted the importance of young people having more control over the timing and pace of their move out of care. Law and policy in the UK have shifted slightly in recognition of the damaging impact of the cliff edge shift from childhood to adulthood experienced by many care-leavers. The introduction of 'continuing care', for example, in Scotland, theoretically enables young people to remain in their foster or residential placement until the age of 21 if it is in their best interests (Children and Young People (Scotland) Act 2014). The resources necessary to implement this policy are lacking, however, and many young people still face prematurely moving away from the people and places that could support a more gradual journey to adulthood (Lough Dennell, et al. 2022; McGhee, 2017). A review of literature on the relationships between young people and residential care workers (Welch, et al. 2018) suggested that despite this enabling policy and legislation, longstanding beliefs and assumptions have also impeded its implementation in some organisations.

> *A strong 'cultural norm' that prescribes independent living at age 16 persists among both staff members and young people. This norm persists despite the overwhelming evidence of its damaging effects on the life chances of young people (Welch, et al. 2018, pp. 18-19).*

Work preparing young people for their transition from care has mainly focused on finding accommodation, education or employment and the acquisition of skills. When a care-leaver experiences difficulties in managing the multiple demands placed on them as an 'independent' young person it can be seen as an individual failure rather than a structural or systemic problem. As Turner and Percy-Smith (2020, p. 1766) point out *'the skills acquisition approach to transition necessarily locates deficit within the young person, inadvertently perpetuating a negative discourse.'*

Qualitative research with care-experienced people has identified the need for a strong social network and emotional support during the transition from care (Adley and Jupp Kina, 2017; Butterworth, et al. 2017; Matthews and Sykes, 2012). Rather than a focus on excessive bureaucratic planning (Rogers, 2011) young people need access to a support system that is flexible and adaptable enough to support them to deal with the inevitable setbacks and challenges that every adolescent experiences on their journey to adulthood (Hung and Appleton, 2016; Munro, 2011). Care-leavers often have few people in their informal social network (Adley and Jupp Kina, 2017). When care-leavers report a positive transition from care, they often felt that experiencing sufficient and good support made the difference between a successful and unsuccessful transition. Many care-leavers, however, felt they had had no support or that crucial aspects of support were missing (Hiles, et al. 2013). Loneliness was common and many found it difficult to make new friends who could empathise with their unusual and challenging situation. Existing negative relationships with peers and complex family dynamics also meant that for some young people their social networks were a source of stress and difficulty rather than support (Sulimani-Aidan, 2017). Some young people felt it would have been helpful if professionals had helped them to identify gaps in their support network before leaving care (Adley and Jupp Kina, 2017).

Although the importance of social networks and emotional support were mentioned in many studies it also emerged that offers of support were often met with ambivalence or rejection. The desire to be free from the restraints and control inherent in the care system was often a powerful motivator to reject support when it was offered, particularly if it was perceived to be conditional or contractual (Adley and Jupp Kina, 2017; Barratt, et al. 2020; Butterworth, et al. 2016; Horrocks, 2002). Some young people regretted that they had rejected help when offered, as the reality of the challenges they faced became apparent, but pride, and shame at failure, made it difficult to reach out. A common suggestion was that professionals should proactively and repeatedly reach out to young people expressing interest and concern and renewing offers of support rather than waiting for young people to contact them (Adley and Jupp Kina, 2017; Rogers, 2011).

The literature about young people leaving care demonstrates that this is a high-risk transition, like those described in the suicide literature. The abrupt removal of support, rupture of relationships and the lack of a support network places some young people in a situation where they face social isolation and overwhelming practical and emotional demands that can lead to the type of despair and hopelessness that underlies suicidal thoughts and behaviour (Amaral, 2014).

Resilience and agency

As well as identifying risk factors research, has identified other factors that appear to provide a protective buffer against young people’s suicidal behaviour (McLean, et al. 2008). Some are factors internal to the individual, but others reflect the importance of the social environment. Various studies have identified the importance of resilience as a protective factor against suicidal behaviour. Everall, et al. (2006) for example, found that girls who had previously been suicidal reported that they had stopped their suicidal behaviour through positive thinking and having an optimistic view of the future. They had also pro-actively changed the aspects of their current situation that were causing them distress. Moreover, rather than escaping from their pain by attempting suicide they had learned to manage their feelings more effectively. Similarly, resilience was identified as providing protection against suicidal ideation in a study of homeless young people (Cleverley and Kidd, 2011). The longer they remained on the streets, however, the more this was eroded even in very resilient young people. They questioned whether intense psychological distress, such as that encountered on the streets, may overwhelm the coping mechanisms of young people who might otherwise appear highly resilient.

The identification of resilience as a protective factor against suicidality in these studies, points to the importance of understanding what builds or compromises resilience in care-experienced people. For example, although there is evidence that personal resources and agency of care-leavers affect their transition to adulthood, in the absence of a supportive enough environment, they will still be likely to struggle (Refaeli, 2017). Similarly, even highly motivated, academically capable care-leavers who believed they were responsible for managing their own futures, frequently faced structural or systemic barriers to achieving their aspirations (Cameron, 2018). One study (Schofield, 2017) identified four factors key to positive turning-points for children in residential care; connection, agency, constructive activity, and coherence. These resilience dimensions were associated with being able to make use of the residential care experience and successfully managing the transition out of care. Particularly important was the feeling that staff were committed to being available to them beyond leaving care. This is echoed in Swan, et al. (2018) in their study on relationship-based practice and the importance of a continuing relationship with keyworkers in the transition from care.

Gilligan (2019) identified the interacting factors of opportunities, agency and support that enable young people to demonstrate resilience in their transition to adulthood. He emphasised the power of constructive activities, especially employment and education, in developing a sense of self-efficacy and agency. He also highlighted the responsibility of carers to challenge the discourse of pessimism and negativity around care and to demonstrate their belief in young people's capacities and their support for their aspirations.

Belonging and connectedness

Whitlock, et al. (2014) reviewed the literature on connectedness as a protective factor against suicide among young people. They argue that there are three potential pathways by which connectedness may confer protection against suicidal thoughts or behaviour: intrapersonal responses and processes which mean that an individual experiences being of value to others as well as social affiliation and attachment which may support emotional regulation; being embedded in a variety of interconnecting social systems creating a greater likelihood of collective responsibility and action both in the identification of psychological distress and the possibility of accessing help; being exposed to positive norms and expectations that reduce risky behaviour and support help-seeking behaviour. They emphasise the importance of density and diversity in social networks pointing out that, for socially isolated young people, or those whose primary social network reinforces dangerous or self-destructive behaviour, connection to their restricted social networks can increase the risk of suicide.

The particular importance of positive and involved relationships with parents, as a protective factor against suicide for adolescents who face personal challenges has been found in several studies (Chandy, et al. 1996; Chandy, et al. 1997; Flouri and Buchanan, 2002; Pharris, et al. 1997). These positive effects can be augmented by good relationships in school (Chandy, et al. 1997; Kidd, et al. 2006). In one study young people reported that the existence of a significant relationship with an adult who provided social support had been essential in their recovery (Everall, et al. 2006). All these studies emphasised the importance of the interactive nature of the social processes they reported and suggested that a sense of belonging, and connectedness emerged through a combination of factors, rather than in isolation.

The emphasis on belonging and connectedness in these studies is mirrored in the research literature on children in care and care-leavers. Several studies explore how a sense of belonging develops for children in care and what factors impede or destroy this. Much of this work has focused on foster care rather than residential care but some findings can also illuminate the experiences of children in residential settings.

Ward (2011) showed that many children in the care system experience a series of destabilising discontinuities throughout their childhood which adversely affect their sense of belonging and contribute to difficulties in their transition to adulthood. She identified multiple discontinuities in living places, education, culture and relationships that often began before a child was admitted to care and continued throughout their care journey and into adulthood. A particularly painful and recurrent experience for children was the loss of irreplaceable possessions that symbolised their belonging to people or places. Often this occurred through a failure to recognise the meaning of such possessions and therefore to take measures to protect and preserve them. Many children, however, also experienced the deliberate withholding of possessions, by birth families or carers, and when this happened *'their loss emphasised the extent to which a child or young person was excluded from, or denied membership of, a particular family'* (Ward, 2011, p. 2515). Some children described having their history and existence wiped away, as they were not even allowed to retain any photographs that recorded their presence in a foster family. Ward (2011) suggests that these discontinuities and losses may exacerbate the difficulties that care-leavers face in their accelerated and compressed transition to adulthood. She notes the sharp increases in mental health difficulties and suicidal ideation and behaviour in the period immediately after leaving care and suggests that:

> *young people whose life experience is characterised by transience and loss will have been required to adopt multiple changes of both cultural and personal identities, and this may make it more difficult to retain a sense of their own continuity through time. Constant changes can hardly fail to reinforce the impression that nothing can be expected to endure, including a sense of self-persistence (Ward, 2011, p. 2516).*

Bengtsson and Mølholt (2018) explored young people's narratives of belonging and not-belonging across time during their transition from care to independence. The usefulness of their work can be found in the depth of reflection from the young participants and the focus on temporal change as young people were interviewed on multiple occasions over an extended period. What was revealed was the effort required over years to achieve even a precarious sense of belonging.

> *A key experience for these young people was that belonging cannot be taken for granted but must continually be negotiated and fought for (Bengtsson and Mølholt, 2018, p. 61).*

They emphasised that the sites of these struggles were not necessarily those on which professionals focus or that are supported through public policy.

> *Creating a sense of belonging involves interactions with people and places, revealing struggles that tend to be lost from sight when we focus only on their lack of social networks or on formal transitions into education or employment (Bengtsson and Mølholt, 2018, p. 61).*

They also highlighted the insidious impact of collective narratives of belonging that do not fit with care-leavers' own lives and histories.

> *Powerful collective narratives linking family and belonging have the capacity to stigmatize young people with care experiences (Bengtsson and Mølholt, 2018, p. 61).*

It is not only at the point of transition from care that children must negotiate complex and difficult experiences that challenge their sense of belonging. Emond (2014) in her exploration of children's relationships with their peers in schools, identified both the importance of these relationships but also the difficulties they posed for many children in residential care. They had the potential to be truly reciprocal in a way that few other relationships in these children's lives did because any positive connection was a result of mutual choice, rather than a consequence of their care status. Nonetheless the current and prior experiences of children marked them out as different from their peers.

> *The move into a residential unit meant for some children that they had to change geographical area, leaving behind friendships as well as social and cultural norms and practices. For these children, their difference was felt at a physical and cultural level. Not only were they seen as different from their peers, they themselves felt that sense of difference and the resultant lack of connectedness and belonging (Emond, 2014, p. 198).*

They frequently experienced a continuous tension between compromising their sense of belonging to their families or previous communities and changing or hiding aspects of their core selves to gain acceptance in their current peer group. School is a primary arena for all children to make connections, learn skills and develop a sense of self. Emond (2014) points out that children in the care system, whose adverse early experiences may have impaired their social skills, may face the challenge of navigating this complex task with very little support from the adults who care for or educate them.

Oke, et al. (2013) explored the factors that appeared to engender a sense of belonging in children in foster families. Alongside the resilience, stickability and reparenting skills that carers displayed, a key factor seemed to be the carers' capacity to manage the inherent ambiguity in their role. They seemed to be able to simultaneously claim children as their own who belonged in their family, whilst holding open the reality that they had their own families.

> *Systemically, their idea of 'foster family' appeared to be closed ('this child is ours and belongs in our family') and open ('this child belongs in another family') at the same time. They seemed able to thrive with the role ambiguity often noted as a feature of foster care (Oke, et al. 2013, p. 19).*

They worked hard to preserve children's relationship with their birth parents and maintained an attitude of genuine respect and compassion towards them. This seemed to relieve the children of the pressure created by the conflicts of loyalty that can disrupt placements. Interestingly, there was a sense in the findings, that this type of concurrent claiming and acceptance of previous relationships had to happen out of sight of social workers as though some boundary was being breached.

Biehal (2014) suggests that the drive for achieving permanence that has underpinned much UK policy for children's social care in the last forty years, has, to some extent, neglected the importance of subjective permanency and focused instead on finding an objectively permanent space, where a child could remain throughout their childhood.

Over the last few years there has been a growing policy recognition of the importance of creating conditions where children are able to develop a sense of belonging that can sustain them throughout and beyond their care experience. The former First Minister of Scotland, for example, made numerous public statements that indicated her personal and political commitment to ensuring that care-experienced people have equality, respect and love throughout their lives.

> *To those young people who are either going through or have come through the care system I say this – you matter, you are loved and I promise we will do everything we can to ensure your future potential is limitless (Sturgeon, 2018).*

The setting up of the Independent Care Review in 2016 was in response to the clear message from many care-experienced people that they felt marginalised, unloved, and stigmatised whilst in care and that this had a continuing impact on their sense of belonging throughout their lives. These high-level policy announcements and change programmes, however, can only hope to succeed if we can identify more closely the human experiences and practice decisions that affect care-experienced people's sense of belonging in their childhoods and into adulthood. One concrete initiative that has the potential for creating a significant change has been the increase in the duties and powers that local authorities to continue to provide care and support to young people as they negotiate their transition to adulthood.

The typical age of leaving care in Scotland has been steadily increasing since the passing of the Children (Scotland) Act 1995 in recognition that it was unrealistic to expect 16-

year-old children to manage the demands of adult responsibilities. A report by the Scotland's Commissioner for Children and Young People (2008), however, highlighted that many young people were still leaving care, some to homeless accommodation or bed and breakfast facilities, despite policy stating that young people should be looked after until 18 if it is in their best interests (Scottish Executive, 2004, 1.3 and 1.2). Subsequent legislation made provision for young people to have the right to continuing care in the same placement until they were 21 (Children and Young People (Scotland) Act 2014). This has been variously implemented across Scotland, but many young people have benefited from being able to remain in their homes with people they trust as they navigate their way into adulthood (Lough Dennell, et al. 2022).

Although this extension provides extra time and space for young people to establish a more consolidated identity as a young adult, there are some concerns that this may just move the cliff edge a little further into the future (Field, et al. 2021). Several authors question the focus on independence alone and argue that it would be more appropriate that the leaving care transition is reconceptualised as a move towards interdependence (Mendes and Moslehuddin, 2006; Stein, 2012; Storø, 2018). They identify the importance of identifying and supporting social systems of support, both formal and informal, for young people transitioning out of care, as well as ensuring that they are well-equipped with practical skills. The importance of involving young people in identifying their key relationships, including extended family and peers, that might offer informal support has been highlighted by some authors (Atkinson and Hyde, 2019; Wade, 2008). They also emphasise that professionals should endeavour to support and nurture the whole of a young person's network of relationships.

Although some relationships with peers may cause stress and difficulties, Turner and Percy-Smith (2020) argue strongly for the importance of supportive communities that can both help challenge the negative discourse that can shape poor outcomes and provide spaces where young people can relax together and have fun. Several initiatives in Scotland have helped to foster a sense of community and have offered a positive identity for care-experienced participants. The work of young people from Who Cares?

Scotland (for example) successfully challenged government policy on leaving care and was instrumental in influencing legislation (Milligan, 2021) as well as instigating the Independent Care Review (Anglin, 2019). Care-experienced people were at the centre of this process – sharing their views and taking on key roles in the process of the Review. Such work not only has positive effects on those participating but also provides the wider care community with a more optimistic sense of their own effectiveness and value (Roesch-Marsh, et al. 2023).

Enduring and genuine connections to adults are also important protective factors for young care-leavers. The meaningful continuation of relationships between young people and residential workers can offer a source of stability and support during the transition from care. Until recently, however, such continuing relationships were conducted unofficially and at times were viewed with considerable suspicion (Welch, et al. 2018). In their study on key-working, Holt and Kirwin (2012) noted the engagement skills and emotional commitment displayed by many residential workers in developing trusting and genuine relationships with young people, whose previous experiences with adults had generated suspicion and mistrust. They pointed out that the rupture of relationship that was often entailed in the leaving care process could have a damaging impact on both worker and young person. As Holt and Kirwin (2012, p. 388) suggest:

> *Having engaged the young person successfully and therapeutically in the "relationship dance" … the rhythm and flow of that dance, which developed from the continuity and stability of the keywork relationship is brought to an abrupt finale before either partner in the dance is ready.*

In recent years, however, there has been a shift in research, policy and practice that has emphasised the importance of a relational approach (Steckley, 2020). This has challenged the professional and organisational defensiveness that viewed close relationships between adults and children with suspicion, particularly where they continued beyond the boundaries of a professional role interaction. The Independent Care Review emphasised (2020, p. 19) that:

> *Carers in all settings must be supported to develop caring relationships and know that those relationships must be nurtured. Young people growing up must be supported to have lifelong links with their carers*'.

It is now more common for residential workers to continue to connect with young people both formally and informally well beyond the point at which they leave a particular home. The Why Not? Charity set up an initiative by which care-experienced people can be linked up with people who cared for them to continue a potentially lifelong, reciprocal relationship. (Welch and McGhee, 2018). This project is an example of strengthening young people's networks by identifying 'natural mentors' from existing relationships that have meaning for young people. Natural mentors can be identified from the professional network around a young person but can equally be someone from their extended family or an adult or older peer with whom they have developed more informal connections. Thompson, et al. (2016) in a systematic literature review found that many studies reported improved outcomes associated with natural mentoring. Newton, et al. (2017) added to these findings by including the voice of care- experienced people. They invited focus groups of care-experienced individuals to explore the use of mentoring in the transition from care to prevent depression. What emerged was that some group members had developed natural mentors for themselves within their networks and they had found these relationships transformative. The important characteristics of a successful mentoring relationship that were identified were: that the mentor was accepting and non-judgemental as well as optimistic and able to offer praise; the possibility of a long-term, preferably lifelong, relationship; that the mentor was not being paid for taking on the relationship and that the mentor understood the challenges and experiences of people who had been through the care system. The authors point out that what was being suggested was *'a level of unpaid, open-ended commitment that comes close to what a good parent would offer'* (Newton, et al. 2017, p. 326).

The evidence that belonging and connectedness are protective factors against suicidal behaviour emphasise the importance of efforts to ensure that young people leave residential care with a strong positive network of social support and with minimal disruption of close relationships with adults and other young people. In making sense of the increased risk of suicide among care-leavers it is important that the focus moves beyond individual psychopathology to understanding the relational and societal context they live within.

Searching for explanations

Although the literature on risk and protective factors is extensive it cannot predict which individuals will attempt or complete suicide or when. Moreover, as Douglas (1967, p. 158) points out:

> *...to explain an exceedingly small number of suicides in terms of the external properties which these individuals have in common with huge numbers of individuals in the same society is to argue in a manner that must surely be given the most critical scrutiny.*

This is highly relevant when examining a group such as young care-leavers, who are likely to have several risk factors but few protective factors. Pokorny (1983) showed that, even in a high-risk population, the factors most closely associated with suicide failed to predict those who would ultimately complete suicide. Out of 67 suicides that occurred in a group of 4800 veterans only 35 were successfully identified using the 20 statistically most powerful predictive factors, and, in addition, over 1200 people who did not complete suicide were incorrectly identified. This poses a serious challenge not only for public health specialists seeking to reduce suicides but also for professionals striving to assess the immediacy of danger to individuals and provide appropriate support.

There have been numerous attempts to develop more generally applicable models that explain the process by which distressed individuals move to active suicidal behaviour. Theorists have tried to locate their explanations at every systemic level. For example, Brodsky (2016, p. 86) use concepts from neurobiology and genetics to argue that:

> *early life events interact with neurobiological and genetic factors to contribute to the diathesis for developing psychological and personality traits that are associated with increased propensity for suicidal ideation and actions.*

Whereas Durkheim in contrast argued that suicide rates were determined by aspects of social structure rather than psychological factors. In his classic work *Suicide: A Study in*

Sociology (1951 [1897]) Durkheim set out explicitly to demonstrate that his sociological method, outlined in *Rules of Sociological Method* (2013 [1895]) could be applied to the apparently individual act of killing oneself. He suggests that every society demonstrates its own level of integration (the degree to which individuals are bound together in relationships that expose them to a shared morality) and regulation (the normative demands associated with membership of the group). He describes four types of suicide:

> Altruistic: where customs require suicide for the benefit of others
>
> Egoistic: where the ties that bind individuals are not strong enough to enforce obedience to the norm
>
> Anomic: where the usual ties that bind individuals are shockingly disrupted and there is a lack of regulation – Durkheim would argue that sudden good fortune as well as misfortune can cause such anomie
>
> Fatalistic: where suicide is perceived as the only escape from over regulated situations

Most recent explanations, however, draw on more psychological, individualised explanations. Shneidman (1993, p. 51) after forty years of research and clinical practice with suicide, summed up his understanding in five words 'Suicide is caused by psychache.' He explains psychache as psychological hurt and anguish in the mind or psyche which arises from unmet psychological needs and suggests that suicide occurs when this becomes unendurable. He dismisses the over focus on risk factors such as demographic differences, mental health difficulties, life experiences or previous self-harm, not because he sees these as unimportant, but because this approach fails to understand that it is the desire to escape something experienced as unendurable that leads to the choice to die. Moreover, the constellation of unmet need that evokes psychache will differ for every individual, as will their personal threshold for enduring it. Although Shneidman (1993) moves the focus from clinical symptomatology to individual lived experience his list of potential unmet psychological needs remains too general to reliably identify people who are most likely to attempt or complete suicide.

An alternative psychological model was proposed by Williams (1997 and 2001) and Williams and Pollock (2000 and 2001) which drew on the idea of ‘arrested flight’ seen in animals unable to escape from situations of social defeat to develop the ‘cry of pain’ model. When an animal experiences defeat, then flight is an adaptive way to communicate surrender and survive. If the animal is trapped in the space where the conflict took place this constitutes a much greater danger than the original conflict. Gilbert and Allen (1998) used these ideas of defeat and entrapment to explore the development of depression. They found that such experiences were, indeed, strongly associated with depression and suggested that, although severe psychopathology is not adaptive in modern times, this response may reflect more primitive mechanisms of defence that were once evolutionarily useful. Drawing on these ideas to understand the genesis of suicidal behaviour, Williams and Pollock (2000 and 2001) suggest that suicide is the reaction (a cry of pain as opposed to a cry for help) when faced with a situation of defeat, entrapment and no hope of rescue. Studies comparing suicidal patients or patients who have self-harmed and matched hospital controls have provided some support for this model (Rasmussen, et al. 2010).

A more interactive model, the Interpersonal Psychological Theory of Suicide (IPT) was developed by Joiner (2005) and colleagues (Van Orden, et al. 2010) to explain both the psychological underpinnings of suicide and how people can overcome the drive for self-preservation and enact their desire for death. They outline the notion of ‘perceived burdensomeness,’ where people believe that they are worthless and expendable or that their death will benefit those close to them, and ‘thwarted belongingness’ where there is a sense of alienation and no close connections. They also propose that increased hopelessness will intensify the desire to die. They suggest, however, that these distressing states are not sufficient to overcome the engrained fear of death and commitment to life unless people have acquired the capacity for ‘lethal self-injury.’ This can occur, for example, through repeated episodes of self-harm, traumatic experience or aggression which can both reduce fear and inure individuals to pain, or, through exposure to other people’s suicide which may remove the taboo surrounding violent death. This model incorporates known risk and protective factors as well as providing a convincing route from suicidal ideation to action. Some recent studies have suggested that the components of IPT interact to provide a better predictive power for suicide attempts than epidemiological models based on risk factors alone, particularly among young people (Christensen, et al. 2011; Hagan, et al. 2015). They also found that the acquired capability for suicide remained more static and less amenable to intervention whereas the other factors were more dynamic and could be changed, not only through professional involvement but also by changes in the relational environment.

Drawing on these earlier models, O'Connor and Kirtley, (2018) created The Integrated Motivational-Volitional Model of Suicidal Behaviour (IMV) which is a three-phase model that seeks to understand the pathway from pre-existing risk factors through suicidal ideation/intent to suicidal acts. As can be seen from Figure 2 the model emphasises the importance of experiences of defeat or humiliation that can lead to a sense of entrapment and subsequent suicidal ideation/intent. Importantly, the authors argue that, at various points on this pathway, different psychological or social factors act as moderators of the experiences, making it more or less likely that the individual will move along the pathway to suicidal ideation/intent and ultimately suicidal action. The distinction between the different phases helps to clarify why relatively few people who have multiple risk factors engage in suicidal behaviours.

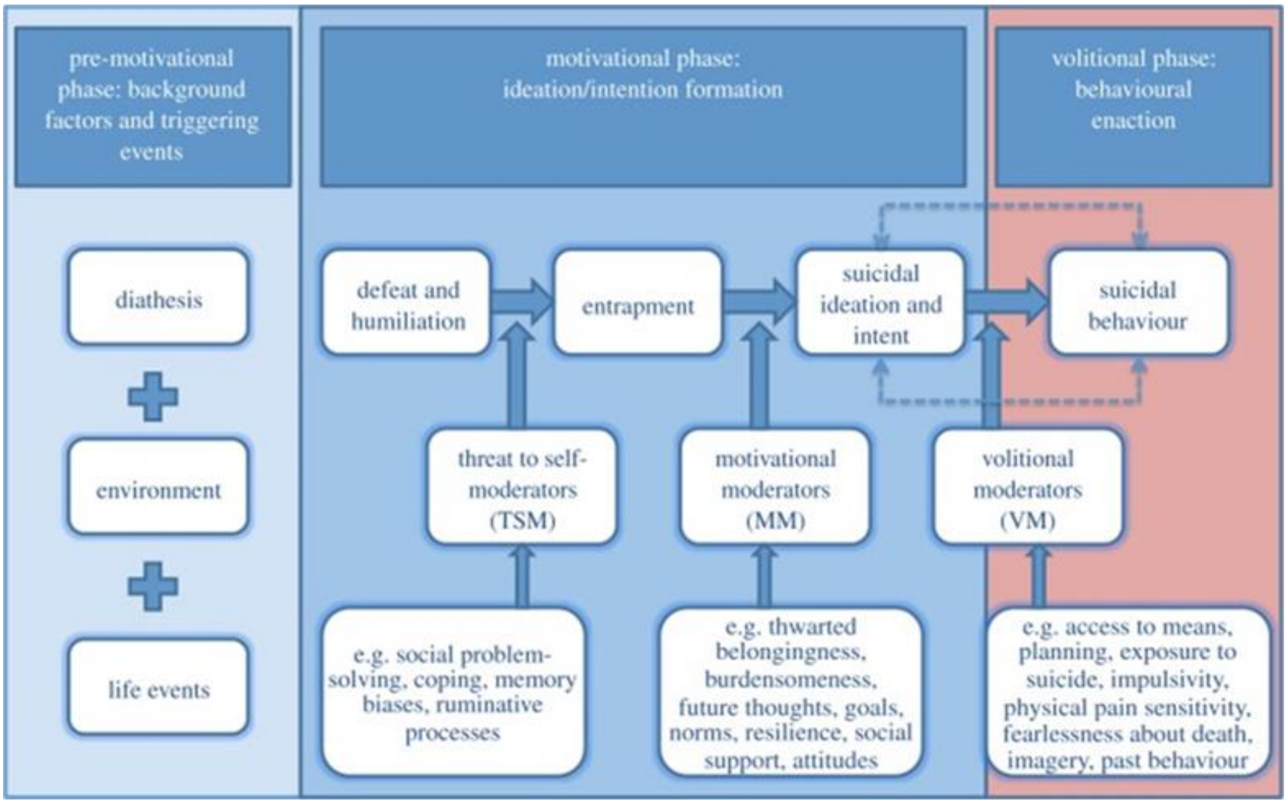

Figure 2 The Integrated Motivational-Volitional Model of Suicidal Behaviour (O'Connor, et al. 2018).

These psychological models help in understanding the process by which an individual might move from ideation to action and are able to incorporate several risk and protective factors. However, there is little recognition in them of the impact of wider social and structural inequalities that can severely constrain the choices available to individuals and contribute to the experience of defeat and entrapment which they identify as a key experience on the path to suicide.

Impact of suicide

This section moves the focus from literature that examines the forces, factors and choices that might impel a person to take their own life, to concentrate on exploring what is known about the impact of suicide bereavement on those close to the person who died.

In examining the literature about the impact of suicide, it becomes clear that because those bereaved by suicide are a heterogeneous group it is difficult to make definitive statements about characteristics that are unique to suicide, rather than other modes of unexpected traumatic death (Pitman, et al. 2014; Sveen and Walby, 2008). Methods that use 'objective' measures of psychiatric symptoms or global functioning, although accurately identifying emotional difficulties, may fail to elicit more nuanced effects of exposure to suicide and can hide the manifestations of distress in individuals as well as their routes to understanding and recovery. For example, Sveen and Walby (2008) in their systematic review of the impact of suicide on the mental health and grief reactions of survivors, identified that evidence of differences between those bereaved by suicide and those bereaved by other modes of death existed more in studies using interviews rather than surveys. Jordan and McIntosh (2011, p. 31-32) point out that '*…findings of "no difference" may be more a reflection of the diversity of survivors, such that actual differences are neutralised when these are combined into a single group for analysis.'* Studies that attempted to capture the more personal effects of suicide, have illuminated the lived experience of stigma, grief, despair (Sugrue, et al. 2014) and the search for meaning (Bell, et al. 2012; Dransart, 2013) as well as exploring how some people have been able to transform loss into growth (Begley and Quayle, 2007; Smith, et al. 2011).

Maple, et al. (2014) in a critical review identified several imitations of the existing literature on suicide bereavement including: concern that research has focused mainly on close kin; that research samples were mainly drawn from individuals seeking help; difficulties in defining who is suicide-bereaved; and determining the size of the suicide-bereaved population. In a later systematic review, they also identified that minority groups and lower-income samples were under-represented and that there was a dearth of intervention/control studies or adaptation of positive examples across contexts (Maple, et al. 2014). Their identification of gaps in the wider research are relevant to this study as some match the gaps that exist in the more focused area of enquiry of this project.

The issues they raised about prevalence and definitions are not only technical they are weighted with meaning about inclusion and exclusion, entitlement, and disenfranchisement. For many years the most widely quoted figure of the prevalence of people bereaved by suicide was that of Shneidman (1972) who estimated that every suicide left six people affected by the death. This was based on no empirical evidence, however, and there have been several challenges to this low figure. Andreiessen, et al. (2017) undertook a meta-analysis of population-based studies examining the prevalence of exposure to suicide. Whilst recognising the variability of data across countries and the differences in research methods and questions, they found a pooled past-year prevalence of 4.31% (CI: 2.50 to 6.58) and life-time prevalence of 21.83% (CI: 16.32 to 27.90). Cerel, et al. (2017) found that in a randomly selected sample of 1,736 adults in the US almost half had been exposed to the death by suicide of someone they knew. From this data they estimated as many as 135 people were affected by every suicide. A much smaller number of respondents had been affected by a suicide in their own families, but the authors argued that it is important to recognise the potential harmful impact of suicide on individuals with different types of relationships with the deceased.

Young people who live in residential childcare settings are likely to live with a group of other children and be cared for by a much larger group of adults. Children may be moved in and out for a variety of reasons and staff too may leave for personal or professional reasons. Many children have multiple placements in their journey through care which clearly involves multiple sets of relationships. Children's homes are emotionally intense environments and young people often have important relationships with adults and each other. Within this context, the impact of the single suicide of a young person may ripple widely across the system affecting many people and quickly reaching the upper estimate of people affected by a suicide suggested by Cerel, et al. (2019).

There have also been several attempts to identify what constitutes suicide bereavement (Andriessen, 2009; Jordan and McIntosh, 2011) which have focused on the degree of closeness of the relationship to the deceased or the perceived impact of the death. Although these have helped to recognise the profound impact of suicide on individuals beyond those with family connections to the deceased, they are less successful at identifying other groups or individuals who may be adversely affected by suicide.

Figure 3 A nested model of suicidal survivorship (Cerel, et al. 2014).

Cerel, et al. (2014) proposed adoption of a nested continuum of suicide survivorship that differentiated between groups of individuals exposed to suicide (Figure 3). In this model categories are represented as subsets of previous ones, with group membership being increasingly restricted by severity or longevity of the effects of suicide. Although this model is helpful to organise thinking about different categories of those bereaved by suicide, it raises questions about who defines a person's category, and whether the long-term bereaved status is one that would be available for those whose relationship with the deceased was perceived to be limited to a time and space that others would prefer to deny and forget. The impact of not being recognised has the potential to exacerbate the effects of bereavement that are outlined in the remainder of this chapter.

Effects of suicidal bereavement

Several studies have identified that loss through suicide can increase suicidality in bereaved individuals. Mothers are at increased risk of suicide after the death by suicide of an adult child (Kessing, et al. 2003) as are partners (Agerbo, 2003; Agerbo, 2005). Bereavement due to any sudden death was found to increase risk of suicidality but this is further elevated in those bereaved by suicide. Parents whose child died by suicide were particularly affected (Hamdan, 2019) but Pitman, et al. (2018) in a cross-sectional study in the UK found that suicide bereavement is also a specific risk factor for suicide attempt among bereaved young adults, whether they were related to the deceased or not. However, the association between exposure to suicide and subsequent risks of suicide is not simple (Miklin, et al. 2019). Although a heightened risk of suicidal behaviour may be evident in some bereaved people for others their exposure to suicide hardened their determination never to take their own life. This suggests that the way individuals make sense of the experience is important. Miklin, et al. (2019) argue that for some the death had made the possibility of suicide a real option to deal with distress and one that they might potentially choose, for others witnessing the traumatic impact of the suicide left them resolved not to inflict such pain on others.

Bereavement through suicide is also reported to be associated with both physical and mental health difficulties. Spillane, et al. (2018) conducted a study of the effects of suicide on the health of bereaved family members. Although there were reports of intense psychosomatic symptoms as well diagnoses of serious conditions that family members believed were stress-related, the most reported health consequences were to their mental wellbeing. This was also true for bereaved children who had a heightened risk of serious mental health problems after their mother dying by suicide (Qin and Mortensen, 2003) as did parents after the death of a child of any age by suicide (Bolton, et al. 2013). Some associations may, however, be the result of genetic or other environmental factors, as there is some evidence that difficulties predated the suicide (Pitman, et al. 2014). Children, for example, who have suffered previous loss or trauma before the suicide are more likely to be adversely affected than others (Christiansen, et al. 2011). Bellini, et al. (2018) in a study exploring the mental health of individuals, recruited from a bereavement support group, who had lost a family member or close friend to suicide, found that over half had elevated scores for a complicated grief reaction, even several years after the death. The participants were already seeking support to manage their grief which may indicate they were struggling more than other bereaved individuals. Nevertheless, the results suggest that for a subgroup of individuals bereaved by suicide, emotional distress can be protracted and severe.

Jordan (2020), reviewing forty years of clinical work with suicide survivors suggests that one distinctive characteristic of suicide bereavement is a high level of guilt. A study of grief in individuals bereaved by the suicides of young people (Bell, et al. 2012) found that guilt and a sense of responsibility were the most common experiences recounted by all those interviewed whether family members, friends, or professionals. The level of guilt experienced was also associated with more severe and prolonged grief reactions (Feigelman and Cerel, 2020; Wagner, et al. 2021). Guilt explained more variance in symptoms among the suicide bereaved than other factors including the type of relationship to the deceased (Levi-Belz and Ben-Yaish, 2022). The capacity for traumatic growth appeared to be reduced by severe and prolonged grief reactions. Levi Belz (2020) suggested that one explanation for this could be that the hope for positive change cannot co-exist with the intense guilt and shame often associated with complicated grief reactions.

Not only do those bereaved by suicide have to deal with their own grief and distress they are also exposed to the reactions of others which can compound their difficulties. Cvinar (2005) in her examination of stigma experienced by families of those who die by suicide, reminds us of the extreme response towards suicide and those bereaved by suicide in The Middle Ages.

> *…human suicide corpses were regularly mutilated to prevent the unleashing of wandering spirits from affecting the local community. This destruction of the corpse was often so extensive that survivors of the suicide victim were unable to collect sufficient remains to meet conventional norms for burial… Property was regularly confiscated and put in possession of the local regent. Beyond this loss of property rights, families were commonly ostracized and frequently denied any support from the community (Cvinar, 2005, p. 14).*

Although such public humiliation and family punishment no longer exists in the same way, families still regularly report their experience of stigma and the powerful impact it can have on their recovery from their loss. They describe being blamed for the death of their family member, experiencing pressure to remain silent, avoidance by significant others and a sense of being contaminated and dangerous (Goulah-Pabst, 2021; Peters, et al. 2016). Three particularly strong experiences stood out in the responses that parents whose child had died by suicide experienced from significant others (Feigelman, et al. 2009). They were often met with a 'wall of silence' about their child; there was an absence of care about their wellbeing despite the devastating nature of the loss; and they were offered unhelpful advice suggesting it was time to 'move on.'

Despite the powerful feelings of stigma that suicide survivors report, some studies found that their experience is not significantly different to that experienced by those bereaved by other traumatic deaths (Feigelman, et al. 2009; Hanschmidt, et al. 2016). It is possible that survivors of many types of traumatic loss evoke primitive anxieties that face those around them with their inability to avert sudden death and that this results in the judgemental attitudes and avoidance that suicide survivors report (Chapple, et al. 2015; Dunn and Morrish-Vidners, 1988; Peter, et al. 2016). This may interact with the guilt and shame that suicide survivors already feel, in a particularly damaging and circular process that traps them in an isolated and painful space where they are more likely to suffer a complicated grief reaction (Chapple, et al. 2015). In addition, uncertainty about the appropriate responses to suicide and other traumatic deaths may contribute to the insensitivity displayed by individuals in survivors' social networks which may have been experienced as stigmatizing (Azorina, et al. 2019; Dunn and Morrish-Vidners, 1988).

Pitman, et al. (2018) found evidence of a persistent death taboo about sudden death, with all their interviewees experiencing a degree of social awkwardness and many of those bereaved by unnatural deaths reporting being blamed and shamed. Some recognised that their perceptions might be affected by their own distress and self-stigmatisation. The negative reactions encountered by those bereaved by suicide, however, were particularly intense. They reported extreme embarrassment (their own and others), avoidance by people they would have expected to demonstrate empathy, intrusive levels of pity, and very little support. In addition, the authors suggest that, despite the shared experiences of stigma among those bereaved by sudden death, self-stigma may have caused these negative responses to have been experienced more acutely by those struggling with a death by suicide (Pitman, et al. 2018).

Most research into stigma around suicide has relied on the reports of those bereaved by suicide which provides no real sense of whether a lingering stigma remains attached to the act itself. As the historical, cultural, and religious context around suicide varies widely across and even within societies it is difficult to make any definitive statements about current views of suicide even within the UK. One study, however, exploring young people's perceptions of suicide identified a process of 'othering' of people who attempt or die by suicide. One way in which young people made sense of suicide was to explain it as something associated with people different from them, for example, 'y*ou'd expect druggies and all really low people to commit suicide*' and '*something that doesn't happen in normal families*' (Roen, et al. 2008, p. 2092). Whether or not suicide survivors face actual stigma, however, there is no doubt that the perception of stigma exists and can have a negative impact on recovery from suicide bereavement (Feigelman, et al. 2009; Oexle, et al. 2018; Pitman, et al. 2018). The silencing effects of suicide stigma may explain the process by which perceived stigma interferes with recovery (Oexle, et al. 2018). Some studies have linked the capacity to be open with others about suicide-associated distress with reduced grief complications (Feigelman, et al. 2018) and increased post traumatic growth (Levi-Belz, 2016).

Sense-making

The need for those bereaved by suicide to make sense of and find meaning in the death emerges in many studies (Carlon, 2022; Dransart, 2013; Mayton and Wester, 2019; Silven Hagström, 2019). For example, Dransart (2013) identified that suicide confronts survivors with a complete collapse of their assumptive world. She identified three main processes they engage in: sense-making, memory building and meaning-making.

Survivors often strive to develop an account and explanation to help make sense of what happened. They may revisit the time leading up to the suicide or talk to others who knew the deceased to help create a more complete picture. They may also begin to discover and accept aspects of the person they had not known about. In the process of memory-building there is an attempt to create a whole life-story which incorporates the suicide but avoids the person being solely defined by it. Four processes were identified in the quest to make existential meaning. Some survivors developed a strong personal commitment to others, often discovering a passion to prevent future suicides. Others experienced an internal transformation in their attitude to life and their personal priorities. Although they looked for plausible explanations, a few were not expecting to find personal meaning and growth in the suicide. For them it meant they had already faced the worst and could now deal with anything. Some were unable to find any meaning in the suicide only pain and emptiness. Their memories of the person who had died were permanently damaged by the suicide and they were unable to move beyond it.

An inability to find meaning in violent death was implicated in the development of complicated grief (Currier, et al. 2006). The same authors suggested that pre-existing negative belief systems may be linked to greater distress in bereaved individuals (Currier, et al. 2009). However, Supiano (2012) described a group work intervention designed to support the process of meaning-making and recovery from loss for suicide survivors where sharing experiences with others seemed to provide healthy challenge to such damaging assumptions.

Hidden suicide bereavement

Although this literature offers multiple ways to understand the impact of suicide there remain serious gaps in its scope which reflect societal assumptions about the meaning and importance of relationships (Maple, et al. 2014). Most work has focused on the effects of suicide within families, in particular the loss of a spouse, parent, child, or sibling (Agerbo, 2003 and 2005; Bolton, et al. 2013; Kessing, et al. 2003; Qin and Mortensen, 2003). The impact on professionals of the suicide of people they worked with has been explored to a lesser extent and has concentrated mainly on mental health professionals dealing with the death of a patient (Gulfi, et al. 2010). Plakun and Tillman

(2005) describe the double bereavement experienced by professionals dealing with the suicide of a client – not only do they experience the loss of a therapeutically intense involvement but their relationships with colleagues and their own professional identity can be adversely affected by the experience. Clinicians interviewed by Hendin, et al. (2000, p. 2022) described the suicide of a client as '*the most disturbing event of their professional careers.'* Their grief was seen as unprofessional or illegitimate and for some had an adverse impact on their therapeutic work and clinical decision making (Gutin, et al. 2011). Suicide of a patient evoked profound emotional responses (Malik, 2022; Morrisey and Higgins, 2021) that were considered more overwhelming than those in response to other sudden deaths (Draper, et al. 2014). The quality and intensity of the therapeutic relationship, both negative and positive, were associated with more negative effects. Feeling responsibility or guilt about the suicide because of professional failure, real or imagined, also heightened the distress practitioners experienced (Malik, 2022; Sandford, et al. 2023). Some studies reported that practitioners felt they could only grieve in private (Malik, 2022) and noted the absence of effective institutional support (Dransart, et al. 2015; Morrisey, 2021).

There is also a limited literature focusing on the experience of social workers losing a client through suicide. Strom-Gottfried and Mowbray (2006) reviewed the literature on social workers bereaved by any type of death in their work examining factors that impacted most severely on grief. They identified that *'those caregivers are most at risk who experience successive losses, "premature" deaths, such as those of child[ren], and sudden or violent deaths, as occur through suicide or homicide'* (Strom-Gottfried and Mowbray, 2006, p. 9). They also emphasised the importance of institutional support and opportunities for review and debriefing. Opportunities to participate in public mourning and memorial rituals such as funerals was found to be important, but they also raised the possibility of creating other memorial rituals within organisations.

The experience of people who are intimately connected through family-like bonds to suicidal individuals has also remained largely unexamined. In exploring the suicide of care-leavers there is a gap in understanding about the experiences not only of young people themselves but also of their “families” including carers, siblings and peers who have shared their living space. The only literature that could be found that specifically focused on the impact of death on residential childcare workers were deeply personal accounts of dealing with the unexpected loss of a young person. Chalupa (2016, p. 173) described the intensity of emotion evoked in her by hearing about the accidental death of a young man she had known well.

> *I cried for hours after reading the email, and each time I gained control over my emotions, I would recall a memory that I would try to suppress as I tried to focus on my preparation for the next day at work. I felt guilt for how much I obviously cared about this young man; I felt my grief was excessive. So many times I had been told throughout my career to have professional boundaries; had I lost objectivity? Do boundaries mean not to care or love the youth in our care?*

This extract highlights both the depth of grief she experienced but also the profound uncertainty about whether this grief was legitimate. It was only in discussion with a previous supervisor that she could let go of this ambivalence and accept that her loss was both real and worthy of grief.

An anonymous article in the International Journal of Therapeutic Care, written about a young woman’s death, displayed similar levels of grief and loss but was suffused with guilt and anger as the author felt at some level complicit with an uncaring and abusive system.

> *I am now aching for the wasted potential, angry that her identity and heritage were taken from her at the beginning of her life and, feeling inadequate, that the system, of which I am a part, was ineffective in addressing this injustice…. I remember the banality of planning meetings, bartering over the extent of the resources that would be afforded to her, reduced to the lowest possible price, when the urgency of a high level of support was pressed with a prophecy of a premature death, those of us that cared for her were shamed with accusations of melodrama, over-attachment and lacking the appropriate objective professional perspective (Anonymous, 2015).*

While there is some evidence of the powerful impact that the suicides of close friends can have on adolescents and young adults (Bartik, et al. 2020) the meaning and importance for care-experienced people of losing someone they lived alongside as they grew up in care is totally absent from the literature.

Conclusion

This research had two different though connected aims: The first was to invite participants to share their thoughts and reflections about why the young care-leavers they had known had died; the second was to explore the impact of the deaths on them. This chapter has sketched out the research landscape where the suicide literature intersects with research focused on residential childcare. As the literature that addresses both subjects together is so sparse it has been necessary to expand into contiguous territory and make links to the wider care and suicide literature. This has made it more possible to clearly outline the gap in knowledge this thesis begins to fill as well as strengthening and informing the conceptual frame that holds the data.

In engaging with the literature, it was at times difficult to resist the pervasive focus on the individual that permeates much literature and retain an awareness of wider structural and societal factors that are central but often hidden in policy, practice and research around both suicide and residential childcare. The importance of belonging and the pain of exclusion cut across both the care and suicide literature and clarified both the vulnerability of young people as they leave the care system but also possible routes to positive change.

Chapter Three: Methodology and Research Methods

This chapter outlines the methodological approach used in this research. It begins with a reflexive consideration of the personal drivers that led me to focus on the suicides of care-leavers and then moves on to explore challenges I faced in taking on the researcher role. The ontological and epistemological positions from which I approached the study are explained and linked to my reasons for adopting a qualitative design. This leads on to an exploration of the specific methodology I adopted. The ethical issues specific to this study and how these were managed throughout the research process are then considered. The chapter then moves into an exposition of the various stages of the research process, exploring the decision-making processes that affected the course of the study with a particular focus on reflexivity. Finally, an introduction to the data chapters is provided.

My Position: The Impact of Personal and Professional Experiences

Heidegger ([1927] 1962) suggests that we encounter and interpret all phenomena with pre-existing structures of understanding – our fore-having is the background pre-understanding we have from past experience; our fore-sight is the perspective from which we enter the situation; and our fore-conception is an anticipated sense of how we will interpret a phenomenon. These constitute part of the hermeneutic circle. He argues that if we seek to study any phenomenon we must work on these fore-structures of understanding to ensure that we uncover what lies beneath the surface and is less visible and avoid reiterating what is already known.

Included in these fore-structures of understanding are the personal biographies of researchers and their potential effects on both the choice of research subject and the way research is conducted. Many researchers are drawn to explores issues that have personally affected them (Berger, 2015; Letherby, 2000) and they highlight the importance of a transparent acknowledgement of their own story. Even where there is no such direct motive for undertaking research, personal experiences can affect how researchers make, understand, and retell the stories of others. As Katz-Rothman (2007, p. 15) argues:

> *… we take the personal and place it in the context of the social; we face troubles and consider issues. Our work of sense-making is a basic human job, done traditionally through storytelling… Our ethical obligations go beyond what we owe our subjects – as urgently important as it is to protect them, to preserve their privacy and their feelings. We owe something too, to our readers and to the larger community to which we offer our work. Among the many things we owe them, is an honesty about ourselves: who we are as characters in our own stories and as actors in our own research.*

Personal and professional experiences were the main motivating factors in undertaking this research and they also influenced my decision making about the conduct of the study.

For nearly a decade I worked in a therapeutic community with very distressed and traumatised adolescents. Sometimes the burden of their pasts and the pain of their current relationships meant that they managed their distress through self-harm, and a few made serious suicide attempts. It was there that I worked with Andy – I was his keyworker, and we had a very strong relationship lasting almost six years. He was intelligent, funny, loving, and reflective but he also experienced times of profound despair and loneliness, as well as being terrified by his own potential for violence. His funding local authority withdrew financial support, and he left the community. Shortly thereafter he returned and hung himself in the grounds. The impact of his death on me, his peers, my colleagues and his family was huge and the loss remains with me many years later.

I have also worked intensively with many residential workers who have faced the suicide of a young person. Shortly before commencing this research, I led a programme of training events focusing on self-harm and suicide. It consistently emerged that the impact of young people’s suicides on practitioners was a common, but overlooked, problem. Along with the inevitable shock, loss and grief associated with suicide, these workers often experienced bewilderment and confusion and appeared to be left with an intensified anxiety in working with other young people who demonstrate risky and self-harming behaviour.

My Role as a Researcher

The personal and professional experiences outlined above affected what I brought to this research and underpinned my motivation for undertaking it. Having experienced the direct loss of a young man to whom I was close, I bring my own grief and search for meaning to this project. I also carry indirectly the pain and distress of those workers I have supported through such losses, and I recognise the risks to their long-term emotional health and capacity to practise in a relational way. I hope to create a shared understanding of the meaning of suicidal acts that can enable practitioners to continue to provide deep, personal engagement with young people in their care, without being permanently damaged by their exposure to suicidal behaviour. Every intentional death of a care-leaver that I hear about is painful for me. It leaves me questioning my profession and the power and purpose of a system that is designed to protect children yet cannot provide sufficient reason for some to remain alive into adulthood. While acknowledging that it may be irrational to believe that all these deaths were preventable, cumulatively they reflect our shared failure and, for me, demand to be understood and represented.

As a researcher in this area my position is not only complicated by my personal and professional experiences but ambiguous, as I am both insider and outsider. Feminist research, such as that undertaken by Gayle Letherby (2000), has emphasised the importance of researchers situating themselves clearly and acknowledging openly the personal factors they bring to the study of any topic. I share the belief that complete objectivity is illusory and moreover that undertaking research that has personal meaning for the researcher may uncover different, but equally important, information, from that approached from a less involved stance (Chammas, 2020; Letherby, et al.

2013; Stanley and Wise, 1990). In his exploration of the challenges of practice-near research, Cooper (2009, p. 438) argues that:

> *emotional experience and epistemology seem to me to be inextricably entangled in this kind of research …good practice-near research seems to me to depend upon subjectivity and emotional engagement with the object of research.*

This lack of distance does, however, complicate the process and requires a rigorously reflexive approach to ensure that personal involvement does not distort or overwhelm the meaning of participants' experiences. Cooper (2009, p. 438) emphasises the importance of emotional and mental flexibility as a safeguard '*against the prejudices and distortions of the researcher's passions.'*

Feminist researchers over the last 50 years, however, have challenged the illusion of value-free research and have argued the merit of being a part of a community of interest (Letherby, 2000; Stanley and Wise, 1990). They argue that acknowledging and addressing these complexities and working reflexively can be an important position from which to work (Berger, 2015; Chammas, 2020; Katz-Rothman, 2007; Letherby, et al. 2013). In undertaking this research, I have attempted to work in a 'value-explicit' way as described by Letherby, et al, (2013) drawing on the concept of theorised subjectivity. This involves an acceptance of subjectivity as inevitable but also a commitment to work consciously to understand and interrogate it.

In this project the participants and I also brought multiple relevant roles and identities to our encounters. My professional background and my personal experience of loss qualify me to some extent as an insider in this research, but I am also quite clearly an outsider too. I have striven to recognise and remain aware of this ambiguity on a moment-by-moment basis. This involved an active reflexive process before, during and after every interview, with a particular focus on the meaning of information that was shared at different points. I endeavoured to manage this complexity by adopting an open and transparent acknowledgement of my professional background and motivation for undertaking the research while maintaining a clear commitment to the role of researcher. I took care not to claim a special understanding of what happened to participants or their feelings and responses. In the information sheets I acknowledged my professional background but not my personal motivation for undertaking the research. My intention was to explain this if any participants directly enquired about my own experience of working with suicidal young people, but no-one did. I also considered sharing my personal experience with all participants from the outset, to reduce the power inequality inherent in the relationship between researcher and researched, particularly when exploring sensitive subjects. On balance, however, I decided that this might suggest an unnegotiated familiarity and sharing of pain that could cause additional distress to participants. Berger (2015) described the constant struggle around when and how much to disclose when undertaking insider research. Whilst self-disclosure can enable participants to share at a greater depth it may lead to the researcher imposing their own experience on participants or even create a feeling of comparison or competition. Moreover, the attempt to address power inequality through self-disclosure may increase the danger of participants sharing more than they later feel comfortable with (Hesse-Biber, 2007).

In their review of qualitative social work research articles, Gringeri, et al. (2013) identified that only a small minority of authors reflexively examined their own positionality and even fewer addressed power issues in the research process. This absence of reflexivity risks researchers inadvertently causing harm both during the data collection process and in the way results are disseminated.

In undertaking this study, I was aware that my history and various identities might adversely affect the experience of participants and that a reflexive approach was essential throughout the research process. For some participants I was aware my professional background might bring traumatic memories and a legacy of suspicion and distrust. Not only am I an outsider, but I may also be perceived as an enemy or an oppressor – a representative of the social work system that caused them distress. Some children still suffer abuse or neglect in residential care (Biehal, et al. 2014) and many parents and other family members experience continuing pain and stigma because of the removal of their children (Schofield, et al. 2011). For the families of care-leavers who have died, this distress may have been exacerbated by the perceived failure of professionals to protect these young people. I had to be aware that for these participants their interactions with me might be affected by the identities we both brought to the interview.

This complexity has been acknowledged by Kazmierska (2004) in considering the implications of German researchers interviewing victims (Jewish survivors) of the Second World War. This does not preclude undertaking research from these positions but the special nature of such interviews and the meaning they may have both for participant and researcher should be recognised. In particular, understanding the experience for some participants of power, agency, and confidentiality in relation to the social work profession highlighted the importance of a continuing dialogue about consent and the control of information. Many care-experienced people and their families have become used to their personal information being shared without their consent and having no control over how it is used in decision making that affects their lives. It was therefore important that it was made clear that consent was a continuous process throughout the interview and beyond.

I share a professional background and an experience of profound loss with the practitioners who participated in the research, but at that time I also held an influential role within the sector that could potentially have affected their engagement with the research. The complexity introduced by such connection and power dynamics does not exclude the involvement of workers in the research, but it is important to acknowledge that the identities and assumptions that we brought to the encounter will have affected how the interviews progressed (Letherby, 2000).

Theoretical Underpinnings

In considering the theoretical underpinnings of this research I need to outline my ontological perspective and my epistemological approach as they guided my choice of research paradigm. Ontology refers to assumptions about the fundamental nature of social reality and the existence or otherwise of objective social facts (Mason, 2017). Epistemology is concerned with what constitutes valid knowledge and how it can be gained (Letherby, et al. 2013; Mason, 2017). A logical research approach requires congruence between ontological positioning, the chosen epistemology, and the research questions to be addressed. Moreover, these need to link coherently with both the theoretical basis of the chosen methodology and the theories and concepts used as a lens to analyse data (Mason, 2017).

The questions I seek to address, and my account of my own position make clear that my ontological perspective in this research is a broadly subjective one. The meaning and experience of the suicidal acts which are the focus of my research were different for all the participants. Even among individuals who experienced the same event-such as the suicide of a particular care-leaver- the 'fact' of this death may be constructed in a variety of ways and the meaning may be different for all (Fincham, et al. 2011). My understanding of the events explored in this research is profoundly affected by my own role, previous experiences, and knowledge. Moreover, the research process itself may have affected the way participants construct the reality for them of what happened. Not only is there not a fixed and observable reality to be discovered but understanding and meaning are fluid and may shift over time or in different contexts. This is not to deny that real events took place – young people did die – but the intention of the research was to explore in depth the meaning of these events for different participants and this could not be established from a traditionally objective perspective.

Nevertheless, this is an academic endeavour, and the purpose of the research is to build knowledge that goes beyond the description of individual experience and that avoids the trap of total relativism (Letherby, et al. 2013). I am also aware that wider social factors may have affected the choices young people made as they struggled with their internal distress. Participants all share an involvement with the care system, whether as service users or as practitioners, and this context is a social reality with an observable legal, policy and practice base, albeit one that has evolved over time and is experienced differently by all those affected by it. Moreover, the care system is the product of a society that is structured in a particular way which privileges some groups over others and defines certain values, norms, and expectations as acceptable (Garrett, 1999). These social realities may frame or constrain both the choices of care-leavers and the meaning that their acts have for them and those around them. Through this research I have therefore attempted to understand the intensely individual act of choosing to kill oneself, by exploring with participants the social context in which such choices took place. I also sought to understand the social and emotional consequences of one person's choices on others around them. This endeavour therefore required me to draw on both psychological and sociological theory to help make sense of this intersection between the individual and their environment. Many key concepts I use to explore the experiences of participants and the care-leavers who died, such as belonging (May, 2013), disenfranchised grief (Doka, 2002) and stigma (Goffman, 1959), only make sense in this space between self and others.

In acknowledging the subjective perspective that underlines my approach I do not deny the importance of striving for objectivity. Clearly, my purpose in choosing this area of research came from a professional interest and concern about the suicide of care-leavers and, as such, is not objective. In seeking the truth of participants' experience, however, I have had to remain open to thoughts and perspectives that challenge or overturn my own assumptions. Moreover, to examine and interpret the connection between the individual experience and the social context, I drew on existing literature describing that context, and on theoretical concepts that can provide a lens for exploration. Although ultimately the choice of literature and concepts and the analytical use I make of them is mine, this requires a rational approach that is transparent. Williams (in Letherby, et al. 2013, p. 73) argues that '…*Objectivity, like any values, will always be situated' and that we '…must assess objectivity in its context.'* He argues that in the pursuance of truth we should seek correspondence with reality but that inevitably we approach our research from a particular perspective. While striving for objectivity is *'a necessary ingredient of good investigations'* (p.75) it may not always be possible to achieve it.

In health and social care there is a strong focus on developing a rigorous evidence-base to build practice and, within such research, a quantitative positivist epistemology is often privileged, as it is perceived to provide more generalizable findings (Milner, 2014). Indeed, Rogers and Lester (2010) argue strongly for just such a quantitative approach to understanding suicide. Although such studies provide extremely important information to guide policy and practice decisions in health and social care (Hawton and van Heeringen, 2000) they inevitably lose sight of the complexity and richness of individual experience (Shneidman, 1998). The research questions addressed in this study focus on the meaning and impact of suicide. Such issues cannot be studied from a positivist epistemological position which requires measurable and standardised data collection. Moreover, the importance of exploring personal narratives to understand many challenging health and care issues facing us, can be overlooked in this approach (Ziebland, et al. 2013). So much is known about the general risks for completing suicide (McLean, et al. 2008) but so little is understood about the individual decisions that people make when they choose to kill themselves (Joiner, 2005). As Alvarez (1972, p. 95) points out, we owe the dead something more: '...*all that anguish, the slow tensing of the self to that final, irreversible act, and for what? In order to become a statistic.'* Similarly, a quantitative approach to understanding the impact of suicide bereavement may neutralise nuanced differences among the bereaved and conceal diversity (Jordan and McIntosh, 2011). The epistemological position adopted in this study is, therefore, an interpretive one, taking an in-depth qualitative approach.

Initially I had considered Interpretive Phenomenological Analysis (IPA) as a methodology. IPA is an idiographic, inductive qualitative methodology that aims to explore the richness of individual experience within the specific cultural and relational space where it is located (Smith, et al. 2009). It employs an iterative, analytic approach to generate themes first within the individual data and only then across the wider data set. This contrasts with some qualitative methods such as grounded theory where a coding frame is developed and then used and expanded with each new data set until data saturation is achieved. The attraction of IPA was that it respects and preserves the uniqueness of individual experience while enabling some comparison between participants to reveal the essence of the phenomenon under study. The final total of participants recruited for the study, however, significantly exceeded the recommended maximum for an IPA research project which made the data very unwieldy and using IPA would have been very time-consuming. Moreover, although I was drawn to IPA because of its intensive focus on individual stories and experiences, in this research these narratives were saturated with pain that echoed my own personal and professional experience. I was also analysing the data during the pandemic when there was a global preoccupation with premature death which also resonated with the content I was wrestling with. I was also asked to provide support to staff from a local authority where two young people had died by suicide just before lockdown. These intersecting experiences made engaging with the already distressing content of the research data almost impossible, and I found myself avoiding the analytic task. I came to realise that reflexive thematic analysis (TA) (Braun and Clarke, 2006 and 2019) could help me to reconnect to the data in a less painful way.

Nevertheless, the desire to understand meaning rather than to seek explanatory causes underpinned my decision to retain an interpretivist approach informed by phenomenology in this project. Hermeneutics is the theory of interpretation which has its origins in attempts to understand biblical texts at a deep level (Schleiermacher, 1998). In relation to social research, it refers to the way that subjective meaning of experience *'is uncovered through the process of interpretive understanding'* (Smith, et al. 2009, p.37). This involves the researcher trying to make sense of participants' attempts to make sense of their own experiences – a double hermeneutic. This involves an empathic hermeneutical engagement on the part of the researcher with the actual experience of the participant and requires a conscious bracketing of the researcher's own experiences, preconceptions and knowledge in order to allow the participant's experience and meaning-making to be captured. Yet the researcher also needs to exercise a questioning hermeneutic that draws on their own knowledge in the process of analysis. Understanding comes not only from capturing the subjective experience of the participant but also through illuminating and making sense of it from the perspective of another.

Houston and Mullan-Jensen (2012) propose that the alignment of an interpretive approach with the theory of social domains (Layder, 2005) can provide a useful way of achieving breadth as well as depth in qualitative inquiry. Furthermore, they suggest that this approach might be particularly useful in the field of social work research, where the issues that practitioners face are so clearly located on the interface of personal pain and structural oppression.

Layder (2005) challenges the perceived conflict between the dualisms: structure and agency; macro and micro; individual and society, by proposing four interlocking domains: psychobiography, situated activity, social settings and contextual resources, that are shaped by time and space (See Figure 1). He also emphasises the key role that power plays in social relations with each domain having a different form of power. Layder (2005) recognises human beings are unique and that their psychobiography has shaped them over time, through their relationships with others, the impact of critical experiences and their genetic heritage. This emphasis on the uniqueness of individuals contrasts with many social constructionist theories which can exaggerate the impact of social forces on individuals. He does, however, recognise that people exist both inside as well as outside society. He argues that meaning arises not only from the domain of situated activity – the intersubjective space in which individuals interact in an episodic and evanescent way – but is an amalgam from all domains. The social settings domain refers to the aggregation of reproduced practices and relations that have developed over time, but which affect behaviour in the present. In some settings such as work or school these positions and practices may be formally enforced but the impact of more informal practices may also be powerful. Socially accepted grieving practices or positions, for example, may create a disjunction between the private experience of an individual and the social setting, leading to the phenomenon of disenfranchised grief (Doka, 2002). Finally, the domain of contextual resources refers both to the unequal allocation of material resources and the accumulation over time of cultural resources.

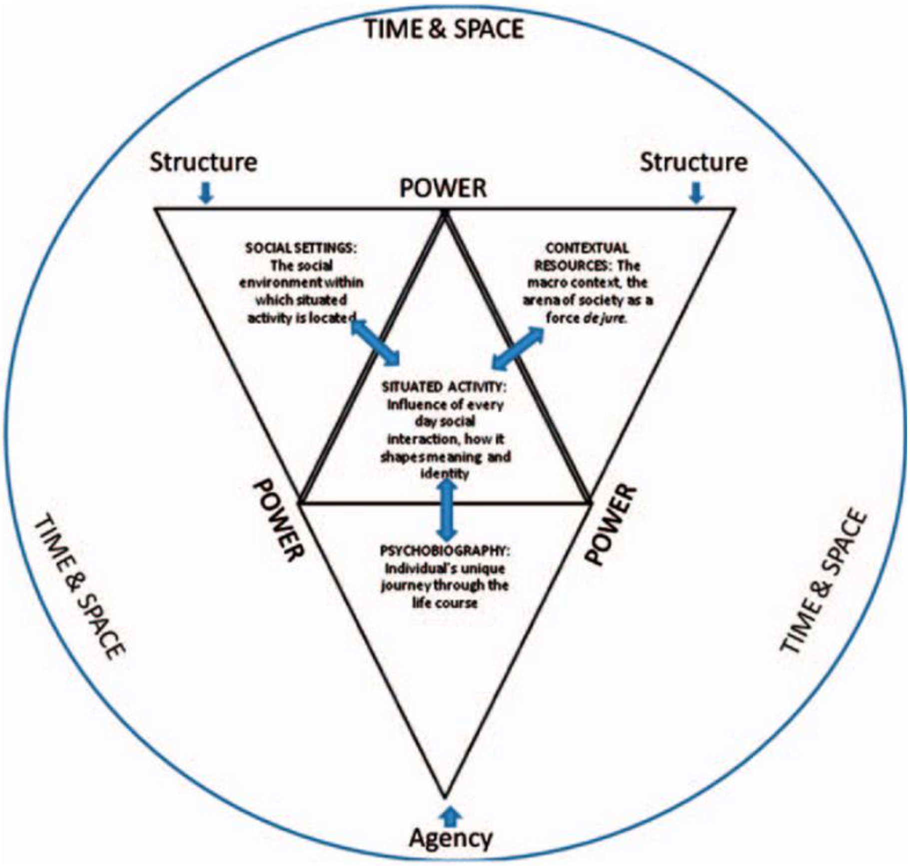

Figure 4 Layder's Theory of Social Domains Theory of Social Domains (taken from Houston and Mullan-Jensen, 2012)

Using Layder’s (2005) theory provided a framework to explore the social context for participants as well as their emotional experience. The emphasis on understanding different types of power also kept me alert to the implications of the various types of power relations that might exist within the interview context. Houston and Mullan-Jensen (2012) also argue that Layder’s theory has the potential to link with in-depth analysis by using the concept of social domains to inform the questioning hermeneutic, thus allowing the examination of subjective experience through the lens of wider social factors. From an ethical perspective I was concerned to ensure that being involved in the research did not leave participants feeling disempowered and that the final representation of their experience does not collude with a simplistic and stigmatising narrative of individual success or failure.

Ethical Considerations

This research required participants to revisit and reflect on very difficult experiences. Clearly reflecting on the suicide of a young person close to them was likely to be uncomfortable and even painful. Unsurprisingly, concern about the ethical implications of such research is frequently raised by ethics committees throughout the world which has led to studies investigating the effect on participants of taking part in such research. This has included research with parents who lost a child to suicide (Dyregrov, 2004), participants involved in psychological autopsy studies of suicide (Cooper, 2009), and patients who were depressed, some of whom had previously attempted suicide (Smith, et al. 2010). Very few participants in any studies reported any distress resulting from their participation in the research. In every study, however, many participants reported benefits both in having the opportunity to talk about difficult subjects and be heard, and in contributing positively to prevent future deaths or distress.

Formal ethical approval was granted by the ethics committee of Stirling University prior to the data collection phase of the research. Using guidelines set out by the Social Research Association (SRA 2021), I identified several ethical issues that required continuous attention throughout the course of the research.

This research was inevitably going to be emotionally difficult for all participants. There is a strong expectation that due care is taken to ensure that no serious or lasting harm is caused to participants or researchers by the research process itself (Hugman, et al. 2011; Kitchener and Kitchener, 2009). This does not, however, preclude undertaking research on emotionally sensitive or painful issues as this would prevent the development of knowledge (Helgeland, 2005). Although I knew that some participants might experience some benefit from taking part in this research, I was also aware that the way it is was conducted was crucial. I regularly listen to the stress and distress of carers and teams, on a range of sensitive issues affecting young people in care and those who work with them. My aim was to bring that professional experience, understanding and skill into the research setting thus ensuring emotional awareness, support, and protection for all those involved. I also had to make clear, however, that my role in this project was that of researcher rather than consultant or counsellor. The recruitment process was designed to ensure that participants were in a socially supported situation before I approached them, and I negotiated with all participants that if I was seriously concerned about them that I could contact someone they nominated to alert them to their distress. Participants also received details of organisations that provide emotional support around the suicide and bereavement more generally. Some care-experienced participants shared their continuing suicidal ideation but were clear that they had no intention of acting on these feelings and knew how to access support. I also contacted all participants the day after the interview to check on their wellbeing.

I was aware that I would also be exposed to distressing material that might resonate with my own experiences. The impact on my own emotional wellbeing exceeded my expectations but I attempted to maintain a rigorous reflexive approach throughout the research process – exploring my own responses as well as the impact I might have on participants. I have had the benefit of supervisors who are themselves skilled practitioners as well as academics. Finally, on the occasions where I felt more powerfully affected at a personal level, I was able to discuss this with my own therapist.

All research requires us to consider the issues of informed consent and confidentiality. Within this study these throw up complex questions. Sometimes vulnerable groups are considered to be those whose capacity to make informed consent is compromised in some way. Although all participants experienced extremely difficult and painful events, that did not necessarily make them vulnerable. Researchers exploring sensitive topics, particularly with groups who experience stigma or oppression, must negotiate a delicate path. Although I was acutely aware of the potential ethical risks of causing unacceptable distress or failing to recognise covert power dynamics that might affect participants' capacity to consent, I also recognised that an approach that is totally risk-averse contributes to the further exclusion of individuals and groups who may have already experienced the suppression of their voices. This was emphasised by Helgeland (2005, p.549) when she suggested that some ethical guidelines about protecting 'vulnerable' groups are ‘*shaped from “above,” from a hypothesis about the best interests of “weak” groups’* which implies a lack of agency and capacity that prevents them making their own decisions. Access to participants was negotiated through gatekeepers who extended the initial invitation to participate and provided written material to those who were interested before I met them. Consent was discussed with all participants before, during and at the end of every interview and it was made clear that they were free to withdraw their consent at any time during the data collection process and their information would be deleted.

Confidentiality is a particularly powerful issue for many care-experienced people who may be used to professional definitions of confidentiality which effectively means that their information may be shared quite widely, even though it is held within a group of professionals. This was addressed with every participant and a clear explanation provided that all hard information would be stored in locked cabinets and electronic information on password protected files on a university server or password protected computers. It was, however, clarified that conducting research within a group who may be known to each other, made it impossible to guarantee anonymity. Some participants were very concerned to protect their own confidentiality or those they talked about. In addition to pseudonymising the research, they requested that potentially identifying details were changed, including for one person a change of gender. Interestingly, however, other care-experienced participants wished to claim their own voice and identity by using their first name in the research. For people who may have experienced a suppression of their voice and identity this can be an important and positive but complicated choice (Duncalf, 2011). The implications of such a choice were explored with all participants who wanted to use their own name. I had to wrestle with my own discomfort and anxiety about supporting their decisions – balancing the potential risks to participants of losing anonymity against the definite impact of exerting my authorial power and thus contributing to a further suppression of identity.

Tisdale (2003) points out that there are several different philosophical approaches that may influence ethical decision making. These different philosophical underpinnings may lead to researchers approaching the same issues in different or even conflicting ways. She suggests that to deal with this '*uncomfortable shaky ground… We must negotiate ethics; we must ask difficult questions of ourselves and our work'* (Tisdale, 2003, p. 15). This is echoed by the SRA (2021, p. 29) guidelines:

> *Rather than impose a rigid set of rules to which social researchers everywhere are expected to adhere, the guidance aims to inform in order to enable a social researcher's individual ethical judgements and decisions to be set in the context of the shared values and experiences of fellow professionals.*

Although researchers are obliged to do their best to identify and address ethical challenges before beginning their research, the responsibility to behave ethically continues throughout the research process. Tisdale (2003) differentiates between the types of 'a priori vulnerabilities' that may be identified and addressed in research design and the ethical approval process and the type of 'a posteriori vulnerabilities' that arise during the research process or after it is completed.

Participants' desires to retain their own names created just such a potential vulnerability – whatever I decided had risks for participants and to a lesser degree to me. Tisdale (2003, p. 27) argues that *'not using a participant's story may at times be as harmful as researchers believe publishing the story will be.'* This resonated for me as I considered how to respond to participants' wishes and when I was sure that we had fully explored the potential problems associated with such a decision, I agreed to use their first names. I was also, however, aware that considerable time would elapse between the interview and publication of this research and that their views and personal situation might have changed by then. We agreed that I would revisit their decision with them before the thesis was submitted and if I was unable to contact them then I would use a pseudonym. In the event some participants had changed their minds whilst others wished to stick with their original decision but appreciated that I had checked and allowed them to explore the implications.

Research Design

The purpose of this research was to explore the meaning and impact of the suicide of residential care-leavers through the reflections and memories of participants. I aimed to recruit three groups of participants: family members, peers who lived alongside young people who completed suicide, and professionals who worked closely with young people and were affected by their death. Although these are distinct groups with different experiences, they share a connectedness to young care-leavers who went on to kill themselves. Their various experiences with young people who have died, and the different ways that this affected them can contribute to an understanding of the meaning and impact of such deaths.

I had originally intended to develop case studies around three individual young care-leavers who had died, to explore the intersubjective experience of this shared traumatic event. Although this would have produced some very rich and important information it would have made the analysis much more complex. A conversation with a colleague, however, also highlighted a potential ethical dilemma in this approach. She was reflecting on the fraught and difficult experiences of funerals of young care-leavers. She explained the complexity and discomfort of the emotions evoked in her and her colleagues when confronted with the overwhelming distress of family members whose damaging behaviour and attitudes, they believed, had contributed to the young person's death. It is not at all unlikely that similar emotions exist among family members or peers of the young person who died, who might perceive that professionals failed in their responsibility to care for and protect the young person. It seemed likely that interviewing people who share a common bereavement, but from such diverse positions, might either prevent participants from sharing their thoughts as openly as they wish or create additional distress as participants might recognise themselves as the targets of negative emotions. Similar ethical dilemmas can emerge in case study research with families when information given in individual accounts is not congruent with participants' publicly presented persona (Gabb, 2010). In her research Gabb (2010) resolved her concerns by choosing to publish only one carefully chosen case study that she felt was unlikely to cause harm. In this study the sensitivity of the subject matter and the potential existence of already conflictual relationships meant it would have been impossible to publish any case study without the potential for harm. Interestingly, however, although I abandoned this restricted focus on a small number of care-leavers who had died, some young people were mentioned by more than one participant.

Recruitment Process

The intensity of engagement and depth of this analysis limited the number of participants that could realistically be included in the project. There was no attempt to search for a representative sample, as the number of participants is too small to draw comparisons across gender, age, or any other demographic characteristic.

The highly sensitive nature of the research meant I decided to identify participants in a targeted way rather than through a general invitation. The stigma involved in both suicidal acts and being involved in the care system means that potential participants constituted something of a hard-to-reach population who were likely to be suspicious and distrustful towards researchers (Ratnarajah and Maple, 2011; Scholte, et al. 1999; Sudak, et al. 2008). Moreover, the group of people meeting the criteria for the study constitutes a tiny proportion of the general population, so the pool of potential participants was limited. Within my own professional network, however, there was an awareness of several care-leavers who had died. I approached senior professionals to act as trusted gatekeepers to make an initial approach to possible participants. These professionals were able to assess my trustworthiness and competence to undertake the research. I recognised that this might have made it more difficult for participants to decline to take part and emphasised the importance of truly informed consent to all gatekeepers. Recruiting participants in this manner, however, allowed me to judge the strength of their support networks and meant I was more likely to avoid including people whose emotional state might place them at risk.

Deuter and Jaworski (2017, p.7) describe a similar approach to recruiting elderly people who had attempted suicide who also constitute a very difficult group to access safely. Recruitment was carried out *'through persons who were both trusted by the potential participants … and supportive of the research.'* They discuss the potential difficulties in this approach but concluded *that 'potential risks to voluntary consent were outweighed by participants' rights to be involved in the study.'*

Previous studies involving suicide used a range of recruitment methods. In some early studies interviewers arrived unannounced at people's houses to ask them to participate (Barraclough, et al. 1974). Although this resulted in a high response rate it cannot be considered ethical and, as was acknowledged in later research, such a practice would no longer be granted ethical approval (Cooper, 1999). In Cooper's (1999) evaluation of a study into suicide conducted in Manchester, using the psychological autopsy method, she found that some participants felt that they should have been asked for permission before they were approached by letter.

It seemed particularly important, with the potentially double stigma of suicide and care experience, that prospective participants were able to refuse any contact at all from unknown researchers. It was also possible that some individuals might know me in my professional role and, again, using a gatekeeper protected them from any unwelcome breach of their privacy. A few participants, however, became involved in the research in a more direct way when they heard about the study and asked to be included. All potential participants were given a letter of invitation, written information about the study and a consent form. If they still wished to participate, we arranged a place to meet for the interview that was convenient and comfortable for them. Before formally starting the interview, we discussed the research process, including the importance of consent as a continuous process, the use of audio recording, what pseudonym they wished to be known by in the research and what would happen if I was seriously worried about them. Everyone expressing an interest in the research continued into the formal interview process.

I planned to recruit slowly as I wanted to include everyone who volunteered. It seemed unethical to offer people the opportunity to take part in research of such a sensitive nature, and then exclude them based on numbers. Nineteen interviews took place – seven care-experienced adults, three family members (two of whom were also care-experienced) and nine professionals who had worked with a young person in residential care who went on to die by suicide.[3]

Interviews

I undertook in-depth, unstructured interviews to provide space for participants to share experiences and reflections as freely as possible. Corbin and Morse (2003) argue that such interviews allow considerable control for the participant in the research process. They suggest that in an unstructured interview the participant decides the information they share and how they tell their story as well as controlling the pace of the interview.

I developed a very broad topic guide for the interviews.[4] This was not to impose unhelpful rigidity within the interviews but to help me prepare for the areas the interview might cover. It allowed me to anticipate difficulties that might emerge and be ready to respond in a sensitive and helpful way. It was also intended to reduce the likelihood that I would undermine the process or rigour of the research by inadvertently using questions that were leading, closed, manipulative or over-empathic. Nevertheless, the freedom involved in an unstructured interview meant that unanticipated ethical issues, such as dealing with participants disclosing their current suicidal ideation, arose that required me to respond in the moment. Corbin and Morse (2003, p. 348) suggest that *'researchers and participants co-construct ethical realities during the course of the interviews'* and they emphasise that it is important that the researcher is aware of and follows an appropriate code of ethics. As a qualified social worker, I am guided by the

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[3] More information about participants in Figure 5 p. 107

[4] See Appendix 1

SSSC code of ethics and as a research student I am also bound by the ethical guidelines of the School of Social Science at the University of Stirling.

The interviews varied in length from 30 minutes to two hours. Dyregrov (2004, p. 396) reported that for participants in a research study examining the impact of losing a child through sudden and traumatic death, it was of immense importance that the research interview they took part in was '*seemingly timeless.*' I attempted to ensure that participants sensed they would have all the time they needed whilst also making sure that, if necessary, they had space for emotional recovery before resuming their everyday life.

All interviews were audio recorded, with participants' consent, and transcribed for analysis. Initially I considered taking brief notes during the interview and writing a full record immediately afterwards. I decided, however, that the approach I used required such a close attention to the actual words spoken that this might distort the analysis and would diminish the accuracy of quotations I might include in any publication. The impact of jotting down even brief notes can be considerable. It may suggest that the interviewer has a particular interest in the issue or memory the participant is exploring and so affect what they choose to say or concentrate on. The process of writing during an interview can be experienced as disrespectful by the person being interviewed particularly when exploring extremely sensitive topics. Taking these issues into consideration, I decided to only include those who agreed to audio recording. I did, however, emphasise that participants could ask for the recorder to be turned off at any point. Occasionally participants became distressed, and I always checked whether they wished to stop the recording, but they always chose to continue.

Unstructured interviews cannot follow an exact pattern but there is still a general shape that needs to be recognised and managed sensitively. Corbin and Morse (2003) identify four phases to the unstructured interview: *the pre-interview phase* where participant and interviewer are getting to know each other and when essential tasks take place such as exploring issues of consent; *the tentative phase* where the participant begins to tell their story but is testing out both the interviewer's responses and their own emotional reactions; *the immersion phase* where trust has developed and both participant and interviewer are deeply engaged in the process. The story may not be chronological, and the participant can approach experiences in any order. They may move back and forward in time with occasional diversions into more apparently peripheral aspects of their story, sometimes to regulate emotion or stress at particularly difficult moment; *the emergence phase* initiates the preparation for ending the interview and the separation between interviewer and participant. It is where the participant begins to share less painful or emotional, though still relevant, aspects of their story. At this point too, a participant may share unrelated aspects of their past or ask questions of the interviewer. It is also the phase where it is possible for the interviewer to share information or discuss support without disrupting the flow of the interview.

Corbin and Morse (2003) suggest that it is important in the pre-interview phase to try and establish what the participant is hoping to gain from the interview. They point out that there is likely to be some underlying reason for the participant agreeing to take part in research. It can be important, where possible, to try and ensure that these hopes are realised, either within the interview or afterwards. It is also, however, necessary, to be clear when participants' expectations are unrealistic and acknowledge their disappointment. Almost all the participants in this study expressed a sense that the premature deaths of care-leavers were rarely publicly acknowledged and that the pain and distress of those affected by their deaths were ignored or minimised. They expressed hope that this research, and their own contribution, would have a significant impact on policy and practice. While I had to explain that it was unlikely that a single study could have the influence they hoped for, I was able to commit to disseminating my findings as widely as possible and promised to provide an electronic copy of my completed PhD to all those participants who were interested.

In approaching emotionally charged issues there is a balance to be struck between immediately launching into sensitive territory and circling endlessly around them Cooper (1999) explained that suicide researchers in Manchester decided, because of a pilot study, to change the order of their questions and address details of the actual death early in the interview process. It had become clear that this was at the forefront of participants' minds and their stress would have been increased by delaying questions to later in the interview.

The approach I adopted was very open and unstructured and I wanted to avoid imposing any specific ordering on participants' responses. Nevertheless, I began all the interviews in a similar way. I thanked them for agreeing to participate in the research and acknowledged that the subject was painful and that they might become distressed. I reiterated that we could stop at any time for a break. I emphasised that they had control of what they spoke about and that, as well as completely withdrawing at any point in the interview, they could also choose to exclude parts of the interview from analysis if they wished. I then explained that there were two areas that I was hoping to explore with them: their understanding or reflections on what might have contributed to the young person's death; and the impact of the death on them, both at the point they heard about it and how it has affected them over time.

I then asked them who they were holding in their mind that they wanted to talk about. From the earliest interviews it became apparent that many participants were carrying the cumulative impact of many premature deaths of young people they had been close to. Only three participants talked about just one young person who had died. One professional could remember twenty young people she had worked with who were now dead. This experience of multiple bereavements was not just confined to professionals who were looking back over many years working with highly distressed young people the youngest participant (eighteen years old) talked about three young men she had known who had died.

Participants spoke freely about their thoughts, feelings, and memories.

> *The approach I wanted to have today was 'I'm going to give all of myself to this process.' Because it's something I've wanted to talk about for a long, long, long time. And even the environment or the sphere that I'm in at the moment, it's not the space and place to do that - even though we touch on it at certain points, but*

> *never to the degree that I've always wanted to. So, I've answered things to the extent that I'm happy with. And I know myself enough to know that I'm happy with what I've given because, again, I've made a point, I've made a decision in my life about, I can't live my life in a way that makes me unhappy. And when I try and pretend that things don't feel a certain way It's not helpful (Keith, FM).*

Analysis

Reflexive TA requires the researcher to identify codes across the entire data set to develop themes - patterns of shared meaning underpinned or united by a core concept (Braun and Clarke, 2019, p. 594). This is an iterative rather than staged process and requires immersion in the data over time. Critics of TA (Aguinaldo 2012; Vaismoradi, et al, 2013) suggest that the process risks being a purely descriptive and subjective one. Braun and Clarke (2021), however, emphasise the importance of researchers' interpretive role in creating their story of what the data represents and argue that for this to be intellectually rigorous requires them to reflect on and be clear about their philosophical and theoretical assumptions.

Familiarisation

I listened to all the interviews multiple times not only to become familiar with the spoken words but also to remind myself of the emotional content of the interviews which was also data. Participants' non-verbal communication was soaked with pain. This became acutely apparent during the transcription process. During the actual interviews, the focus was on providing a containing space for participants and allowing them to share their stories and, for many, their tears. In transcribing the interviews, however, the emotional presentation of participants came into focus as well as the content of their words. Their agonisingly long pauses, deep sighs, and faltering speech, as they described the deaths and their impact on them, contrasted powerfully with more fluent accounts of young people's backgrounds or experiences that they had shared with them. Poland and Pederson (1998) argued that silence is often perceived as a problem to be overcome in qualitative research rather than a further source of data. They suggested that it was important to appreciate the multiple meanings silence can have and recognise that when we construct meaning we interpret the meaning of silences that confront us. Other authors have highlighted the significance of emotions in every aspect of the research process (Dickson-Swift, 2007; Holmes, 2019) and emphasised the importance of researchers being able to cope with the impact of emotions:

> *We need to be able to sit with uncomfortable emotions—our own and those of our participants—and attend to their effect on both. Strong emotions are rarely expressed just in words (Holmes, 2019, p. 75).*

It was not just through words that participants in this research communicated their emotional response to the deaths they were remembering. Recognising and incorporating these non-verbal expressions of distress into the analysis strengthened the understanding of the impact on participants.

I transcribed about half the interviews myself, but pressure of time meant that I paid for the remaining interviews to be transcribed by a student social worker. This professional background meant that the transcriber would understand the context of the research and appreciate the importance of confidentiality. Because of the painful nature of the material, I checked in frequently to provide support and a space to reflect on the impact of the process on her. I knew from my own experiences of transcribing the interviews that it was an emotional experience. I checked all these transcriptions against the original voice recordings for accuracy.

Creating Codes

The process of creating codes is fundamentally one of indexing the data but this still involves the researcher making their own subjective choices about which codes to use and requires a rigorous reflexive engagement with the data. While listening to the recordings and reading transcriptions I had already begun the process of generating the initial codes. As my approach was primarily an inductive one, I attempted to code the data without specific questions or assumptions in mind. I am aware that my pre-existing experiences and knowledge will still have influenced my decisions. I did, however, identify some codes that surprised me such as the impact of funerals on the professional participants, and others that challenged my assumptions, such as the divergent views that existed between care-experienced and professional participants about the family-like nature of residential care. I also found that some codes crossed the data from all three groups whereas others appeared in only one or two of them.

Developing, Reviewing, Refining and Naming Themes

In reflexive TA themes are patterns of shared meaning that the researcher generates through active and reflexive engagement with the coded data (Braun and Clarke, 2020). Within this study the different groups of participants had diverse backgrounds but shared the experience of losing at least one young care-leaver through suicide. Some themes or subthemes were relevant mainly or totally to one group of participants such as ‘the denial of relationships between young people’ while others were experienced in different ways by participants in different groups such as ‘the hidden costs of professional boundaries.’ Overall, however, there was a remarkable congruence between the reflections and experiences across the groups which also meant that themes that were generated portrayed a pattern of shared meaning relevant to most participants.

The process of coding began a tentative development of themes, but these initial themes had to be reviewed and refined. Braun and Clarke (2019, p. 595) emphasise the analytic work involved in this process:

> *Themes are analytic outputs developed through and from the creative labour of our coding. They reflect considerable analytic ‘work,’ and are actively created by the researcher at the intersection of data, analytic process and subjectivity.*

The iterative nature of the analysis meant that I developed some themes and sub-themes that in the reviewing process I discarded or modified. At times this was through the reflexive recognition that I was trying to force the data to tell the story I expected rather than the one it supported. This stage was messy, painful and took a long time. Braun and Clarke (2006) suggest that writing is an integral part of the analytical process and in this research the process of writing helped clarify and define the key findings of this study. The final results of this TA are presented in Appendix 2, and they form the basis for structuring the data chapters.

Presentation of data

The data from the interviews are presented in two ways in the following three chapters. They are organised around the research questions that this study seeks to explore – the meaning and impact of the suicides of young care-leavers on those close to them. Chapters Four and Five focus on the impact of young people's deaths on participants while chapter six explores their understanding and reflections about what may have led to young people dying and how participants have or have not been able to find meaning in these deaths. The relevant overarching themes developed through the analysis provide the structure for these chapters and are presented with supporting data from the interviews and contextualised through discussing relevant research literature.

In addition, the data chapters all begin with an account of the experiences of an individual participant or a summary of a participant's perceptions of the experiences of a young person who died. These accounts are constructed directly from the words of participants to highlight phenomena identified from the data. This draws on the Gateway Approach developed by Carolyn Mears (Mears, 2008) in her research into the Columbine High shooting. She describes the process by which traumatic events can leave people cut off from others who have not shared similar experiences. This separation works to create a 'trauma membrane' (Lindy, 1985) that protects people from intrusion of others who cannot understand the experience. She used unstructured interviews that left participants free to identify what was important to them thus providing as much control as possible to participants. She argues that by using participants' own words to create a chronological or thematic account *'the findings emerge from the narrative since it tells the story — instead of telling about the story' (*Mears, 2008, p.166). Mears used a free verse form to present these narratives which powerfully evoked the shock, terror, and horror of the experience of the shooting for those readers who were not directly affected by the event. She suggests that wider understanding of the individual and systemic consequences of traumatic events can be facilitated by allowing access across the 'trauma membrane' to those who are unaffected directly – creating a gateway for a shared understanding and more finely attuned policy and practice responses.

> *Documenting stories of trauma and recovery does more than bear witness to the trauma. It provides an opportunity for others to observe how people are affected by events and how they reconstruct order out of chaos (Mears, 2008, p.163).*

The crafted stories in this thesis provide stark illustrations of some key experiences of the participants and those young people who died. Critics of this approach emphasise the danger of the researcher selecting excerpts that reflect their pre-existing assumptions. Researchers, however, inevitably select how they interpret and present data, and this approach requires a reflexive examination of their experience, assumptions and thinking, providing some balance against abuse of power in the researcher-participant relationship. Moreover, this approach honours and preserves the individual's own account of their experience rather than reducing their accounts into codes and themes where their story may be lost.

Summary

So far, this chapter explained my ontological position and epistemological approach and how these led me to adopt a qualitative methodology to answer my research questions. The different options I considered for collecting and analysing data were described and the decision to use unstructured interviews with participants and reflexive TA to analyse data explained. The ethical issues that were anticipated in undertaking this study were explored and the ways in which I managed continuing ethical dilemmas discussed. The research process was outlined and an explanation of how data has been organised, analysed and presented in this study was provided.

Regardless of personal or professional position or the methods used to collect the data it is only ever possible to collect a partial insight into people's lives or experiences. In analysing data, we must always hold at the fore the reality that we only hold a snapshot of a life and never the whole picture; always partial and always incomplete (Hockey and James, 2017). The whole picture is elusive, not only because this changes as participants engage with new experiences and so change their interpretation of events, but also because the whole is infinite – *'for one thing, what one man sees as a whole, another* *sees as only a part…'* (Mills, 1959, p. 153). There were many themes that vied for attention in the analysing the data but through a consciously reflexive methodological and ethical exploration I strove to stay connected to the participants and the experiences that they entrusted to me.

Introduction to data chapters

The next three chapters present data from interviews conducted during 2017 and 2018. This introduction provides basic information about participants, their different roles, the number of deaths they mentioned and their relationship with those who died. Participants also mentioned some deaths which affected their perspective of the issues being examined that were not suicides but were traumatic. Participants' information is presented in tabular form in Figure 5. Key information that was shared by participants about the young people who died is also presented in Figures 6, 7, and 8. This introduction will also revisit the original aims of the research and explain how the data gathering process and analysis shifted these slightly. A brief explanation of current issues in the residential childcare sector is provided to contextualise the research. Finally, the rationale for the organisation of the chapters and the presentation of data is explained.

Who were the participants?

Participants in this research were unique individuals with diverse life experiences at different points on their developmental trajectories. Whilst all shared the experience of losing at least one care-leaver close to them, their responses and reflections were individual. Although differences emerged in responses of participants among different groups there were also similarities across all three groups. In presenting the data and analysis, the differences and similarities between and within groups are noted but individual responses and experiences that challenged the majority view are also explored. Participants had lived or worked in a range of settings, including those managed by local authority and third sector organisations across Central and Southern Scotland. Whilst this study did not set out to undertake any comparative analysis, there appeared to be no systematic difference in findings across different geographical areas or types of organisation.

Participants were recruited based on their membership of a particular group of people bereaved by the suicide of a care-leaver – family members, care-experienced peers, or professionals. Most participants, however, also inhabited additional roles that affected their reflections. All care-experienced participants were involved in care activism, and some had worked in social care settings. Two family members were also care-experienced and the third had held senior roles in Scottish social work. Many professionals were managers and had been responsible for informing others of the deaths and supporting them. Whilst we all have multiple roles in our lives, the additional roles identified here were immediately relevant to the research and inevitably framed the responses of participants and may have affected the findings. Although this group of participants is too small to undertake any meaningful quantitative analysis based on demographic characteristics it is interesting to note that most care-experienced participants were less than 40 when they were interviewed, in contrast to the professionals, who were all over 40. This may reflect a gradual natural distancing from their childhood for care-experienced people and a consequent reduction in interest in being involved in this type of research. Alternatively, it may have been created in by the recruitment process which relied on personal connections to gate keepers. This may have skewed recruitment towards people who had only recently left the system or had a continuing involvement in it through care activism. Other factors may have influenced the type of professionals recruited. Not only were they older but they had worked in the care system for many years. Gate keepers may have approached only people they felt were professionally secure in their roles or there may have been a process of self-selection by those approached, based on their experiences. Alternative recruitment practices might have attracted older care-experienced people or younger professionals who might have offered different perspectives. Within this study the safety of participants was prioritised, leading to the use of gatekeepers who had close personal relationships with potential participants. A more well-funded study could have found alternative ways to ensure greater representation across the care community whilst retaining a focus on providing adequate relational support to participants.

Figure 5 provides some key information about participants. It highlights the burden of traumatic deaths carried by participants and the closeness of many relationships between participants and those who died.

Figure 5 Participants' Information

Name	Role in research	Additional roles	Age	Premature deaths	Closest relationship(s)	When was most recent death?	When was most distant death?
Pauline	CEA	Care activist	40+	8	Best friend	3 years	30+ years
Patrena	CEA	Care activist	18-30	3	Friend	1 month	2 years
Hamish	CEA	Social work student Care activist	30-40	5	Former girlfriend	1 month	10+ years
Shannon	CEA	Care activist	18-30	6	Girlfriend	Less than one year	4 years
Daniel	CEA	Residential worker Care activist	30 -40	10	Former girlfriend	10+ years	10+ years
Keera	CEA	Care activist	18-30	3	Brother's friend	1 month	2 years
Declan	CEA	Residential worker Care activist	18-30	1	Friend	5 years	5years
Tommy	FM / CEA	Care Activist	18-30	3	Brother and girlfriend	10+ years	10+ years
Keith	FM /CEA	Manager Care activist	30-40	3	Two brothers	10+ years	10+ years
Kate	FM	Social Worker Manager	40+	3	Adopted daughter's brother	10+ years	20+ years
Amy	CW		40+	20	Looked after in care	Less than one year	20+ years
Wren	CW	Manager	40+	4	Looked after in care	1 week	10+ years
Jillian	CW	Manager	40+	5	Looked after in care	5 years	10+ years
Lesley	CW	Manager	40+	4	Looked after in care	5 years	10+ years
Graeme	CW		40+	4	Looked after in care	10 + years	10+ years
Daisy	CW	University manager	40+	1	Outreach work	20 + years	20+ years
Charlie	CW	Manager	40+	10	Looked after in care	3 years	9 years
Robbie	AW	Manager	40+	6	Advocate	Less than one year	10+ years
Davy	AW	Manager	40+	3	Looked after in care	10+ years	10+ years

Key: CEA: Care-experienced Adult. CW: Care Worker. FM: Family Member. AW: Advocacy Worker

Revisiting expectations

The original aims of this research were twofold: firstly, to develop a picture of the lives and experiences of young care-leavers who died by suicide, drawn from the memories of participants – care-experienced adults, professionals, and family members – who had known them well; secondly to explore the impact of these deaths on participants. The original expectation was that participants would share their memories of just one care-leaver, but most talked about several young people they had known who died in early adulthood. There were therefore fewer in-depth accounts of the lives of care-leavers who had died than anticipated. This was compounded by the lack of detailed knowledge participants had of some young people's life histories and the social and emotional situation they had experienced just prior to their deaths. Care-experienced participants were clear they seldom discussed their early lives with their peers in care, even those with whom they had close friendships or romantic partnerships. In addition, although many participants had heard of the deaths almost immediately, some only found out many years later and knew little of the circumstances of the death. Even when participants heard quickly, many knew few details about the young person's circumstances. This relative paucity of 'factual' knowledge meant that the original aim of creating a clear picture of the lives and deaths of young care-leavers was inherently unrealistic but there remained an opportunity to explore how participants made sense of the deaths.

In their attempts to make sense of the experiences of others, participants appeared to be already engaged in their own interpretive endeavour. Participants seemed to be trying to create meaning, to help them cope with the distress evoked by their losses and to find pointers that might lead to changes in policy and practice that could reduce the risk of future suicides. As well as reflecting on the factors that led to the deaths of young people, some participants also explored the adverse impact of these losses on other people they knew.

Many care-experienced participants drew heavily on memories and reflections from their own lives, frequently identifying factors that helped them survive serious adversity and contrasting this with the experiences of the young people who died. This unexpected and immensely rich data, proved to be a central aspect of the research and contributed important insights which may potentially influence future practice.

Professional participants also used their practice knowledge and experience to make sense of the deaths of young care-leavers they had known. Many talked about care-experienced people who were still alive and reflected on the varying trajectories they had observed. Some expressed extreme concern about the continuing vulnerability and isolation of young people they knew, whilst others recognised that there were many care-experienced people who had endured and survived extreme difficulties and reflected on the factors that had helped them to do so.

In contrast to these reflective explorations, participants' accounts of the impact of the deaths on themselves were often characterized by raw emotion, embodied responses, and less cognitive engagement. The deaths of young people they had known affected participants profoundly. As they recounted their experiences it became clear that not only were they directly affected by the suicides of specific young people, but that the responses of other people, both to them and the event, also had a significant impact. The suicide of somebody close is known to evoke a range of negative feelings that can often threaten to overwhelm the bereaved individual (Dransart, 2013; Sugrue, et al. 2014; Wagner, et al. 2021). This was echoed in the research, but aspects of the residential childcare context not only intensified the impact of the deaths for participants, but also made it hard to disentangle the effects of individual bereavements from the impact of frequent exposure to traumatic events, either in participants' personal histories or vicariously through professional experiences.

Who were the young people who died?

It is clear from Figure 5 that participants had been exposed to several traumatic deaths, but the amount of information provided about young people who died was variable. In some cases, participants provided detailed accounts of young people's lives and the circumstances leading up to their deaths. In others, participants only mentioned a name with no accompanying detail, and many explained that in addition to the young people they spoke about at depth they had been exposed to several other deaths of care-experienced young people that had also affected them at some level.

Where there was sufficient relevant information available within participants accounts this is presented in Figures 6, 7 and 8. Key details about the young people are presented in Figure 5. About a third of young people were mentioned by two or more participants. Strikingly, almost all young people who died left care between the ages of 15 and 17. Although the Local Authority duty to provide continuing care, established by the Children and Young People (Scotland) Act 2014 would have come too late for them, they almost all left care after the Children (Scotland) Act 1995 was enacted which created a presumption that children remain in care until the age of 18. Sixteen died before their 20th birthday. Four pairs of siblings are included in the group of young people who died.

The next two figures present the information that was shared by participants about the young people's adverse experiences in childhood (Figure 7) and young adulthood (Figure 8). Where information was unknown or did not apply this is indicated in the table. The fact that information was unknown to participants or was not shared in the interview does not mean that individual young people did not experience a particular difficulty. All the young people who died experienced considerable childhood adversity and for most this continued into adulthood.

Figure 6 Key information about young people who died.

Name	Mentioned by	Age leaving care	Accommodation on leaving care	Age at death	Means of death
Aaron	Lesley	16	N/K	19	Hanging
Abbie	Pauline	17	Own tenancy	19	Overdose
Alicia	Robbie	16	N/K	16/17	N/K
Angus	Pauline	16	N/K	20+	N/K
Antony	Keith & Robbie	15	Parental Home	17	Overdose
Brian	Kate	16	Own tenancy	22	Overdose
Casey	Amy	16	Own tenancy	20 +	N/K
Demi	Charlie & Shannon	16	Prison	19	Hanging
Donny	Lesley, Jillian & Declan	16	Homeless	17	Hanging
Jack	Tommy, Davy, George, Jillian & Carole	16	Parental Home	16	Overdose
Jamie	Daisy	16	Homeless	16	Overdose
Jason	Casey, Hamish, Patrena & Shannon	16	Parental Home	16	Hanging
Jenny	Wren and Daniel	16	Own tenancy	20+	Overdose
Johnnie	Pauline	16	Parental Home	16	Hanging
Jordan*	Davy	N/A	N/A	16	Hanging
Leanne	Amy	16	Own tenancy	20+	Hanging (while pregnant)
Lee	Jillian	16	N/K	20+	N/K
Lewis	Patrena & Wren	16	Through care flat	19	Hanging
Lizzie	Daniel	16	Parental Home	20	Overdose
Michael	Wren	16	N/K	20+	N/K
Millie	Hamish	16	Parental Home	20+	Overdose
Patrick	Keith & Robbie	15	Parental Home	18	Hanging
Peter*	George	N/A	N/A	17	Hanging
Ricky	Amy & Shannon	16	Own tenancy	18	Overdose
Ryan	Patrena & Wren	17	Prison	18	Hanging
Scott	Robbie	16	N/K	20+	Overdose
Stevie	Hamish	N/K	N/K	20+	Hit by train

*Died days before leaving care.   Same colour highlighted names are siblings.

Figure 7 Known negative childhood experiences of young people who died.

Name	**Trauma/ Neglect**	**Rejection by parents or other carers**	**Bereavement or loss**	**Exposure to suicide**	**Violence ***	**Multiple moves**	**Secure care**	**Mental health issues**	**Self-harm****	**Family breakdown**	**Parental alcohol/drugs**	**Sibling Separation**
Aaron	Y	Y	Y	N/K	Y	Y	y	Y	Y	Y	N/K	N/K
Abbie	Y	Y	N/K	N/K	Y	N/K	N/K	Y***	Y	Y	N/K	N/K
Alicia	Y	Y	N/K	N/K	Y	Y	N	Y	Y	Y	N/K	Y
Angus	Y	Y	N/K	Y	N/K	y	N/K	Y	Y	Y	N/K	N/K
Antony	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Brian	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Casey	Y	Y	Y	N/K	Y	Y	N	Y	Y	Y	Y	Y
Demi	Y	Y	N/K	N/K	Y	Y	Y	Y ***	Y	Y	N/K	N/K
Donny	Y	Y	N/K	N/K	Y	Y	N	Y***	Y	Y	N/K	Y
Jack	Y	Y	Y	N/K	Y	Y	Y	N/K	Y	Y	Y	Y
Jamie	Y	Y	N/K	N/K	N/K	Y	N	N/K	Y	Y	N/K	N/K
Jason	Y	Y	Y	N/K	Y	Y	N	Y ***	Y	Y	N/K	Y
Jenny	Y	Y	Y	N/K	Y	N	N	Y	Y	Y	Y	Y
Johnnie	Y	Y	N/K	N/K	Y	N	N	N/K	Y	Y	N/K	N/K
Jordan	Y	Y	N/K	N/K	Y	Y	N	N/K	N/K	Y	N/K	N/K
Leanne	Y	Y	Y	N/K	Y	Y	N	N/K	N/K	Y	Y	Y
Lee	Y	Y	N/K	Y	Y	Y	N	N/K	N/K	Y	N/K	Y
Lewis	Y	Y	Y	Y	Y	Y	N	Y ***	Y	Y	Y	Y
Lizzie	Y	Y	Y	N/K	Y	N	N	N/K	Y	Y	N/K	Y
Michael	Y	Y	Y	N/K	y	Y	N/K	Y	N/K	Y	Y	Y
Millie	Y	Y	N/K	N/K	Y	N	N	N/K	Y	Y	N/K	N/K
Patrick	Y	Y	Y	N/K	Y	Y	N	Y ***	Y	Y	Y	Y
Peter	Y	Y	N/K	N/K	N/K	N	Y	N/K	N/K	Y	N/K	Y
Ricky	Y	Y	N/K	N/K	Y	Y	N	N/K	Y	Y	N/K	Y
Ryan	Y	Y	N/K	N/K	Y	Y	Y	Y	Y	Y	N/K	Y
Scott	Y	Y	N/K	Y	Y	Y	N	N/K	Y	Y	N/K	Y
Stevie	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K	N/K

* Includes violence suffered, witnessed or perpetrated. ** Includes alcohol and substance difficulties. *** Hospital care.

Figure 8 Known negative experiences of young people after leaving care.

Name	Homeless	Prison	Psychiatric care	Alcohol/ Drugs	Domestic Violence	Separated from own children	Caring for own children	Relationship breakdown	Bereavement
Aaron	Y	Y	Y	Y	N/K	N/A	N/A	N/K	N/K
Abbie	N/K	N	Y**	Y	N/K	N	Y	N/K	Y
Alicia	N/K	N	N/K	N/K	N/K	N/A	N/A	N/K	N/K
Angus	N/K	N	Y	Y	N/K	Y	N	Y	N/K
Antony	Y	Y	N/K	Y	N/K	N/A	N/A	N	Y***
Brian	Y	Y	N/K	Y	N/K	N/A	N/A	N/K	Y
Casey	N/K	N	Y	Y	Y	Y	N	Y	Y***
Demi	N/K	Y	Y	Y	N/K	N/A	N/A	N/K	N/K
Donny	Y	N	Y**	Y	N/K	N/A	N/A	N	N/K
Jack	Y	N	N/K	Y	N/K	N/A	N/A	N/K	N/K
Jamie	Y	N	N/K	Y	N/K	N/A	N/A	N/K	N/K
Jason	N/K	Y	Y**	Y	N/K	N/A	N/A	N/K	N
Jenny	Y	N	N/K	Y	Y	Y	N	Y	N/K
Johnnie	N/K	N	N/K	N/K	N/K	N/A	N/A	N/K	N/K
Jordan*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Leanne	N	N	N	N	N	N	Y	Y	N/K
Lee	N/K	N	N/K	N/K	N/K	Y	N	Y	N/K
Lewis	N/K	Y	Y	Y	N/K	N/A	N/A	N/K	N/K
Lizzie	Y	N	N/K	Y	N/K	N/A	N/A	Y	N/K
Michael	N/K	N/K	N/K	Y	N/K	N/A	N/A	Y	Y***
Millie	Y	N	N/K	Y	Y	N/K	N/K	Y	N/K
Patrick	Y	N	Y	Y**	N/K	N/A	N/A	N	N/K
Peter*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ricky	Y	N	N/K	Y	N/K	N/A	N/A	N/K	N/K
Ryan	N/K	Y	Y	Y	N/K	N/A	N/A	N/K	N/K
Scott	Y	N	N/K	Y	N/K	N/A	N/A	N/K	Y***
Stevie	N/K	N	Y	Y	N/K	Y	N	Y	N/K

*Died before leaving care. **Hospital care. ***Including suicide.

Wider Context of the Research

This research took place during a time of extraordinary scrutiny of the care system in Scotland while both the Scottish Abuse Inquiry and the Independent Care Review were taking place. All participants knew that Scotland's childcare system was being examined at depth and some were actively involved in one or both processes. It is likely that this context affected the content and tenor of the interviews, as participants reflected on their own experiences with an awareness of the emerging accounts and themes from these investigations. Analysing the interviews, I too was conscious of the wider context and found myself recognising similar themes that challenged my fundamental assumptions and optimism. Inevitably the experience of hearing about the suicides of so many young people was challenging, reports from the Scottish Abuse Inquiry and participation in the Independent Care Review, however, seemed to act as an echo chamber in which the systemic and structural failures identified in the interviews were amplified. It was, at times, hard to hold on to the reality that participants also described multiple examples of transformative care and relationships.

Organisation of the data chapters

The next three chapters are organised around the research questions that this study set out to explore. Participants were asked about the impact of young people's deaths and how they made sense of them. Chapter Four explores the direct emotional and social impact of the deaths on the participants as they described it. Chapter Five focuses on the indirect impact of the deaths that participants described, and examines the various societal, organisational, and professional factors that left most participants experiencing their grief as somehow inappropriate or illegitimate. Chapter Six explores the various ways in which participants made sense of the deaths. This includes their attempts to understand both the particular and general stresses and challenges that contributed to the premature death of these young care-leavers and their thoughts about what systemic or professional changes might have averted such catastrophic outcomes. It also explores how participants tried to find meaning and significance in the deaths. Some themes or sub-themes identified in the analysis were relevant in only one chapter but others, for example 'the hidden cost of professional boundaries,' were significant in answering both research questions.

Chapter Four: Direct impact of deaths on participants

Keith, who spent most of his childhood in care, describes his emotional journey after the deaths of his brothers and the impact on his mental health.

> *The aftermath was horrendous …the impact that both had had on me.. with Paul because he'd hung himself, I found myself one night wrapping a belt around my neck. I tried drugs, I drank loads, I'd been in fights put myself at extreme risk, my behaviour was erratic. Work-wise presenting fine and engaging but life-wise a total mess. I hated life. I went through phases of wanting to die. Standing waiting on the train and you go 'ok, I'll just tip myself forward' and visualize it. I'd try and replicate what might have been going through Paul's head or, or Andrew's when he took drugs…what did that feel like, what space could it take you psychologically, to behave or act in certain ways. So it was a terrible time... It feels like yesterday most days. And time, it's not as if time's a healer but the things that you do with your time can heal. Time has not healed me, time made it worse because I never addressed anything… we've got a job, kids, cars... but it wasn't making me happy. I knew I was running away from it. I was trying to put it into everything else... it wasn't even physical things. Everything was just a distraction so I didn't need to cope with it... I went to the other side of the world [Australia], but as soon as I arrived I knew I was there for the wrong reasons. I thought my life would be completely transformed but it was the same feeling, it was the same. So, I decided "well I'll go back and study, I'll do a degree – that will make me feel better, because I'll feel more academic." But then I'd got to a place where I was like "I've actually got all the things that I thought would... and it's not that." It's actually all the stuff that happened when I was... well, my entire life, but these two moments… then a few years ago I pushed myself… I'd tried everything but it never worked… and I thought "I need to face this at some point." So I have, and I will continue to. It's taken me a while, but I realised that more than anything I wanted to do it because I felt miserable my entire life... I went for CBT intensively, all unbeknown to my employment, unbeknown to my friends, just my wife. I'm in a very good place. The support I've received from the NHS has been great. I've got my space and I've actually got an environment in terms of my wife and even, my wife's family where I can talk openly about this.*
>
> *(Keith, FM)*

Introduction

Keith, who spent most of his childhood in care, provided this account of the profound impact of his brothers' deaths. It graphically illustrates the overwhelming raw emotions participants described, as well as some effects on their connections to other people. These will form the core material of this chapter. The emotions participants described are common responses to loss and familiar from the literature on bereavement. What makes participants' experience of grief distinct is the residential childcare context which frames it and affects when, where, how and to whom it is expressed. The deaths of young people also affected the way participants connected to and interacted with other people. This varied among participants with some withdrawing from social contacts and others being drawn more intensely to invest in relationships. The first part of the chapter will explore the overwhelming feelings reported by participants and will examine how these are expressed or suppressed. The words of participants will be used quite extensively to capture the nuanced differences between participants as well as highlighting common themes. The second part will move away from the raw emotion and examine how the deaths affected participants' social interactions. It will consider how some participants withdrew from personal and professional relationships in response to their loss while others increased their commitments. The effects of the bereavements on some participants' capacity to trust will also be explored.

Overwhelming feelings

> *The person who commits suicide puts his psychological skeleton in the survivor's emotional closet—he sentences the survivor to a complex of negative feelings and, most importantly, to obsessing about the reasons for the suicide death (Shneidman, 1969, p. 22).*

Shneidman (1969) provides this powerful metaphor of the profound impact of their loss on suicide survivors. It captures well the overwhelming nature of the feelings evoked by this type of death as well as the constant questioning and rumination as survivors search for answers they may never find. Moreover, the image of the concealed skeleton conjures up the shame and guilt that can push people to hide the cause of death and reduce their social contact for fear of a negative response. This section of the chapter explores the overwhelming feelings participants described being evoked by the suicides of young people. As well as the immediate shock and horror they felt, they also identified a range of other emotions that, for some, still lingered many years after the event. These feelings were described across all three groups of participants.

Shock and horror

Hearing of the death of the young person evoked shock for all participants, even when this took place years after the event. Participants often described a bodily response that literally overwhelmed them, often leaving them unable to remain standing. Keith, for example, had seen his brother, Patrick, the evening before his death. Patrick was in a secure psychiatric ward because of his suicidal behaviour. Keith's anxiety about his brother had been extremely high for weeks but he felt his concerns had been dismissed by the professionals caring for him who also knew Patrick. Despite this extreme anxiety and concern Keith was still overwhelmed by Patrick's death. He described its physical impact:

> *I went to walk in the door, and I couldn't even walk, yeh, I couldn't even walk because my legs had just fell away (Keith FM).*

Jillian heard about the deaths of young people she had previously worked with soon after they occurred. Despite not having seen the young men for many years, she also described a similar physiological impact at hearing the news.

> *With Lee and Donny and I remember feeling that like, literally just like, like, had to take a seat to literally like, and my stomach just dropped (Jillian, CW).*

Hamish only heard about the death of Millie, who had lived in the same care home as him and with whom he had had a romantic relationship, long after he last saw her and several years after the death took place. Despite this temporal distance his physical reaction also overwhelmed him:

> *It was like I was punched in the throat. I just cried… I don't know why either, like, because we hadn't been close in a long time and… but I guess it's historical and there's always been a closeness (Hamish, CEA).*

Although shock was the initial response, for a few professional participants and family members, it was quickly followed by a horrified recognition that they had almost expected the death. Keith's anxiety about his brothers, for example, meant that he was always anticipating that their distress might eventually lead to their deaths. When Lesley heard that Donny had hung himself her initial disbelief was followed by a sense of despairing inevitability.

> *I was gutted when I first heard – it was that initial, the disbelief- but actually it wasn't even disbelief …I'm saying disbelief, because I didn't really disbelieve it, actually I did believe it and I did know it could happen, it was that horror- you know oh Christ! You know, he's finally done it (Lesley, CW).*

Daisy had taken sixteen-year-old Jimmy from his children's house to a homeless unit several miles away because it was decided that he had 'aged out' of care. Within weeks she heard of his death alone under a bridge:

> *I remember sitting going, holding my head, because I knew what a ridiculous decision it had been … "oh God how on earth did we put him in that situation?" And thinking what a ridiculous decision it was…. almost a completely predictable situation (Daisy, CW).*

Interestingly among those care-experienced participants, who were not family members, this sense of inevitability was not so evident, despite many knowing several young care-leavers who had died. The exceptions to this were when participants were known to have been intensely involved with a young person up to the point of death either through a romantic relationship or a very close friendship as was the case for Shannon with Demi and Pauline with Abbie. Many care-experienced participants lacked detailed information about a young person's situation or heard about a death long after it occurred meaning they were completely unprepared for the news.

Anxiety

Most participants in all three groups felt that the deaths of young people had left them feeling anxious that other care-experienced people they knew might die by suicide. For some this anxiety was very specific as the continued vulnerability of care-experienced individuals they knew well, left them constantly expecting the next death. Robbie, for example, described his ongoing relationship with Finn, who experienced the double suicides of his sister and mother. Finn only reached out at times of extreme despair which reinforced Robbie's sense of impending doom and his pain at witnessing such distress, yet each time he heard from him, he experienced relief:

> *I dread and love his phone calls, because one, at least he's alive, but secondly, what the fuck is going to be happening now? (Robbie, AW).*

For Keith, the shock of his older brother Patrick's death transmuted into a continual anxiety about his younger brother Antony's decline into hopelessness and chaotic drug use. When he was woken by a phone call from the police to ask him to come and support his mother, he initially refused to answer, as he 'knew' what it would be about.

> *I got a phone call at two in the morning, and I knew- it was like this fear when I woke up. And I didn't answer my phone because I knew...my girlfriend at the time was like "answer your phone" and I was like "I'm not answering it, I'm not answering it, I'm not answering it" (Keith, FM).*

This experience of continuous anxiety, however, was not just focused on specific individuals seen as particularly vulnerable – for many professional participants it infused their practice with a generalized fear that someone else they had looked after might kill themselves. This was exacerbated for those who had experienced the suicide of a care-leaver who they had thought would do well. For example, Amy had experienced the deaths of twenty young people during the twenty-two years she had worked in residential childcare. Not all of those had been suicides and she had not known all the young people well, but she described how destabilizing it was dealing with the 'unexpected' deaths and the lurking uncertainty she experienced about the future for young people leaving care.

> *So, you've always got that feeling… it's very emotional thing, as I say, I can think of two wee lasses who I worked with for years both sisters, both killed theirselves... within a year we were at both their funerals (Amy, CW).*

She had recognized the vulnerability of one sister, Casey, whose life had been chaotic and difficult since leaving care, but she was completely blindsided by her sister, Leanne's suicide. Leanne, who was already a mother, had killed herself while she was pregnant, despite having an apparently successful and happy life.

> *She seemed to be doing really really, really so well and then next we had heard that she had killed herself - I just was absolutely horrified because I thought she was doing okay (Amy, CW).*

Many care-experienced participants such as Shannon, also talked about people they had known in care and expressed profound concern about the precarious situation that many had been in since leaving care.

> *…there were three units. That's 18 people, 18 lives. Four of them are dead, four of them went on to prison, three became teenage parents, four became addicted to substances, including heroin, two became heroin addicts and I suppose three were transferred down to specialist adolescent mental health in-patient services, myself included (Shannon, CEA).*

Most care-experienced participants were deeply involved with the wider care community either as volunteers or in a professional capacity. These interconnections meant that they were often aware of young care-leavers' deaths, even those they had not personally known. The cumulative impact of such exposure seemed to magnify their perception of the risk of suicide or other sudden death for care-leavers. It also created an anxiety that any young person they knew might kill themselves and a consequent determination to provide them with extreme levels of support to prevent them becoming suicidal. As Patrena illustrates:

> *You're 25 times more likely to die by the age of 25. And that's just unacceptable…it makes me think when I'm working with young people, it makes me think a couple of things. It makes me think first of all, are they putting up a really good persona that I cannot see through? What's going on for them? And it also makes me look at myself like am I being supportive enough? Sometimes I go crazy like stupid above and beyond for things (Patrena, CEA).*

Some participants, particularly among the professional group, were also anxious about the impact of suicides on others, both young people and colleagues. Not only was there concern that one suicide might trigger suicidality in another young person as Robbie's continuing concern that Finn might kill himself because of his sister's and mother's suicides demonstrates, but participants also shared their anxieties about less obvious impacts on others. Lesley gave a vivid account of how she felt that the sense of safety was punctured for the other young people in the Warren after Donny's death.

> *Donny had lived life on the edge but then had gone that further step into something very, very different … we were totally powerless. We didn't we didn't keep him safe; we weren't able to keep him safe. I suppose that brought into question for young people their own safety, and what that meant for them …was that their future? was that their life? … there is always talk about self-harm, and there is always talk about suicide … we become the containers of these emotions and feelings, we're able to soak them up and hold on to them - and I mean literally and physically hold on to the young people, and their feelings of hurt and pain. But that was gone. that the safety blanket was gone, you know…because we were no longer, no longer containers of fear, because it's about, young people's fear as well as their hurt (Lesley, CW).*

There was also awareness from some professional participants of the lingering trauma experienced by colleagues who had been involved in finding a young person's body. One participant, George, suggested that his colleague, who had found a young man hanging had received no support and was so badly affected that it led to excessive drinking resulting in his own premature death.

The anxiety evoked by these suicides was not only felt in one service – the connected nature of residential care is evident from the number of participants from different services across Scotland who talked about the same young people who had died by suicide. Participants in this study were deeply affected by the deaths of young people they had worked or lived with even when they had moved on some time before. There was an acknowledgement of the ripple effect of such deaths across the residential childcare sector and the amplifying effect of each suicide on the anxiety that participants experienced.

Guilt

Several participants across all groups shared that they felt some degree of guilt about the deaths of the young people they had known. This tended to be triggered in different ways for different groups of participants. Many professionals, for example, wondered whether they could have done more to support the young people who died. Jillian's example was a common feeling among this group of participants:

> *I think whenever there's a tragic end- and it's so tragic - that you think, you think "could I have done more?" (Jillian, CW).*

Such self-questioning became much more intense and disturbing when the worker believed their own failings might have adversely affected the young person. Amy, for example, felt intense guilt that, despite Ricky reaching out to her in the weeks before he died, she had not visited him.

> *I kept meaning to phone him and you get caught up on things and maybe four or five weeks went by and then the phone call to say he was dead. So why did I not phone? Why did I let it go? I should have phoned him- And I didn't …. So, did we fail him? Did he end up in that house thinking "I've not got anybody?" (Amy, CW).*

Similarly, Lesley had promised to visit Donny in hospital on his birthday, but work pressures meant that she was unable to go. She still held guilt that she failed him although she also recognised that his level of vulnerability and despair meant he was continually at risk of suicide.

> *The guilt, you know, for me - saying "I'll come. Oh yeah, I'll be there" and then, of course, his birthday day passed and went and then we were a week after his birthday and I'm thinking I need to get over and see Donny and I'm thinking tomorrow, tomorrow, tomorrow. But, of course, tomorrow is too late for Donny (Lesley, CW).*

For the two family members who described the deaths of their brothers, some of their guilt derived directly from their own behaviour towards them rather than a failure to maintain contact. Tommy had been violent towards both his brother and his girlfriend, and he felt some responsibility for both their deaths. This was exacerbated as he found his girlfriend's body in the flat that they shared. Keith blamed himself for his brother Patrick's death because he was the last to see him and because Patrick used the CD

Keith had given him to cut up sheets to hang himself. When his younger brother, Antony, died later in homeless accommodation, Keith felt he had not supported him enough.

> *And again, guilt because I had a flat, and I gave money but, you know. I could have taken him into this flat and, what if I'd got bunk beds? (Keith, FM).*

This level of guilt contributed powerfully to what could be considered prolonged grief reactions where these participants continually ruminated about the deaths and their own responsibility for them (Levi-Belz and Ben-Yaish, 2022). Social isolation, common among care-experienced people, prevented these participants from gaining relief and perspective through talking to others. The only person Keith really talked to was his mother and they often found themselves engaged in a dance of mutual blame which reinforced their guilt rather than relieving it:

> *There was this dynamic that played out with me and my mum, you know. She was drunk and she said, "well what did you say to him?" and this kind of blame stuff. And then I was like "well if you'd went to see him when you said" (Keith, FM).*

For a few care-experienced participants who had particularly close relationships with young people who died, their intense guilt about the suicides appeared to instigate or significantly exacerbate their own suicidal ideation and actions. Often their own suicidal behaviour was linked to anniversaries or echoed deaths of young people they had lost. Misusing drugs and placing a belt round his neck, for example, mirrored Keith's brothers' means of death. One of Shannon's most dangerous suicide attempts occurred a year after her girlfriend Demi died.

> *…almost like a year to the day I swallowed 10 lithium batteries while I was on two to one constant observation and the staff didn't know and they didn't find out for like 24 hours. So, then I had to get like a major operation, and I nearly died… I couldn't say that every attempt on my life [was connected to Demi's death] but that specific one was definitely (Shannon CEA).*

The guilt felt by many care-experienced participants often seemed to be connected to the experiences they had shared with young people who died. Patrena, for example, believed that she could understand the difficulties and distress of her peers better than professionals. She believed that if she had used this understanding to reach out to Lewis, she might have prevented his death.

> *Sometimes, I just feel guilty - he was always like asking me to hang out and things like that. And most of the time I said no, and I felt as if I should have done more…maybe been there for him more. Cause like I have something that the staff don't have - I know what it's like. I instantly get a part of him. I could have, I don't know, supported him in the things he was going through, cause I've more than likely went through some of that too (Patrena, CEA).*

Care-experienced participants' guilt was not only connected to a feeling they could have prevented deaths – some also described a deep sense of guilt that they had survived the system while their peers had experienced such despair that they lost the capacity to stay alive. Most were able to identify at least one positive relationship from their time in residential care and could recognise aspects of care that had been protective for them. Nevertheless, there was a strong sense that not only had the system of care failed to address the trauma they had experienced before entering care, but also that the system itself could be traumatising for many young people. Daniel explicitly named his experience of survivor guilt in his interview while reflecting on the young people he had known who died in or shortly after leaving care.

> *I probably have a wee bit of survivor's guilt; I think there's that as well. I think that's why I had to keep going back the system because I felt deep down, I fucked up somewhere because how did I make it out and they didn't? That pisses me off and I think that's something I've struggled with over the last couple of years (Daniel, CEA).*

For Daniel the fact that he had been involved with Lizzie in dangerous behaviour when they were in care together exacerbated this guilt, even though he was aware that there was no direct connection between this behaviour and Lizzie's subsequent death.

> *It really eats me up because there's times, oh God I'm getting all emotional about this. But there's times where I'd encourage her to take aerosols and, you know, I would egg her on to do stuff and aye I feel that it's horrible (Daniel, CEA).*

Daniel, however, was able to find a route through this guilt and stated that he can now use this emotion to feed his passion to improve the experience for young people leaving care.

> *I've thought a lot about that and I'm ok. Like I get there's nothing I could have done, but I think there's part of me that just wants to go back and fix it for the other kids that are coming through. I need to know that I'm doing everything I can to make sure that never happens to anybody else, I think, so I can sleep at night (Daniel, CEA).*

Others, however, were less able to deal with their loss and guilt through positive action. Pauline, for example, describes the impact on her of her friend's suicide.

> *I felt really guilty. I felt really guilty because, and at the time I felt, not angry with Abbie, I felt angry with myself. I felt like a failure. I felt like I'd failed her. And what happened was I became desperate to commit suicide to be with her and that's why they had to keep me in the hospital (Pauline, CEA).*

This guilt has persisted throughout most of her life and her suicidal ideation has been so intense that she has had to bargain with herself to stay alive.

> *… suicide is the ultimate sacrifice, you know, when you want to take your own life … it's such a deep, deep feeling that you keep it so secret …you just go over it and over it and over it. I mean I had a suicide plan. I only gave myself, up until a few years ago, I gave myself three years to live at a time… Permission to live for three years yeh and then I'd review it in three years (Pauline, CEA).*

Although many care-experienced participants clearly expressed their determination to use the discomforting experience of this guilt to fuel their commitment to change, there were also glimmers of the personal cost this involved. Hamish, for example, commented that there was not a single day he did not think about suicide, and several other people described their continuing struggles with their mental health. This gave insight into the continuing impact of trauma in their lives and the effects of their personal involvement in supporting others.

Some participants, on looking back, identified behaviours or communications that might have indicated suicidal intent which left them feeling that they should have realised that the person was contemplating suicide. Charlie reflected on the last time she had seen Demi in prison, shortly before her death. It had been an unexpected but powerful meeting where Demi was very tactile and expressive, which Charlie described as very unusual behaviour for her.

> *I was walking out and Demi turned and ran into my arms again and she said "I can't believe I saw you today I just can't believe I've saw you today" … the prison guards were at the door waiting to take her out and she broke from them and ran up to me again and gave me another hug … looking back now I realize it was almost an exaggerated moment I was having with her - then I got a call on the Sunday to say she had committed suicide on the Saturday night.*
>
> *Did I miss something? should I have picked up on something? should I have known? I have known her for five years should I have somehow maybe picked up on the fact that that was an exaggerated goodbye or a prolonged that's the word I'm looking for a prolonged goodbye? (Charlie, CW).*

Wren described Jenny bringing her possessions back to the house over a period of weeks before she came seeking support the night she died. Hamish noticed a positive change in Stevie's social media communications but had not realised that appearing more content could indicate a solidifying of suicidal intent rather than a recommitment to life. This capacity to recognise signs of distress or covert communications of suicidal intent only in hindsight is common amongst people bereaved by suicide (Owens, et al. 2011) and can contribute to feelings of guilt.

Anger

In this study participants were not only angry with individuals, including themselves, but they also targeted their frustration at policies, systems, and structures that they perceived had contributed to the deaths. This appeared across all three groups. For some this anger added to the pain of the deaths because there was no way to use this to effect change.

> *I don't think it's just upset and grief. Because I think there's a lot of anger there and the anger is at self and others in respect of "I've done nothing and what could I have done better?" "Or what could they have done better?" "Why is no one doing this?" There's lots of questions I want answered and that adds to pain. Because there's no answers to them, either (Robbie, AW).*

Interestingly, only one person directly expressed anger towards the person who died. Shannon initially felt that her girlfriend, Demi, had failed to understand the impact that her suicide would have on others and particularly on her. She reacted with hurt fury by destroying many of her most precious mementoes of her. Later she regretted this and was desperate to find scraps of memories through social media sites. Her rage became relocated onto people within the system, as well as the system itself, that she felt had let Demi down and had failed to understand or respond to her distress.

> *I was so hurt, and I was angry and initially my anger was directed at her and I was like "well fuck you, I'm hurting too but you don't see me doing that, that's fucking selfish." And like I destroyed [letters and photos] … And I ripped them all down, I ripped every single one into a million tiny bits and just sat there for the full day. Every letter, everything...*
>
> *[in her letter] she said sorry. And I suppose at the time I was like "well you should be fucking sorry" but now I'm like "why are you saying sorry? This isn't you; this isn't your doing." And I know that this isn't what she wanted but it was what she needed because she couldn't cope any longer and nobody was listening to her (Shannon, CEA).*

Some, though not all, professional participants in this research found themselves unexpectedly overwhelmed with anger towards the family, particularly the parents, of the young people who died.

> *I felt so angry with her birth parents like really, really angry because, I sort of, wanted to blame them (Wren, CW).*

This type of anger became particularly acute at the funerals of young people where the contrast between the expression of love and loss from family members and the actual support and care they had provided for their child was felt so powerfully.

> *Both the girls, the mother turned up, wailing and greeting and carrying on… and you do, you stand back, and you think what's that performance all about? I mean you didna, you didna look after them …so have they really got a right to be there? Aye I suppose they do - it's their kid… but there's a bit of you, you know, you're, you're a joke. I mean they didn't look after their weans, but here they are taking the sympathy off everybody (Amy, CW).*

Having these negative feelings towards family members felt uncomfortable for participants and it challenged their sense of themselves as people who feel compassion and concern for others. They were embarrassed and apologetic as they expressed them, seeming quite shocked by the continued intensity of their emotions several years after the event. Robbie's anger about the mismatch between the emotions expressed by parents about their dead child and how they behaved when the child was still alive, was quickly followed by guilt at even thinking like that.

> *And it's hard because you sit there and have a family member going up and speaking a load of shite- they don't even mention the fact that they've been in care- how wonderful this child was. And you're going it took them to die for you to say that out loud and they're not even hearing you. And that's hard. Why couldn't you have done this six years ago? Why couldn't you have said... how wonderful she was, how wonderful he was, why could you not let them know when they were alive? And you had a chance to do that. Instead of having to wait and be the chief mourner in a funeral…Then you feel angry with yourself for thinking that, because that's a parent who's lost a child regardless of whether they looked after them or not on a full-time basis. They're grieving horribly (Robbie, AW).*

One way of conceptualising a funeral is '*as a product and display of the doing of family*' (Woodthorpe, 2017, p. 598). All families use funerals to some extent as a performance of the story they wish to portray about the person who has died and their family. The families of care-experienced young people who die through suicide are exposed to the double stigma of not only having a child taken into the care system (Morriss, 2018; Schofield, et al. 2011) but losing them through suicide (Pitman, et al. 2018). It is perhaps unsurprising that both their child's difficult history and the circumstances of their death remain at least partially obscured in the organisation of the funeral. For the workers who cared for the young people, however, their relationship with them only existed because of this history and its suppression meant a denial not only of the importance of the relationship but of the relationship itself. One function of funerals is the deliberate differentiation between family and non-family, and, in most cases, formal kin structures are privileged over any other group such as 'chosen family,' friends or professional carers (Walters and Bailey, 2020). Some professionals who were interviewed for this study felt that they had been closer to the young person than those with a formal family relationship for many years, but that the funeral had diminished the meaning of their relationship with the young person and denied them a space for their grief.

> *I remember her mother standing up and talking about her angel and I remember, excuse me, but I was fucking raging because she stood up there ….she was standing there all in her clothes - she didn't know her daughter like we knew her because she never came to see her, she was never in contact with her but in that*

> *moment she was invited to speak about her daughter she was speaking about a stranger to us who were there, we were closest (Charlie, CW).*

The most virulent anger was directed towards the mothers of young people who died. The keen distress of carers who had lost a young person they cared for deeply and their feelings of exclusion seemed to unleash an unexpected capacity for blame and stigmatisation. Some feelings expressed echoed the type of stigmatising response that mothers of children in the care system frequently experience (Morriss, 2018)

Most mothers whose children are taken into care have themselves experienced considerable childhood adversity and the emotional, social, and financial implications of the removal of their children exposes them to further adversity. It appears that the pain experienced by some professional participants at the traumatic loss of young people, however, created a barrier to feeling empathy for these mothers. Briggs (2009) using a psychoanalytical perspective seeks to understand the unconscious dynamics that can emerge among suicide survivors. He suggests that projection of blame, guilt and anxiety can easily occur among those affected by the trauma of suicide. This displacement of feelings acts as protection against these feelings of guilt and anger, but a receptacle is necessary for the disowned feelings and so a scapegoat must be found. The responses described by participants in this research may be indicative of a complex reciprocal interaction where both the mothers and workers projected their guilt and anger about the death on to the other, resulting in a harsh punitive reaction from the workers and a process of exclusion and diminishment from the mothers. There is some indication that Lesley had some awareness of this process in her reflections about Donny.

> *As much as I have anger about his mum, I also have my own guilt thinking I should have been there (Lesley, CW).*

Care-experienced adults expressed much less of this kind of anger but there were examples where they too were upset about the behaviour of family members. Shannon, for example, was shocked by the way Ricky’s funeral was conducted:

> *…his family who had totally disowned him for the last four years, who wanted nothing more to do with him and would talk bad about him at every turn they had a priest …but Ricky was a protestant and he loved Rangers …and they were carrying out this very Catholic ceremony because that was who they were. But actually, they didn't even know who their own son was and that made me angry as well (Shannon, CEA).*

All participants expressed anger and frustration about the systemic problems they observed that they believed meant young care-leavers were repeatedly failed by the various agencies they encountered. Patrena was confused and upset that her experience of the system was dramatically different from others. She felt loved and secure, but her friend died of suicide in prison as did another young boy she had lived alongside.

> *I think what annoys me most when I think back on it is… we both lived in children's units in Burndale, like the same kind of environment, and had the same social worker for years. But I'm still here and I got that support and I'm not just surviving, I'm thriving... And he's not alive anymore… how the hell does that happen underneath the same local authority? (Patrena, CEA).*

Many participants expressed anger that, from their perspective, lack of resources and procedural pressures often pushed social workers into making decisions about young people's transitions out of care that ultimately compromised their safety. This is borne out by several accounts of young people being returned home to situations that were known to be unsafe and which broke down within months, catapulting young people into homelessness.

> *Because you're very angry about the system because here's another young person who's not getting a choice, not getting opportunity… because of poor choices made by professionals. And it's always easy to see the poor choices when someone's died... it's the easy option, it's easier just to do certain things (Robbie AW).*

It was not only problems within the social work system that angered participants. Insufficient resources that led to inappropriate placement within criminal justice settings, as well as depersonalising processes that cut young prisoners off from human contact, were seen as systemic issues that contributed directly to some deaths. Shannon was angry that Ryan had to go to prison despite his recognised vulnerability and young age because there was no space in the secure care estate.

> *So, I remember having a conversation about the fact that this young boy had to go to Polmont because there was no secure beds - that was the Friday and then we heard on the Monday. The following Tuesday there was a meeting for the secure care board and everybody was like "yeh we need to acknowledge that it's been a horrible situation" and just something in me was like "no let's not just acknowledge that it's a horrible situation, let's acknowledge that every single person in this room could have and should have done something differently and they didn't and because we didn't, he's dead" (Shannon, CEA).*

Vaswani and Paul (2019) recognised that despite the vision of developing trauma-informed practice in Scottish prisons there were numerous barriers to its implementation. They identified an inherent tension between the punitive controlling purpose of imprisonment and attempts to address the distress and trauma experienced by most prisoners. Existing personnel, places, practice, and procedures all act as barriers to implementing a more therapeutic model and can in fact contribute to the further traumatisation of prisoners. Such barriers were evident in the accounts given by participants. For example, Charlie found it hard to accept that Demi was left alone, without human support for prolonged periods of time despite her obvious vulnerability.

> *it's all done by a camera now - you've got a vulnerable girl with serious mental health, self-harm is all over her for you to see, why, why would she be put into a cell for 14 hours without any physical contact (Charlie, CW).*

Others felt that the health service had failed to protect young care-leavers that sought help for their emotional anguish but who ultimately killed themselves on hospital premises as happened with Donny and Patrick.

> *I heard Donny went to hospital for help and they declined him help. If somebody of that age came into the hospital and asked for help, they shouldn't have rejected that help, they should have got that help. They're there because they need that help (Declan, CEA).*

Robbie described being regularly contacted by Finn, a young man who lost his sister to suicide and shortly after his mother also killed herself. Robbie outlined his continuing frustration that no mental health service appears willing to support Finn despite his extreme trauma and desperation.

> *…this young person has been bumped from mental health service to mental health service. No real support has helped him deal with the issues... he has been up and down the country… he's not a human being any more he's just a problem... He has to sit on top of buildings and say he's going to kill himself to get support and get sectioned. He just needs more containment. He can't contain himself. He needs to be contained, and no service will touch him… he hasn't got a life, he's currently in prison, because he was in a fight. He has nothing to lose, nothing to lose (Robbie, AW).*

Robbie found Finn's current situation appalling but he also has no confidence that Finn will survive in the long term.

> *This is horrific. It's a slow death in my eyes, it's a really slow death and you can see it. And I don't know a social worker or residential worker that couldn't identify someone who's in that similar position. You can see what's going to happen and no one feels powerful enough to do something about it. We are all powerless because the system does not allow him to get support. So, he will be the next one. Next funeral I'm going to - I have no doubt about that (Robbie, AW).*

Although Robbie emphasized his respect for individual social workers and residential workers, he made it clear that he could not himself work in a social work setting because he could not tolerate feeling complicit in a system he perceived as failing.

> *I do not want to be complicit in a system I don't trust. I don't trust it. And its main priority is to protect and save children… but the system itself is killing people (Robbie, AW).*

There was also a recognition, however, that social care system is embedded in wider Scottish society and to some extent reflects its values and priorities. Charlie was scathing in her views about how the number of suicides of care-leavers reflected on Scotland's culture.

> *if you have a kid, one kid decides that death is better than life when they've left… then that's a shameful Scotland, I think. I think that's, that's a shameful Scotland (Charlie, CW).*

Underpinning this anger was frustration at the type of collective turning away from young care-leavers' needs and distress that participants believed contributed to so many deaths they reflected on. Long (2002) identifies a semi-conscious dynamic that she calls the perverse social defence where a reality that challenges vested interests or previous certainties is simultaneously both recognized and denied. She suggests that such processes are most likely to occur in situations where instrumental concerns are prioritized above human needs and that as a result society and organisations develop a thick skin which proves impermeable to distress. There has been evidence since the 1990s that care-leavers face a very different route to independence than their peers which pushes them abruptly into the adult world with low levels of practical and emotional support (Dixon and Stein, 2003; Matheson and Connelly, 2012; Viner and Taylor, 2005; Zlotnick, et al. 2012). Nevertheless, the level of resources required to implement the type of structural changes that could improve the process of leaving care are missing. Long (2002) and Steiner (1985) would argue that politicians, policy makers and practitioners often 'turn a blind eye' to the human costs of the current system. We are simultaneously aware and unaware of these damaging implications but unconsciously collude to deny them. Rather than societal or systemic failure being acknowledged, individual care-leavers are seen as failures. Even when policy changes, the resources required to implement necessary changes are lacking (Lough Dennell, et al. 2022; McGhee, 2017).

Some care-experienced participants made a distinction between their frustration about systemic failings and individual instances of poor professional practice. Shannon, for example, felt that some residential workers' response to Demi's distress had been uncaring.

> *…there was one time where she tried to tie a ligature and the staff were just so cold when dealing with all that stuff - it was like "oh fuck here we go again" and they would go in and do what they had to do and then they would leave (Shannon, CEA).*

Some had witnessed attitudes and reactions to other young people that indicated to them that their care was sub-optimal, often contrasting this to the positive care they had received from the same staff. Despite the anger this evoked, some care-experienced participants had a nuanced understanding of how workers could become cut off and unresponsive to distress. Shannon, for example, demonstrated her understanding of how such defences evolved in residential settings whilst clearly recognizing their cost:

> *There's obviously an element of them having to protect themselves as well and I suppose I don't blame them for that, not at all, but it's a double-edged sword. So, you either completely emotionally detach yourself and shut yourself off and become like a robot and that can actually inflict more pain and hurt than kind of embracing it and trying to work with it (Shannon, CEA).*

Menzies Lyth (1960) suggested that depersonalization and detachment can emerge as part of a complex social defence mechanism to protect practitioners in caring professions against the distress evoked by their daily exposure to pain and dependency. Residential workers experience the deep distress of the children they care for and an overwhelming demand to respond to unmet infantile needs. Defences against this pain and despair can develop at both an organisational and individual level, which as Shannon points out can be harmful to both young people and workers. Alternative ways of managing the pain of connection can be found, however, by offering practitioners holistic organisational containment through supportive mechanisms such as supervision, debriefing, staff meetings and reflective spaces can enable them to avoid such emotional disconnection (Ruch, 2007; Steckley, 2010).

A few care-experienced participants, however, also expressed their anger about incidents that they had observed that were abusive. Pauline, for example, described beatings, humiliation, and emotional cruelty in the home she lived in during the 1970s and linked this terrifying context to the suicides of young people she had lived alongside. Such incidents of grossly unacceptable practice were, however, uncommon in accounts, and they were usually understood to be caused by individual failings, whereas participants shared a widespread anger about existing structures and systems across several agencies which they perceived to be directly implicated in many deaths.

There was also recognition among participants, however, that, although their anger with wider systemic failings was genuine, they also felt angry with themselves, and this fueled their own guilt. For example, shortly before his death, Jack had contacted Davy in a very distressed state asking him for help. Davy also knew that Jack had asked his social worker to be taken back into care. In describing his reaction to Jack's death, Davy clearly showed not only his frustration at being unable to provide the support Jack had begged for, but also his reawakened anxiety and guilt that he previously let down a different young man, Jordan, who had gone on to kill himself.

> *fucking words hit me like a train, man... again, I felt like - it's happening again, again! How many of these weans am I going to fucking no support before they die (Davy, AW).*

As Robbie spoke about the prevalence of severe distress and suicide risk among young care-leavers, the realisation suddenly emerged for him that the silence surrounding the frequency of premature deaths among care-leavers, including from professionals like himself, risked maintaining the status quo.

> *And so, every day folk are holding on to "Oh, my God," kind of feelings, and every day, we don't talk about it. And every day we bury it - and every day we are all complicit, oh, my God, we are all just as bad, we're as bad as the system. Because we don't talk about it. And we don't highlight it (Robbie, AW).*

Interestingly, Robbie found the anger that was released by this realisation of his and others' 'complicity' to be energising rather than demoralizing, as he felt it helped to counter the pervasive sense of powerlessness he experienced in the face of a massive faceless system – if he was part of the system, he could help to change it.

Sadness and grief

Many participants across all groups struggled to find words that felt right to describe the pain they felt at the loss of young people. Despite the intensity of emotion expressed by participants, only one person specifically talked about the grief they experienced at the suicide of a young care-leaver. Pauline described being overcome by grief at Abbie's funeral.

> *And all I could do was sit on the stairs on the inside stairs and cry. I couldn't mingle, I couldn't talk, I couldn't do anything. I was just paralysed yeh. I was just paralysed with grief, and I was such a mess that the hospital was watching every single move I made (Pauline, CEA).*

Shock, guilt, and anger which are regularly reported as part of the grieving process (Bell, et al. 2012; Jordan, 2020; Spillane, et al. 2017) pervaded most accounts. Most participants, however, were hesitant about using the term 'grief' to describe their experience. When grief was mentioned, it was usually not directly in reference to the loss of a young person but to the barriers to expressing grief openly. Charlie, for example, was scathing about the impossibility of finding legitimate expressions of grief in her professional role.

> *when theories talk about how to manage a loss and how to manage a separation, manage a bereavement, they don't actually say but if you're a residential worker or social worker - then just ignore all those because actually any grieving you do will be in your personal life (Charlie, CW).*

It was not until several years after hearing about Lee's suicide whilst undertaking a counselling course, that Jillian was fully able to acknowledge her pain. At that point the enormity of the grief she felt really hit her and she began to process it.

> *I've never experienced grief until that time, like, and I think because he was a young life, it just it's a different, it's a different feeling of grief… that was the time when I actually processed it and allowed myself to go God, like, "that was… that hurt, that hurt me," like, really been able to explore some of those feelings. And that was really helpful (Jillian, CW).*

For many participants, it was as though they did not feel they had the right to speak about or even experience their grief. They were unsure whether their relationship permitted them to claim to be grieving although the intensity of their distress was evident in the content and expression of their words. Several people talked about the 'sadness' evoked by the deaths in general. For example, Amy's (CW) descriptions of attending funerals of young care-leavers who die highlighted this response:

> *It's very, very sad, very, very, very sad (Amy, CW).*

What emerged from the accounts of several participants across all groups, however, was that the term ‘sadness’ failed to express the depths of their personal bereavement. Jillian, for example, contrasts the depth of reaction she had to the deaths of the two young men she deeply cared about with that of another who she had known less well but felt very ‘sad’ about.

> *The young man who Lee shared a room with, that took his life, I feel pure sadness, just sadness (Jillian, CW).*

For Patrena, the sadness expressed by so many at Lewis’s funeral, whilst a welcome recognition of his life, just fueled her anger that more was not done for him.

> *Obviously, it was really sad and lots of people were crying and that made me feel quite a few things - it made me feel happy and kind of glad in a sense that all these people cared about him, but at the same time I was like this is a lot of people here that are obviously upset about this. We all could have done more (Patrena, CEA).*

Some participants in every group experienced people describing a death as ‘sad’ as dismissive of the importance of the event and the young person’s life.

> *…they just think it’s like a ‘sad’ thing that a young person’s passed away, but they don’t feel it (Patrena, CEA).*

Amplifying impact of cumulative loss

For several participants across all the groups the overwhelming emotions that they described were exacerbated by the experience of losing several young people to suicide or other premature deaths. The cumulative impact of such deaths was highlighted by Charlie in her reflections:

> *So, when we lose a child – our grieving is not just one or two, our grieving can be for the loss of eight, nine, ten kids. How many people could survive the loss of ten children? (Charlie, CW).*

Keith explained that although he had been very anxious about Antony’s recklessly self-destructive behaviour, his death breached the emotional defences he had built up after his brother Patrick’s suicide.

> *I was very angry because, I'd built myself in a way that I thought what I'd experienced before was the worst thing that could ever happen to me (Keith, FM).*

Shannon's grief and rage about Demi's suicide is triggered every time she hears about another care-leaver dying.

> *It boils my blood. It makes me so angry because we are continuing to fail them (Shannon, CEA).*

Although there is some indication that suicide may cluster in families (Baldessarini and Hennen, 2004), the level of exposure experienced by participants in this study to the suicide of young people they were close to seems very unusual and may be a particular risk of involvement in the residential childcare sector.

Social impact

As well as evoking a variety of powerful feelings, it was clear that the deaths of young people also affected the social interactions of many participants. There was no clear distinction among the different groups in relation to the social impacts of the losses they experienced although the experience of mistrust seemed to have a more pervasive effect on the lives of care-experienced participants than on professional participants where it seemed to be confined to the professional sphere. In some cases, increased commitment and social withdrawal could be discerned simultaneously within the same individual. Among some participants in all groups there was evidence that the trauma of the deaths had damaged their sense of trust in others and optimism about the future.

Personal /professional withdrawal

In this research some participants coped with their pain and loss through a degree of disconnection from others. Some professionals found it intolerable to remain in the same place or type of work and moved into alternative roles with young people where they believed suicide was less likely to happen, or to an advocacy organization, where they felt they could challenge the system more effectively. Others who had remained working in residential settings acknowledged that, though their commitment to young people increased, their professional optimism was severely damaged.

> *Have I become more cynical from it? Yes. Have I become less enthusiastic? Yes. And so, what are the long-term effects of Donny's suicide on me personally and professionally? Yes, in terms of professionally, less engaged, less willing to be engaged – with the system, not with the young people, not with the young people, I would just with them more, much more – but less willing to engage with a system that's out there, the bigger system (Lesley, CW).*

Others described the difficulty of avoiding a defensive retreat into disconnection and denial of the meaning and usefulness of their work.

> *But sometimes you just think "what are we doing? Are we just keeping them off the streets until the next one comes in?" And I had to fight that in myself because at one point I felt myself taking that attitude that "it's just a bedroom" and when somebody leaves that room there will be somebody else move into that room and then my focus then becomes on that person (George, CW).*

Some care-experienced adults, particularly those who had lost a sibling, like Keith, also described a similar process of disconnection from others that sometimes lasted a long time.

> *I struggled with it massively and the impact of it I was kind of a recluse for about a year. Like I started eating my dinner in my room, training loads like running and trying to take my mind off it and saying I was joining the army, I was away. But basically, for a year I didn't engage with people much and I got no help at all (Keith, FM).*

Increased commitment

Interestingly, a more common response amongst all three groups of participants was a deepened commitment to young people and an urgent desire to ensure that no other care-leavers they knew would die through suicide.

Several residential workers acknowledged having moments of questioning themselves and their continued investment in the work but emphasised that this did not change the way they related to young people. While clearly still committed to her work with young people in care Charlie, for example, acknowledged the enormity of the impact on her:

> *I questioned, I questioned whether or not I could go on doing this job. But it was a fleeting question. But the impact personally on me, its massive, massive impact. Oh, absolutely massive (Charlie, CW).*

Wren never contemplated reducing her level of involvement, but Jennie's death highlighted for her the fact that despite all the care she and her team had offered her they could not prevent her dying which left her acutely aware of the emotional costs of the work.

> *That whole bit about putting everything into your job - seeing if you can make a difference, by understanding the young people, by having powerful relationships with young people - and so to actually have all of that, but then somebody feel so utterly awful about themselves that they, they, they die at that age, does make you question all of that... but I've never felt, never felt I didn't want to do it, but it made me feel the difficulty of doing it and sort of, I suppose, the sadness of doing it (Wren, CW).*

Jillian acknowledged the temptation to withdraw from such intense relationships to prevent future pain but was clear that for her that response was fundamentally at odds with her sense of herself.

> *Some people would have liked could have maybe said, you know, when you experience that, those feelings, you protect yourself, and then you don't build the same bonds. Because of that bit about self-preservation as well, because the horrible feelings - however, I don't think my nature would allow that to happen, you know, you just you continue you just love these kids. And that's, that's what it's essentially about, you know, so that's hard, you know, really hard (Jillian, CW).*

Many care-experienced participants were in roles that involved direct contact with care-experienced children and young people, whether as residential workers, advocacy workers or contributing to the Independent Care Review or Future Pathways.[5] Most had known several young people who had died. They were powerfully motivated to fight for change to the system as well as ensuring that any personal relationships they had with care-experienced young people were underpinned by a deep and unconditional

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[5] 'Future Pathways supported people who were abused or neglected as children while they were living in care in Scotland. It was supported by funding from the Scottish Government and was managed by an alliance of organisations to oversee the fund and make sure it was reaching as many people as possible'. (https://future-pathways.co.uk/)

commitment that they hoped would offset the loneliness and despair they had seen in their dead peers.

> *I want to know so we can prevent it, so I can work to do that. Because I'm like, I just want to change all the shit things in the care system… I just want to fix all of it. I don't want that to ever happen to another family, any other person, loads of people that know that person - because even though we weren't that close, it still affects me (Patrena, CEA).*

Shannon recognized that this passionate commitment to change was also a way to provide comfort for her own profound loss at the death of her girlfriend.

> *That's why I throw myself and I throw my heart and soul into trying to change things. But whatever changes that are made for tomorrow will never ever change yesterday. But I suppose I'm doing them in the hope that it maybe gives me a bit of comfort that there won't be someone else sitting in the same predicament and that it won't have been for nothing (Shannon, CEA).*

Participants were self-selected and their desire to be involved in this research suggests that they had been powerfully affected by suicide and were motivated to create change. It is possible that the type of defended withdrawal from commitment that Jillian alludes to in her reflections may be a more common response than the data from this research suggests. There is some evidence of this in descriptions given by participants of some responses they encountered from professionals. Daniel (CEA) for example was shocked by the lack of reaction to Lizzie's death from those who had looked after her for several years:

> *I'd expect a reaction, you know when you tell someone that. I was so upset about it ...but a lot of the staff were just "that's a shame" and you go "you looked after this wee girl" if you told me that one of the bairns I'd cared for, I would have cried - there would have been a reaction, something, but there was just nothing. And that baffles me how can you talk about attachment and love in these houses but that's not love. She was there for a long time. She was there much longer than me - it was maybe about 6 years she was there (Daniel, CEA).*

It is difficult to know whether such responses were the result of detachment, desensitisation and reduced enthusiasm characteristic of compassion fatigue (Coetzee and Klopper, 2010) or indicative of a belief in the importance of professional distance.

It may also be that participants' own distress meant that they misinterpreted other people's responses and assumed they indicated a lack of concern and care.

Mistrust

One effect of trauma is that it can shatter a sense of trust in the world and other people (Janoff-Bulman, 1992; Schuler and Boals, 2016). There were indications in many participants' accounts that the suicides and their aftermath had eroded their optimism and hope or confirmed existing experiences of being let down. Several professionals spoke scathingly of managers failing to offer support which continued to affect their trust in management and organisational support structures. George was on night cover when Peter, who was about to leave the unit, hung himself. He stated that no staff were offered any support or even asked how they felt, and he believed that if a similar event occurred the level of support would be no greater now. His comment shows his mistrust of his own organisation but also illustrates his sense that this is the prevailing attitude in the wider sector:

> *I think sometimes what I've discovered within the care sector, that the word 'care' is forgotten (George, CW).*

Both professionals and care-experienced adults also expressed a sense of despair that any meaningful change would occur for young people leaving care, despite sweeping changes in policy and legislation (*Children and Young People (Scotland) Act 2014; McGhee, 2017)*. This distrust in the system may have been exacerbated for many care-experienced adults because, as they described in their interviews, they were already dealing with the impact of cumulative trauma from their previous negative life experiences before and during their time in care.

There is evidence from the literature that mistrust of services is a particular problem for siblings of those who die by suicide (Royden, 2021). Keith described the detrimental impact this pervasive mistrust had on his life. The NHS had acknowledged serious professional negligence had contributed to his brother's suicide and for over ten years Keith avoided any contact with medical professionals, despite escalating difficulties with his own mental health. The excellent, life-saving care that his infant daughter experienced, shifted his attitude, allowing him to seek support for his trauma.

> *…she was in intensive care for ten days the NHS were phenomenal and saved her life, there's no way she would be here. It's these life events that have even helped me resolve some of the hang ups that I've had because I understand that, when I say 'the NHS' - it was just a group of people that were negligent at that point in time. It might have been part of a structural thing, culture, but at that time it stopped me getting help for ten years because I couldn't trust them (Keith, FM).*

One factor that can impede recovery from trauma is the lack of epistemic trust (Fonagy and Allison, 2014). This has its roots in difficult early attachment experiences and childhood trauma which can make connection with the minds of others very frightening and therefore hard to accept their support (Fonagy and Allison, 2014; Luyten and Fonagy, 2019). For some care-experienced participants there were indications in their accounts that relationships with significant adults during their time in care had helped to build at least a partial capacity for epistemic trust that had helped them to survive the further trauma of the suicides they described. Patrena, for example, had a secure sense of belonging through her long-standing relationships with adults who had cared for her throughout her childhood and to whom she could turn to share her grief at Lewis's death.

Key findings and discussion

Participants' descriptions of the effects on them of the suicides and other premature deaths of young care-leavers they experienced echo the existing literature of those bereaved by suicide. In the model of suicide survivorship suggested by Cerel, et al. (2014) most would have fitted into one of the two most powerfully affected groups (short-term or long-term bereaved). They suffered the overwhelming negative feelings associated with loss by suicide (Bell, et al. 2012; Jordan, 2020; Spillane, et al. 2017) and some experienced considerable social disconnectedness after the deaths (McGill, et al. 2022). A few care-experienced participants were still displaying signs of complicated and protracted grief many years after the deaths (Bellini, et al. 2018). Interestingly, no participant described receiving effective formal recognition and support with their loss.

Most research on the impact of suicide has been conducted on close family members or friends of individuals who died. The similarity of emotional and social responses described in this study to those identified in such research suggests that people exposed to suicide within the residential childcare sector constitute a neglected group of the suicide bereaved.

The initial overpowering and embodied responses of shock that were experienced by many participants in every group in this study have been reported in research on the effects of suicide bereavement on family members (Spillane, et al. 2017). The creeping anxiety they reported about the possibility of future premature deaths has also been found among the family members and close friends of people who died by suicide (Azorina, et al. 2019).

The feelings of guilt described by participants also resonate strongly with findings from the literature. Guilt is a common response in those exposed to suicide (Jordan, 2020) and can contribute to prolonged grief symptoms in the bereaved (Young, et al. 2017). Suicide can be perceived as preventable, and the bereaved person may feel they could have averted the death or that their own behaviour may have contributed to it. An over-estimation of personal responsibility for the death is common amongst those bereaved by suicide (Young, et al. 2012). This contributes to the continual replaying of events and memories and sense of lost opportunities to change events. This feeling of blameworthiness can lead to the type of self-stigmatising response that, for example, affected Keith and can interrupt the process of healing and integrating the loss (Feigelman and Cerel, 2020).

The vulnerability of the care-experienced adults in this study to guilt in response to the death of their peers is also supported by research. The care-experienced participants had shared living spaces as well as experiences of loss and disruption with the young people who died. People risk survivor guilt if they have share traumatic experiences with someone who goes on to die by suicide (Pathania, et al. 2018). Most care-experienced adults also described their own experiences of trauma and other adversity in childhood and there is emerging evidence that ACEs can lead to an increased propensity for experiencing guilt in adulthood (Wojcik, et al. 2019).

Anger is often experienced by survivors of suicide but within the literature, when anger is expressed, it is most often directed towards the person who died (Royden, 2021). This type of anger was conspicuously absent from the account of almost all participants in the study. Young, et al. (2022) identified that, as well as anger towards the person who died, many people bereaved through suicide feel angry with themselves, as well as with others in their family and social networks. They also often direct their anger towards professionals that they believe failed to keep the person alive. There was certainly evidence from participants across all the groups that they were often angry with themselves because they felt they had failed the young people who died in some way. The most intense personally directed anger that was expressed, however, was that of some professionals towards the birth families of young people. The intensity and virulence of this anger, which was simultaneously a source of extreme discomfort for participants, seems to be different to the anger reported in the literature. Similarly, the focus from all participants on the structural and systemic failings that they believed led directly to young people's deaths and their helpless rage at feeling powerless to effect change seemed unlike the anger described in the literature towards individual professionals and their failures of care.

Bereavement through suicide is known to increase the risk of a complicated grief reaction (Wagner, et al. 2021). Suicide still carries with it a stigma that can leave the survivors of suicide ashamed and alienated, cut off from the normal expressions of grief and socially isolated (Chapple, et al. 2015; Hanschmidt, et al. 2016). Arguably, this was exacerbated for some participants in this study because the context of their work or lives, within the care system, seemed to restrict their opportunities to talk at depth about their feelings which reduced the potential relief and stress-related growth that can be associated with self-disclosure (Levi-Belz, 2016).

The literature on bereavement reports a sense of disconnection from others as a common initial response to a death of any kind (Smith, et al. 2020). This seems to be due in part to the bereaved person's avoidance of others because of their negative interpretations of the behaviour they experience or expect from those around them, as well as a more general sense of alienation from others because of their loss. The social isolation experienced by those bereaved by suicide appears to be more intense, however, as the stigma and shame associated with suicide contributes to an inability talk about their intense feelings. They also report feelings of overwhelming isolation and a belief that nobody could understand their situation (McGill, et al. 2022). Although such social withdrawal and disconnection are common responses to bereavement through suicide (McGill, et al. 2022; Smith, et al. 2020), the cumulative impact of loss through several suicides or premature deaths in a context of intense personal or professional relationships that was found in this study seems particular to the children's social care context.

Alongside the distress they experienced, however, many participants were demonstrating post-traumatic resilience (Papadopoulos and Hsiu-Chuan, 2022; Tedeschi and Calhoun, 2004) in a variety of ways. Several professionals described strengthening their commitment to young people and continuing relationships beyond the point they left care. Most care-experienced participants and family members were active in organisations and campaigns that aimed to change policy and practice that would improve the experience of young care-leavers, and a few demonstrated their resilience by making a conscious commitment to their own survival despite their continued suicidal ideation.

This study demonstrates that all three groups represented here are potentially at risk of the distressing effects of suicide bereavement. There has, however, been little previous research that considers the direct impact of the suicides or other deaths of young care-leavers on those close to them. In addition, there is a lack of awareness about the factors that affect these groups in different ways from others who are bereaved by suicide. Arguably, shock, horror, anger, and guilt are natural responses to the unexpected loss of a young life (Bell, et al. 2012). What emerged from these interviews, however, were some additional complications faced by people in the residential childcare sector faced with the suicide of a young person they knew well. The findings of this research suggest that many workers and most people who have lived in residential childcare settings for a lengthy period are likely to know more than one young person who has died – some have known several. Although people in certain occupations, such as emergency services, are likely to be exposed to multiple suicides in their lives (Lyra, et al. 2021), it is very unusual for any one person to lose several close connections to suicide. In this research, however, it was common for participants to talk about many deaths that had affected them. This cumulative experience may explain another difference that emerged in this study. Although anger is a common response to suicide – often towards the person who died or to other individuals who could be perceived as culpable – in this study there was a consistent pattern of anger about the structure and systems, policies and practices that were perceived to contribute directly to the difficulties that most young care-leavers experience and that, for a few, may end in death. The cumulative impact of such losses and the powerlessness evoked by a sense of the inevitability of some deaths, due to engrained systemic failures, exacerbated their distress and anger.

The attitudes and responses of others to their losses often added to the distress that participants experienced. This and the constraints imposed by participants' roles and status affected expression of their grief in complicated and disenfranchising ways, which will be explored in the next chapter.

Chapter Five: Disenfranchised Grief

Charlie describes the impact of the responses of others to her grief.

I've probably had between eight and ten suicides, I can name them. The common theme was that I didn't really exist. Because if I showed my emotion, I was being unprofessional. I was to be part of a media hunt. I was dehumanized, I was not allowed to be a person, I was, in some shape or form, to blame. We are faceless, we are nameless and we have absolutely no right to exist. I remember feeling very isolated in my grief. Who's caring for the carer? Who cares for the carer in their darkest moments? And the truth is – not very many people – that's the truth. Did anybody say to me "How are you doing?" Not, not once! Not once! That's why there was that feeling of absolute isolation. I was a professional and that was my job – I should have been able to cope with all those things and all that pain and, and I wasn't, I seriously wasn't coping at all. When we cut, we bleed, you know, our tears are real tears and we're human beings. So, when we lose a child – our grieving is not just one or two, our grieving can be for the loss of eight, nine/ten kids. How many people could survive the loss of ten children? I remember feeling like I was aching like a parent would and yet I don't have any children… but I loved them, I genuinely gave a piece of my heart to them. There is no opportunity at the funerals of our young people to stand up and say I miss them, and I loved them, and I cared for them and I'm you know – I'm grieving.

(Charlie, CW)

Introduction

As well as the direct impact of the deaths, participants were often exposed to more subtle interpersonal and group processes that left them feeling their grief was devalued. These were often connected to societal or professional norms that conflicted with their personal experiences. Many are powerfully expressed in Charlie's account of her experience constructed from her own words. This chapter uses Doka's concept of disenfranchised grief to explore participants' feelings that their grief was perceived as inappropriate or unimportant (Doka, 1989). Participants' differing use of family as metaphor is explored and linked to the various ways in which participants experienced their grief as disenfranchised. The lack of importance accorded to the relationship and the young person who died is also examined by exploring how participants heard the news of the deaths and the continuing impact of stigma. The anxiety felt by participants that the care-leavers who died will be forgotten, both as individuals and a group, is also highlighted. Participants' sense they had no right to grieve is examined by exploring the internalised effects of professional boundaries as well as the alienating experience of attending funerals. Finally, the various ways that the experience of disenfranchised grief contributed to participants' sense of isolation are explored.

Doka (1989, p. 4) described disenfranchised grief as: '… *that person's experience when they incur a loss that is not or cannot be openly acknowledged, socially sanctioned or publicly mourned.'* As he pointed out, social norms and 'rules' exist in every society that frame the process of grief. When the loss falls outside these prescribed parameters, individuals may experience their grief as being 'disenfranchised.' Grief and distress are customarily perceived as more acceptable for certain kinds of losses than others which may be to do with the type of loss, the assumed importance of relationships or the value ascribed to the person who died (Doka, 1989). There is a societally accepted hierarchy of bereavement which elevates the importance of family members' grief and devalues relationships outside the normal hierarchy (Robson and Walter, 2013). In addition, the stigma associated with some deaths, including suicides, can lead to people experiencing a sense that their grief is not legitimate (Corr, 2002). This continuing stigma may lead to a reluctance to talk about or acknowledge the death and can distort perceptions of those bereaved by suicide (Oexle, et al. 2018).

Devalued relationships

Throughout the interviews care-experienced and professional participants highlighted the mismatch between their experience of relationships with those who died and the way these were viewed by other people. This led to a sense that their grief was seen as inappropriate or unimportant. This section examines the intensity of relationships described and the various ways in which participants were made to feel that they did not matter.

Contested nature of family as metaphor

In this research all the professional participants, particularly those still working in residential childcare settings, stated that, despite their closeness to care-leavers who died, and their central role in their care, they encountered numerous personal, organisational and societal responses that diminished their role as mourners. The intensity and nature of the relationships that they believed they had with the young people who died were unrecognised by others and therefore their grief was dismissed as irrelevant compared to that of family members. Residential workers made frequent use of the idea of family as a metaphor for practice and relationships in their residential settings and linked this to the intensity of their grief when young people died. Whilst still recognising their role as professionals, several described their relationships with young people as being like that of parent and child.

> *… these are kids who, for all intents and purposes,… you were a parent, like, long before I had kids of my own, I was a parent,… I never thought of it at times as going into work it was you're gonna to see like your second family, not just your colleagues, but the kids, you know, the, these are kids, that brought you real joy and laughter and difficulty, but it was challenging (Jillian, CW).*

A few care-experienced participants also acknowledged that individual workers had become like family members for them and wondered if their peers who had died had enjoyed such closeness and trust.

> *I don't see her as my old keyworker – she's family… She's my rock… if I need her – if she needs me – we make time for each other. If I've got any problems I pick up that phone. Lorna's always on the other side of the phone. Maybe that's what Donny should have had when he was going through that (Declan, CEA).*

Overall, however, there were fewer accounts of family-like relationships from care-experienced participants. Instead, several described an overwhelming sense that the level of instability they experienced made it very difficult to trust people. Despite claiming Lorna as 'family,' Declan, for example, explained that his care experience made it hard to develop secure relationships with those responsible for his care.

> *…throughout your full care life… you're used to people coming and going like traffic lights. One minute you're green, then amber then they're gone, you know. You're used to people walking in and out of your life (Declan, CEA).*

Care-experienced participants did not actively resist the possibility of family-like relationships in residential settings, but they often described disappointment or frustration when the hope or offer of something special that echoed family failed to meet their expectations. Finch (2007) argued that display of family requires both an audience and an act of recognition from that audience. In the residential childcare context, the daily interactions between children and staff provide multiple opportunities to display family but when such displays take place, they are not always acknowledged by the audience they are directed towards or, alternatively, their authenticity may be questioned. For example, Keith's experience with his favourite member of staff undermined his developing sense that a family-like relationship was possible with her.

> *It was wee things like, or big things, you know like... even your favourite member of staff, overhearing them being disgusted at the fact they had to work Christmas day… it just reinforced the fact that it wasn't love... I've still got a photo album y where I'd wrote her name and I wrote I loved her like a mum and then I'd scrubbed it out because I was so angry. I've still kept it, if you look really closely you can see it, because it felt as if it was - I felt as if I wanted to express the relationship like that, but, of course, when you hear something like that you understand it's not what you thought it was (Keith, FM).*

Daniel described a conversation with a manager of the children's home where he and Lizzie grew up together – a man whose practice he deeply respected and who had explicitly described the home as 'a different kind of family.' They were going through photos together and remembering the young people who had lived in the home. For Daniel, however, far from confirming the familial nature of the home and the relationships available there, this process forced him to question it.

> *…as this manager is going through all the photos there are about seven young people that killed themselves or died because of drugs. Seven. And I was just sitting there thinking to myself. So, you're saying, "Our kids are perfectly happy, they don't need advocates, we provide love, we give them a family." But you're talking about seven kids. And it was just that acceptance of it (Daniel CEA).*

The differences between participants who worked in residential care settings and those who lived in them are interesting and worth exploring, to understand how the presence or absence of a sense of family contributed to their experience of disenfranchised grief. Although there is the obvious difference in role - worker or resident - among this group of participants there were also other fundamentally different experiences. Unusually, all the residential workers in this study had worked for a long time in residential childcare, often in the same setting and with a core group of colleagues with whom they had significant and longstanding relationships.[6] Some relationships echoed family, Lesley(CW) for example talked about her assistant manager Al as being like her work husband and described Donny's relationship with them, as a pair, as being 'like his mum and dad.' Most residential workers could identify several young people they had known with whom they had formed significant reciprocal relationships that felt to them family-like. These included relationships with some young people who died and whose loss they still grieved.

In contrast, most care-experienced participants had experienced considerable instability in their care journey, including multiple placements and the sudden disappearance of important relationships when staff members or fellow residents left homes where they had lived. Continual ruptures in their emotional connections contributed to a persistent sense of loss and mistrust in the permanence of any relationship. Most suggested that the way the care system is constructed and operates creates barriers against the development of such relationships. As well as the constant turmoil and change that they had experienced they also identified processes such as the extensive sharing of personal information and the type and level of behavioural restriction and control that contributed to a more general mistrust of adults. Keith, for example, felt that his experience in care, not only did not help him recover from trauma, in some ways it created it:

> *…absolutely it made it worse. I mean I think it would be an understatement even to say it made it worse. It caused it in circumstances - you know how we were moved, where we were moved, and even the way your childhood is constructed.*

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[6] This does not reflect the general picture of employment in the sector where staff retention is a serious problem and turnover can be very high (Gaskell, 2010; Mulholland, et al. 2016).

> *It becomes, it is taken away by the sheer design of it, you know. When you're forced into adult spaces, constructs, discussions, reflection, all of these things that are forced upon you (Keith, FM).*

Patrena's experience, however, was noticeably different and she explicitly labelled her relationships, and Laurel Place, the house she had lived in since she was seven, as family-like. She, however, had been in Laurel Place with the same key adults, whom she perceived as raising her, for over twelve years. She described deep and continuing relationships with them though she had moved out some years earlier. Moreover, these were shifting into more reciprocal adult relationships where, as well as accepting support, she knew more about their personal lives and struggles and could be supportive to them in return. They had a long history of shared memories and were able to create and maintain a narrative that linked them over time. They had a web of relationships that reinforced this narrative which included connections with family members of the adults who had looked after her. Over many years they had engaged together in the everyday family-like practices that Morgan (1996) described, and their interactions with each other, and those external to Laurel Place, displayed that these were family-like relationships (Finch, 2007). Patrena's description of getting ready to leave care provides a powerful example of this doing and displaying of family.

> *Annie (keyworker) said "I'm basically your mammy I'm taking you. Callum (throughcare worker) is a nice guy and that, but I am your mammy, I'm doing this with you, we're going to decorate it together." And she did do all that stuff with me, so it was actually like really, really nice before I even moved in. I had nice, funny memories of me and Annie having to rebuild my TV stand like three times because we had it back to front …And so I have happy memories of how loved I was because I remember them saying as well when we were standing outside Kerry (House Manager) was like that to me "It might not look like much from the outside but we're going to make it look like a palace on the inside for you" (Patrena CEA).*

Her continuing emotional connection to Laurel Place was demonstrated by the way she labelled it compared to the flat she was living in.

> *… on Google maps I actually have my address as under "house" and I have Laurel Place's address as "home" (Patrena, CEA).*

Patrena was not only explicit about perceiving many adults as 'family' she also talked about young people with whom she had shared her living space as her 'corporate brothers and sisters.' She described the shock and grief she experienced when Ryan died, even though they had not been close when they lived in Laurel Place together. This acknowledgement of the importance of relationships between young people in a residential setting and the possibility that these might also be family-like was, however, unusual among participants, whether professionals or care-experienced. Although Lesley (CW) was concerned about the impact on Declan (CEA) after Donny's suicide because their shared experience of several residential settings meant for her that they were almost like brothers, this perspective was uncommon among professionals. Although Laurel Place felt like a family to Patrena, she was aware of the prevailing mistrust staff had about any kind of relationships between children. She reported hearing numerous instances where children were warned not to get too close to others in the home with comments such as:

> *… these people here aren't your friends. They'll turn on you, they'll stop being your friend whenever it suits them, just go out and make your own friends in the community that aren't care-experienced cause you won't be living here forever, you won't stay with these people forever, you won't know them forever (Patrena, CEA).*

She also described concealing her meetings with Lewis, a young person who went on to die by suicide, knowing adults would disapprove of her friendship with him because he too was in care. This attitude sits uneasily beside a professed belief that a home is like a family and suggests that even for adults the family-like nature of residential care was partial and limited to some, rather than all, relationships in any setting. Some care-experienced adults also described cultures within homes where the relationships between young people involved a lot of bullying, and any weakness would be exploited. Declan, for example, suggested that young people had to create a

> *… shield that you're in and you keep everything close to your chest and you don't trust anybody with it (Declan, CEA).*

Despite this difficult environment, care-experienced participants described some intense and important relationships that had developed and thrived with other young people, but these were generally conducted covertly because of the perceived disapproval of staff.

The patchy and contested nature of family-like experiences in residential settings can illuminate the various ways that participants experienced their grief to be disenfranchised. The continual use of the metaphor of family, not only to describe the relationships and living environment in residential care but also to contrast them with those in birth families, highlighted the gap in conceptualization and language for describing the residential childcare experience. Residential workers seemed to use family-like comparisons to describe the intense grief and loss they experienced because the depth of their response did not fit with the way professional relationships were conceptualized. Societal norms and the responses of those around them, however, combined to disallow their claim to a family-like level of grief. As Charlie reflects:

> *we underestimate the impact it has on residential workers hugely because there is a lack of recognition of the power of the relationship that you have with the kids you care for (Charlie, CW).*

In contrast, when the care-experienced adults reflected on their relationships with young people who had died, they often remembered continual attempts to separate them from each other and a culture which disparaged the meaning of closeness and connection between children. Far from being a family-like experience of siblings growing up together, relationships with others in care were viewed with suspicion and, as a result, young people learned to hide these relationships and conduct them out of sight of staff.

Hearing the news

Some participants in this study felt that the way they learned about the deaths contributed to their feeling that their relationship with the young person who died did not matter. Several care-experienced participants only found out several years after the event that someone, whom they had been close to in care, had died. Even when participants did find out about a death quickly, the way the information was shared sometimes reflected a lack of understanding of the importance of the relationship.

Patrena, for example, overheard staff talking about Lewis's and Ryan's deaths when she was visiting the house she had lived in:

> *that's how I found out about it- it was just like a throw away comment… some of the staff… I don't think that all of them knew him, like personally knew him, and so it kind of felt as well that like... "Oh, they just think it's like a sad thing that a young person's passed away, but they don't feel it. So, like how should they get to know but someone that actually knows him doesn't?" Then they were like "oh also Ryan is dead too, they done it on the same week" it was very… they lacked empathy in telling me (Patrena, CEA).*

Hearing in such a casual way about the suicides of two young men, with whom she had significant relationships, affected Patrena profoundly. It is clear from her comment that she felt that the meaning of her relationships with them had not been recognised.

Lesley (CW) also felt her relationship with Donny had been devalued by the way in which she had found out about his death:

> *…social work had been advised on the Saturday that Donny was dead... on the Monday there were rumours about Donny's death... it was confirmed to me later on the Monday by my manager… the social worker was a newly allocated social worker, she didn't really know Donny… it was staff within residential services, that had been more connected to Donny - but we were an afterthought, and for me the loss of Donny had greater impact on our service than on the social worker who didn't have that relationship with him… For me that's not unique. Each young person when I've found out about their death I've found out by accident (Lesley, CW).*

Lesley had known Donny for seven years and he had lived in houses she managed for much of that period, yet she felt there was no organisational recognition of the importance of this relationship for both her and Donny.

Two participants first heard about young people's deaths on the national news. Although Daisy (CW) had known Jamie for several years and had taken him from his care placement to the homeless hostel only a few weeks earlier, she was not informed directly of his death.

> *I heard it on the news. That's how I found out. So, I was sitting in my living room and they had said that a young boy had died and told me what his name was and that they'd found him under the bridge (Daisy, CW).*

Hamish (CEA) had been involved with Stevie in charity work but the significance of his friendship with him had gone unrecognised, so he too was never informed directly about the death but also heard it on the news.

The belittling of relationships between young people in care meant that the grief of care-experienced participants at the death of those they had lived with was not recognized and little thought given to how or whether they were told. The reality of their loss was not socially validated because of their unrecognized status as bereaved individuals. The meaning and intensity of relationships professional participants had with those who died were also unrecognised and some also did not hear the news in a timely or sensitive way.

These experiences contrasted strongly with the care taken to break the news when the relationships were perceived to fit into established hierarchies of loss (Robson and Walter, 2013). Keith, for example, was staying overnight with his younger brothers' foster carers when his oldest brother, Patrick, died by suicide. The carers took great care to break the news to him sensitively and in a safe space. Similarly, when participants such as Shannon and Pauline were in current romantic relationships or intense friendships with a young person who died, they were informed quickly and directly.

In their systematic review of the process of notification of violent unexpected deaths, De Leo, et al. (2020) emphasised the shattering implications of poorly managed delivery of the news for bereaved individuals. They highlighted the importance of respect in the interaction as well as a considered use of language and tone of voice pointing out that *'these are details that a survivor could potentially remember throughout his/her life and therefore deserve special attention' (De Leo, 2020, p. 12).* In this study many participants learnt of the deaths in ways that demonstrated little respect for them or the people who had died and, as Patrena's memory of hearing about Lewis and Ryan's death demonstrated, this continued to cause distress.

Impact of stigma

People who have suffered a bereavement can experience their grief as disenfranchised when the death is perceived as less important than other deaths. Deaths of people from marginalised or ostracised groups may not attract the same concern or sympathy as those from more mainstream communities (Baker, et al. 2021). Certain types of death, such as suicide, which carry some degree of societal stigma may also deny bereaved individuals the social validation of their grief (Bell, et al. 2012). Goffman (1963, p. 4) described stigma as 'an undesired differentness' that can result in a person being perceived as 'not quite human.' He also described the mechanisms people use to conceal differentness to avoid being stigmatised. For example, the continuing stigma associated with suicide as a means of death can lead bereaved individuals to conceal or deny the cause of death.

Some participants in every group provided evidence that they were exposed to the lingering stigma associated with suicide. Patrena, for example, was hurt and angry about her sister's response to Lewis's and Ryan's deaths based on a religious belief that suicide is wrong.

> *I remember, talking to my little sister about it recently cause I told her I was going to do this and my little sister is adopted and her adoptive mum is very religious and she was like "oh that's a sin" and I was like "Hah! That's the wrong thing to say to me!" yeah. I was like "it's a sin for everyone that's let him down" (Patrena CEA).*

Participants also gave examples of people wanting to reframe the suicides as accidental or not really intentional, even when the nature of the death -such as hanging or jumping from a height – meant that survival was extremely unlikely. Wren, for example, reported conversations with colleagues about Lewis, who hung himself in prison:

> *People that are really close to him, two or three of them, said to me 'I don't feel, I don't feel that he, he wanted to, I feel he was asking for help' (Wren CW)*

There were also some indications of the stigma associated with a care identity and how this acted to devalue the meaning and importance of care-leavers' deaths. The dismissive comments that some participants across all groups experienced, in response to the deaths, contributed to their sense that these young people were perceived not to matter and therefore that their own grief was devalued. For example, the cynical comment of a colleague, who had been a prison officer, shocked George, when they were working together the night that Peter's body was discovered:

> *An extra breakfast in the morning. That's the way it would be looked at if it happened in a prison (George, CW).*

Although this was an overtly crass comment that diminished both the meaning of the death and the value of the young man who died, participants were also sensitive to responses that they experienced as superficial and lacking real concern. When, for example, Lesley (CW) was breaking the news to staff of Donny's death she found some responses disturbing.

> *The ones I found quite hard were the ones that kinda felt almost (and there weren't many) but there were one or two that almost kind of almost felt a bit dismissive (Lesley CW).*

One phrase repeatedly mentioned by different participants was 'it's a shame' which was experienced as very dismissive. Shannon (CEA) described both the anger it evoked in her and the experience of othering she felt when she heard the phrase.

> *…it's like a red rag to a bull, but also, it's like a distancing mark (Shannon, CEA).*

There was clearly something in the tone of those who used the phrase that evoked this response and when participants repeated it, they used an exaggeratedly indifferent voice, and some even turned their bodies away slightly as if trying to reenact their experience of their grief being disdained. This was in direct contrast to Charlie's use of the term 'shame' and the excoriating anger she expressed about the 'shameful' absence of support for Scotland's care-leavers which she believed led to premature deaths.

Implicit in some interviews was the sense that these deaths didn’t count and indeed, at the time of the interviews literally were not counted, and that this somehow diminished young people’s humanity. Robbie (AW) talked about the deaths of six young people with whom he had personal relationships, but his work also made him aware of many more. He expressed his frustration at the failure to gather evidence that could even demonstrate there was a problem.

> *And because the stats haven't been collated, we haven't got the evidence to say these young people are dying. We've got, you know, yeah, lots and lots and lots of stories, or voices, we will never hear again, But numbers. We don't have numbers. And that's the worst of it because you can't prove anything. Until you've got stats, nothing will happen until you've got stats (Robbie AW).*

He went on to describe his concern for Finn, a young man whose sister and mother had both killed themselves, and whose spiral into chaotic distress caused him continual anxiety. His view was that Finn was no longer perceived as a person of any worth:

> *he's not a human being he's just a problem now (Robbie AW).*

When Daniel wanted to create a lasting memorial to Lizzie by planting a tree in the house they grew up in, he was shocked by the marked difference in response to Lizzie’s death compared to that of a staff member:

> *The manager of that house died a few years earlier with breast cancer, it was devastating, it was really sad. And they had a beautiful tree put just outside her office where she could, you know, be remembered. And I had the thought why don’t we get a tree on the other side that would actually look quite nice, you know, the two of them together. And they were like “oh no, you can’t do that, how sad would that be for the children coming in” and thinking “oh I might die.”’ And I was just like “but this is one of your kids, there should be a place for her. If she doesn’t have a grave then she should have a place.” (Daniel CEA)*

In a less extreme form this echoed the differential treatment between the magnificent requiem masses said for nuns who had worked at the Smyllum Orphanage in Lanarkshire and the unmarked mass grave where child residents were buried (Scotsman, 2003).

Keith felt that the staff’s reluctance to mention his brother Patrick’s suicide, was a denial of his worth and left Keith feeling that his grief was unimportant:

> *Once the funeral was over, we got back to living - it was just like it never happened. It was like he hadn't existed (Keith, FM).*

The only time he remembers any residential worker saying anything about Patrick's suicide was when one commented that he could sue the NHS. There had been medical negligence, and his mother was offered and accepted a small compensation payment which she divided among her remaining children. Keith's discomfort about the staff member's comment and the compensation payment was apparent in the interview. He felt that his mother accepted the money because:

> *obviously, she was poor which, you know I've got no judgement on I just know that's the structure for taking advantage of someone that lives in poverty (Keith, FM).*

There was a sense that the intersecting stigma of extreme poverty and a care identity meant that Patrick's death could be expunged by a monetary payout.

Disturbingly, the examples participants gave of comments and attitudes that diminished the importance of young care-leavers' deaths came mainly from professionals working within the care and health systems. Some devaluing responses were even from residential child-care workers. This suggests that the intensity of relationships and depth of grief that were characteristic of professional participants in this study are by no means universal among those working in this sector.

In this research, most examples that highlighted the stigma associated with a care identity, and its impact on the perceived invalidation of participants' grief, drew on the personal reactions to the deaths that participants encountered. The perspective of the two advocacy workers, however, hinted at an awareness of wider societal drivers of stigma production that maintain existing power relationships and structures. Robbie's concern about the failure to collect appropriate mortality data for care-leavers, and his descriptions of the systemic failures in Finn's care, move beyond the distress engendered by individual experiences of discrimination or insensitivity. Davy (AW) is explicit that in their campaigning work his organisation supports care-leavers to identify and challenge stigmatising processes.

> *We support young people to have a critical reflection of their life - within that they then identify systems or structures that they feel oppressed them. And then we'll try and give them tools in order for them to speak on behalf of themselves and others… because the system, because the system is really powerful and you feel it pushing back, you feel it, you feel it (Davy, AW).*

Rituals and remembering

Most participants across all groups felt there was no real place for them to mourn and remember the young people who died, and the following section of this chapter explores this aspect of the disenfranchisement of their grief. As has already been identified, the experience for participants, particularly professionals, of attending funerals often triggered considerable anger towards family members. They were also spaces where many participants felt excluded and their relationships with young people devalued. Moreover, participants often felt that the real identity of the young person who died was often hidden in these rituals. Several participants felt that there needed to be an additional process of memorialisation that acknowledged young people's care identity, and which ensured that they and their deaths would not be forgotten.

The experience of funerals

Within this research, attendance at funerals was often mentioned by participants, particularly professionals, as a trigger for their sense of disenfranchisement. For many, the experience of a young person's funeral failed to contribute to a resolution of grief, instead it exacerbated anger and a sense of exclusion because their relationship with the deceased was not acknowledged.

> *I kinda felt that her grief was given an importance and a place, but my grief wasn't you know, and Donny meant a lot to me and… but it was it was like it, that was trivialized like, do you know, that wasn't, that wasn't given any, not even any significance. It just wasn't given any importance, that was like it didn't really matter (Lesley, CW).*

These experiences fit with the work of Romanoff and Terenzio (1998) who in their examination of grief and ritual processes, found that, although funerals may be effective transition experiences for most bereaved individuals, those who are experiencing disenfranchised grief may derive little benefit from traditional mourning rituals.

Although this sense of active exclusion was described by some participants, others struggled with their own reluctance to claim a space in the funeral that might distress the family. Jillian (CW) was unable to attend either Donny's or Lee's funeral, but she wondered how intrusive their families might have found any real expression of grief if she had gone.

> *I would have gone. There's no question about that. But you're then sharing your grief with a family who are like, you know, you don't know how comforted they would feel about that – that day wouldn't have been about anything other than a mum who's lost a son, a guy whose lost his brother… These were, these were boys who we loved, you know, we really cared about, but we're reminded that they were not ours (Jillian, CW).*

Despite having been quite involved in supporting Jennie's adoptive parents in the planning of the funeral and choice of music, Wren still felt that she and her colleagues had to remain in the background on the actual day.

> *I suppose you feel quite, I don't know, really taking a kind of back seat as well, because, in many ways during Jennie's teenage years we'd been her parents, but we just sort of sat there quietly… just cos you're a service at the end of the day (Wren, CW).*

The experience of the funeral highlighted the complicated role of residential workers. They are expected to provide the care, nurture, boundaries and, in many cases, love, for young people that good parents would, but they also have to cope with the loss of these young people as though they were 'just professionals.' This sense of displacement and exclusion was profound and even though there was a recognition of the primacy of the family's role at the funeral there was a desire for a space where they could speak their grief and own their relationships with the young people. Often their time in care remained unacknowledged which emphasized the sense of exclusion for participants.

> *…at the funerals again, we were missing. Nobody made any reference to us in a speech, in a tribute, no one even said "You know we're thinking about the staff who knew them." We just didn't exist - now when you don't exist how do you find a place for your grief, when you don't have a place to put it because no one wants to give you it (Charlie, CW).*

In their reflections on the funerals they attended, it was not only a sense of personal exclusion that participants described. Funerals are a space in which the identity of the deceased can be affirmed and celebrated, and the number and variety of mourners can provide confirmation that they had mattered to other people (Maple, et al. 2014). When a person dies by suicide, it also offers the opportunity for them to be reclaimed as whole person rather than seen as just a suicide statistic (Maple, et al. 2014). Funerals can also, however, be places where uncomfortable truths or inconvenient aspects of the deceased's stories are concealed (Walter and Bailey, 2020).

Keith's experience of his brother Patrick's funeral highlighted for him the emptiness of Patrick's life. Rather than a ritual that recognised Patrick's worth and value, for Keith, it emphasised how little he had impacted on the world.

> *The funeral felt bleak. It felt empty. Because when he'd left care, and because he didn't have a community of people around him… he'd had this like homeless lifestyle. And it was like he was 18 and he died, and I remember looking about thinking it was like my mum's alcoholic pals and people that were in the same situation as him at his funeral and I was like, at 18 a funeral, a church should be packed. You shouldn't be able to get a seat because you should be just out of school and there should be all your clubs, all your teachers, like and it was like nobody… (Keith FM).*

Professional participants also felt that sometimes families portrayed only a partial identity of young people to help cope with their guilt and shame about the deaths. This meant that important relationships, qualities, and achievements could go unrecognized. When Demi's mother spoke about her daughter, for example, Charlie (CW) and her colleagues found it hard to recognize the girl they knew.

> *she didn't know her daughter like we knew her because she never came to see her - she was never in contact with her - but in that moment she was invited to speak about her daughter - she was speaking about a stranger to us who were there (Charlie, CW).*

Similarly, Lesley was upset that the family's portrayal of Donny did not acknowledge his many positive qualities and achievements.

> *At the funeral, the time to celebrate his life, he was lost in that process, too, because it wasn't all of Donny. All the stuff that was said and spoken about it wasn't all about who Donny was. There was the real bits that were missing… they didn't actually capture who Donny really was… we didn't talk about what a loving young man he was, how warm he was - there was none of that there... the focus was very much on the cheeky chappie, which was Donny. But there was all those other bits that that they didn't get, and that was all missed (Lesley CW).*

Some participants however, found different ways to preserve their own memories of young people who died, sometimes even at the funerals.

> *We walked up to where she was being laid to rest and we were all walking together and we were upset clearly upset but we ended up laughing and we knew that we had to stop laughing because we could be seen as being disrespectful… we started to exchange a lot of memories that were our memories but we never had a place at that funeral (Charlie, CW).*

Although participants struggled with their own pain at being unrecognized, they were also concerned about the meaning that this exclusion had on the way a young person was remembered.

> *It wasn't that I didn't matter it was that it didn't matter that I mattered - does that make sense? (Charlie, CW).*

Charlie felt that this lack of acknowledgement of Demi's relationships and experiences in the care system meant that a key part of her identity was lost. It was not just the experience of funerals that contributed to this erosion of identity. Many participants across all groups shared memories of young people who had died that were full of laughter and joy as well as sadness and pain – these were young people who had evoked love and connection. As Wren described Jennie:

> *She was just very, very, very clever and very, very funny and just a real character, so everybody kind of loved her (Wren CW).*

Participants were frustrated that the manner of their deaths left them trapped in flawed identities that were subsumed into a narrative of victims of the care system.

> *You reinforce all the negatives. But there can also be a twist because he had a really good life. "They did this, and they did that, do you remember when this happened?" And you can make it much more positive and hold on to the positives instead of going – [big sigh] "It's really sad." "No, they didn't live a great life." "We can do better. It's all over now" (Robbie, AW).*

One powerful example mentioned was the way that Georgia Rowe's and Niamh Lafferty's identities had merged to become 'the Erskine Bridge girls, the suicide pact girls'[7] and the meaning and importance of their separate personalities, histories and experiences were in danger of being lost.

Fear of being forgotten

For some participants in every group, there was a profound anxiety that the care-experienced young people they had known would be quickly forgotten. Amy (CW) explained how important she felt it had been when her local authority organized a reunion of care-experienced people, that those who had died were remembered and their photos put on display on a special memory wall. Others talked frequently at conferences or training events, or among friends and colleagues, about these young people so that they were not forgotten. For some care-experienced participants the fear young people would be forgotten resonated with their own history of abandonment and worry that they themselves might not be remembered.

> *One of my worst fears in life is being forgotten about and that is because I was abandoned really. I think everybody just needs someone to be crazy about them and just want to keep memories and hold that history. Lemn Sissay talks about that… there's no photographs of when he was a wee boy, but he wrote his poems and that's how he copes with it… he just didn't want any of the young people to die or be forgotten. It's just horrible, it just shouldn't happen Daniel (CEA).*

Young people and staff at the Warren decided to create a memorial to Donny in their garden so that he could be held in mind by those that had known him. Unfortunately, the way they chose to remember him was derided by the psychologists who were supposed to be providing support to the team to deal with their loss and grief. Rather

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[7] Georgia Rowe and Niamh Lafferty were two young women who were in care together and died by suicide in October 2009 after jumping off the Erskine Bridge.

than helping them to recover, this response contributed to their already existing sense that their grief was perceived as inappropriate.

> *We had planted a tree at the Warren, that was a tree for Donny. And when the psychologists came I felt that they ridiculed our tree because they were very quick in saying that when suicide was through hanging, the last thing that you should do is put a tree… this psychologist, she - you could tell that actually, she'd probably never known anybody that had taken their own life. So, it was a theoretical response, it was straight out of a book. And it was nothing to do with the actual connection to it... it was who Donny was, he loved the outdoors. He loved the trees, he loved climbing trees, and he loved planting stuff in the garden. So why would we not plant a tree, so we never took our tree out, we kept the tree and the tree's still in the Warren and people still see it as Donny's tree and there are a lot of staff that's still there that knew Donny, it's five years on since Donny died. But there's still a connection (Lesley, CW).*

For those who had known and loved Donny, the tree symbolised who he had been, but they felt that their way of grieving and remembering him was belittled by people who had never met him. Providing professional support to those bereaved by suicide is not easy and can be experienced in a negative way. In a qualitative review of studies of social interaction after suicide loss, Sajan, et al. (2022) found that psychological support was not always perceived as positive, particularly when provided by people who are perceived as unsympathetic or too distant from the experience. Drawing on abstract or ‘textbook’ approaches to suicide and loss were perceived as particularly alienating. In the case of Donny’s death, the psychologists were perceived as failing to understand either the needs of those at the Warren who were grieving his loss, or who Donny had been in his life.

Having an actual place to go to remember people was also felt to be important. Daniel (CEA) was desperate to know where Lizzie had been buried but quickly realized that it was unlikely that there was anywhere for him to go to remember her.

> *I asked her best pal Josie “is there a place for me to go and visit?” - she was like “well not really”… that devastated me -probably more so than her death, actually. I was like “well where do people go to celebrate her life?” As far as I know there wasn’t a funeral, her dad wouldn’t have paid for it. So, I think she would have been forgotten which is devastating. I've not even got a photo of her, I think that’s the saddest thing, there’s not a photograph. The manager and I were looking at all the old photos, like there’s photos, Lizzie’s not one of them. This wee girl*

> *literally hasn't left a mark on the world… it's appalling. Obviously, I mention her in talks that I've done just so she's there… so that people know she was here - I'll always take her with me, she's part of that journey. But, aye, who else was doing that? (Daniel, CEA).*

Some care-experienced participants and family members described reluctance from those who had looked after young people during their care journey to provide space or support to ensure that young people could be remembered. This was demonstrated in the unwillingness of staff in Daniel's previous home to allow a tree to be planted in Lizzie's memory. Similarly, Kate described the struggle to get the bills for Kristy's birth brother, Brian's funeral paid, and her sense that, even in his death, he was not claimed by those who had had responsibility for his care.

> *… finally, finally, finally, social work, because Brian was section 16, so they coughed up in the end and he was only 22 when he died, remember, so he was pretty close to the care system. But even to the end they were battling about who was going to pay. And of course, obviously he's got a headstone which we sorted out. He wouldn't have had one otherwise (Kate FM).*

Brian's funeral was unusually inclusive because Kate had a personal and professional understanding of the importance of embracing and acknowledging Brian's whole identity. Nevertheless, if Kate had not helped to organize the funeral and pay for a headstone there would have been nowhere his family and others close to him could come to remember him.

Young people who had died were also remembered through social media or when those who had known them came together but there was a pervasive desire for a formal space to remember and celebrate the lives of care-experienced people they had known. Daniel shared his fantasy of a memorial that demonstrated that Scotland would never forget those care- experienced people.

> *Every time I hear about another one dying, it breaks my heart - I hate it. It's something that I always talk about - can we get a memorial for people that have died. There's not a place for so many of them. it would be beautiful to have a [book] or something that's for all of the ones that have died. And then it's a beautiful thing that's created, it's not morbid… I imagine this book sitting in the Scottish Parliament, in this glass box so we cannot forget. And that's in the heart*

> *of Scottish politics - that whatever happens we must always think about those kids. And that would be a memorial (Daniel, CEA).*

Isolation

The lack of any communal space or shared ritual where they felt they could acknowledge the intensity of their loss left many participants across all groups dealing with their grief in isolation. This section explores the various internal and external processes that contributed to this experience of isolation.

No right to grieve – the hidden cost of professional boundaries.

Many care workers wrestled with their own internalized norms that were at odds with the depth of feelings they were experiencing, and this led to a degree of self-censorship and disconnection from others. Several made comments suggesting that they felt they did not have a right to grieve. For example, Daisy, a throughcare worker, had been very upset by Jamie's death, but felt uncomfortable about the depth of her feelings of loss.

> *I don't think I would have felt like I had a right to have gone to his funeral. Not feeling like I had a right to be that upset (Daisy, CW).*

Jillian similarly felt that the depth of her pain would be seen as somehow inappropriate and illegitimate for someone who had had a 'professional' relationship with a child.

> *Am I allowed to feel this way? Am I allowed to feel like that I, I need to talk to somebody about this because professional boundaries would, would, do you know what I mean, it, like, God are people gonna think, like, that I've overstepped the mark here because I'm weeping for a child who's died... Does that make sense? (Jillian, CW).*

Several described how powerfully the concept of professional boundaries contributed to their sense of discomfort about their own level of grief. This was particularly true for managers who felt an even stronger pressure to suppress their own feelings to be able to deal with the distress of young people and other staff members.

> *I wasn't sure how I should feel and the reason was [a previous suicide] had made me question my professional life but also there was an expectation as a [senior*

> *manager] that I behave professionally so I wasn't allowed to show my emotion I had a duty to support the staff and to support the kids (Charlie, CW).*

Although when Donny and Lee died, Jillian also experienced pressure to suppress her emotions as a manager, she recognized that, within her organization, practice had changed. There was now an increased focus on reflective processes and opportunities for staff to explore the emotional impact of every aspect of their work together, with support from an external consultant. She felt that this would now allow a different expression of grief.

> *She (the consultant) would be able to hold that grief and maybe now, in retrospect, for the people that worked with Donny specifically, it would have been good to have had her facilitate something like that where she could hold people's grief and that permission-giving of it's okay to cry (Jillian, CW).*

She felt that this recent focus on reflective practice had legitimized emotional expression, and she might, therefore, feel more able to share her feelings rather than suppress them, but she acknowledged that the pressure to keep in control still remained.

> *I think I probably felt a duty to kind of be composed about that. Never really had the opportunity to deal with it - like at all, even. If I had it differently now I'd probably have shown them much more of what I was really feeling... but you still feel as if you've got that responsibility to hold it together (Jillian, CW).*

These reflections highlight the tension between the expectation that workers should be able to cope with such losses in a 'professional manner' as part of the job and the reality that, many had loved these young people as though they were their own children and that their deaths were hugely significant.

Being silenced and lack of support

Residential childcare workers also described responses from other professionals, particularly external managers, that left them feeling isolated and unsupported. Apart from Jillian's account of the developments in reflective practice in her organisation, professional participants provided little evidence that appropriate organisational support was available for staff affected by the deaths of young people. Jillian herself, suppressed her own grief for several years until she went on an external course where she began to process her emotions.

> *A couple of years ago, I went on the COSCA counselling skills course and one of the modules that we did was about grief… so I had the opportunity, because we kind of went into wee triads… you had to bring something to the table and I talked about Lee (Jillian, CW).*

Even when concern for staff was expressed, it could quickly become contaminated by a focus on protecting the organisation. Wren, for example, remembered a cursory enquiry from external managers about how people were managing, followed by a rapid focus on possible blame.

> *It's that kind of thing that you get in all social work all the time [laughter] – in that you've got how are people feeling? what really happened? and then you've got is anyone to blame? are you responsible? And, did you do all the right things? is it your fault in any way? (Wren, CW).*

This organisational anxiety about blame and responsibility can also contribute to silencing grief and suppressing emotion. Simpson (2013) suggested that many social care workers are reluctant to acknowledge the distress and loss they may experience in their work, and this can lead to a self-disenfranchisement of their grief. She argued, however, that this takes place in a professional and institutional climate which initiates and reinforces the denial of the legitimacy of the difficult feelings experienced and encourages their suppression. She suggested that the prioritisation of the immediately urgent and the impact of inadequate resources mean that social work organisations are at risk of creating cultures and practices that deliberately ignore the distress and grief of social care workers exposed to serious loss in their work. This type of self-censorship has also been found among other care and health professionals. Morrissey and Higgins (2021), for example, identified a sense among mental health nurses that acknowledging distress about a client's suicide, whether to colleagues or families, might suggest they were covering up some type of malpractice.

Care-experienced adults also described a variety of isolating and silencing responses from other people to the losses they experienced. For example, Pauline (CEA) explained that an older boy in the home she grew up in hung himself, just before he was due to leave care. All the children saw his body and witnessed the staff's panicked response when it was discovered. After that day, however, it was never mentioned again.

> *It was awful, it was really, really scary. And what was even scarier was that the staff didn't know what to do. They were all running around and screaming and shouting at each other and nobody could hear what they were saying because everybody was shouting… when I came back at lunch time everything was quiet and hush hush… no-one ever talked about it… I think if you tried to speak about them you'd be closed down… you'd be in trouble yeh (Pauline, CEA).*

Not only were Pauline and the other children offered no support to deal with their terror and loss, but they were also completely silenced and there was no acknowledgement that the death had even happened. The events Pauline described took place over thirty years earlier and such a complete denial of experiences and silencing of emotions is less likely to occur in residential care now. Nevertheless, some care-experienced participants' accounts of more recent losses make clear that they too felt isolated and silenced in their grief by the responses of others. Keith's (FM) description of the immediate aftermath of his brother Patrick's suicide illustrated not only the failure of those around him to respond sensitively to his distress but also how effectively his behaviour kept people away.

> *At that time, I just, just isolated myself massively, but externally behaving differently so… I was in school… they said they were going to exclude me… my behaviour was challenging, you know, aggressive and pushing the boundaries, all of that was playing out in school and in different circles. You know, taking risks and pushing people - in my own life and in the home and stuff I was just isolated. I kind of lived in a room (Keith FM).*

In Keith's account a self-reinforcing circular relationship between isolation and disenfranchised grief begins to emerge. The nature of Patrick's death and the stigma associated with his care identity left Keith feeling that his brother's death was not seen as important. His distress about his brother, which was expressed in challenging ways, was unrecognized or perceived as inappropriate, which added to his experience of disenfranchised grief. His social withdrawal was both a reaction to his grief and a protection against anticipated stigma. Although he both chose to withdraw and, to some extent, actively drove people away by his behaviour, his isolation only contributed further to this experience of disenfranchised grief which in turn consolidated his sense of isolation. Interestingly, the only people that were able to disrupt this circular process and reach out to him in his isolation were his fellow residents, despite rules that effectively discouraged private conversations between them.

> *Nobody came... other young people, just the other young people would come into your room, and you'd have a talk. But then obviously the rules were you don't go into each other's rooms, especially if you're male and female. So, I had a really good relationship with one of the lassies and it was just like, she'd sneak into my room, and we'd talk. And her brother actually died as well. He died so there was a commonality there (Keith FM).*

As well as demonstrating the potentially healing power of relationships between young people even in the face of adult disapproval, Keith's account emphasizes the importance of shared experience and feeling understood. This was also apparent in Patrena's (CEA) description of how she only felt able to express her grief about Lewis and Ryan's deaths with someone who shared her distress. The insensitive way in which she first heard about their deaths left her feeling that the staff involved devalued the meaning of the deaths and her initial response was to hide her shock and grief. This changed when she and Callum (her and Lewis's social worker) were able to share their grief together and talk about their memories.

> *When I first heard I was like "oh my god, oh my god!" but I didn't get upset or really show any emotion or stuff like that. And then my social worker came in and he was like "oh I heard that you, I found out you heard" and I was like "yeah" and that's when I let it all out we were both crying on the couch. And that's when I let it out (Patrena CEA).*

The nature of the care system as a place to work and to live may also have contributed to the isolation participants experienced in dealing with their grief. Several care-experienced participants, such as Keith, who lost a friend or family member to suicide, particularly whilst still living in a care or health setting, had to endure the loneliness of managing their grief surrounded by people to whom the loss had little or no relevance.

> *I struggled with it massively and the impact of it I was kind of a recluse for about a year. Like I started eating my dinner in my room, training loads like running and trying to take my mind off it and saying I was joining the army, I was away (Keith FM).*

When professionals, such as Charlie, were unable to obtain emotional support within their organisation, issues of confidentiality and a lack of understanding restricted their capacity to explain or share their grief with their own family members except at a most basic level.

> *So, I was going home and I was going home with pain -now my partner doesn't work in social work - I was speaking to her as my partner, but she couldn't quite understand she'd never experienced that type of grief. So, who could I turn to? I took it home but couldn't really or didn't want to, more to the point, bring it into my house (Charlie CW).*

For several participants across all groups the research interview was their first safe opportunity to talk freely about their grief and their memories of the young people who died. Although some had moments when they were distressed by the process, they said they were glad to have had a chance to tell their stories. Previous studies have identified positive benefits that participating in grief research can have for bereaved people (Dyregrov, 2004; Varga, 2021). For those grieving a loss by suicide these included the opportunity to relate their thoughts and feelings about the traumatic event they had experienced, as well as the chance to reconstruct identity and re-order meaning that had been disrupted by the death (Dyregrov, 2004; Morrisey and Higgins, 2021). Similar benefits were also identified by participants in this research. Many, however, also felt positive about their involvement because they believed that, as well as highlighting the importance of their deaths, the research reaffirmed the value and meaning of the lives of the care-leavers they had lost. Taking part in the research seemed to have strengthened their capacity to resist the disenfranchisement of their grief by reasserting their right to express their distress as well as to challenge the devaluation of the young people they had lost. Robbie (AW), for example, expressed the hope that something of the young people he had known might live on through the research:

> *I have found it very therapeutic actually to discuss it. I'm not, I'm not holding on to it. I haven't let go of it… you know, I haven't given it to you. But the fact is, I've*

> *been able to share that... the void's slightly smaller in the sense that, you know... just by talking to me, you've now got a sense of who these young people were in a, in a small sense, but that's somebody else who didn't know them beforehand and now there's a slight legacy there. And that legacy might even live on your PhD. So, you know, it's cathartic, I suppose (Robbie, AW).*

Key findings and discussion

The use of family metaphor in residential care has been explored in recent academic literature (Fowler, 2018; McIntosh, et al. 2011; Smith, 2009). Kendrick (2013), for example, described how young people in residential care may use family and kinship terminology to talk about their positive experiences. He also pointed out that the daily shared activities and interactions in residential settings echo practices that constitute family life. In their exploration of therapeutic parenting in residential childcare, Burbidge, et al. (2020) found that practitioners regularly described their workplace as being like an extension of their own family. McIntosh, et al. (2011) also acknowledged that both staff and young people described some activities and relationships as 'family-like', but they highlighted the tensions and ambiguities that exist in residential settings which are simultaneously workplaces, living spaces and institutions. They identified that the food practices apparent in the homes they observed were regularly described by staff as deliberately family-like but that they could also be the focus of resistance from some young people to the idea that the home was in anyway comparable to family life.

These ideas help in examining the intensity and meaning of the complex set of relationships that can develop among those who live and work in residential childcare setting. This may illuminate the various ways different participants experienced the deaths of the young care-leavers they talked about and their responses to the way their grief was or was not recognised. The residential workers in this study experienced their grief as being like that of a bereaved parent but felt that their relationships with the young people who died were not valued. In contrast most care-experienced participants, except for Patrena, did not feel that the relationships they had with the adults looking after them while they were in care had the unconditional or enduring nature of family. Although there were examples of individual workers who had provided security and continuing connection the residential setting was not experienced by them as family-like and therefore provided little comfort to them in their grief. In particular, the active disruption of relationships between young people prevented the development of sibling-like bonds and encouraged covert connections between young people. The meaning and importance of such hidden relationships often remained unrecognised and the grief of care-experienced participants unnoticed.

The stigma associated with the care experience that seemed to be evident within the accounts of participants is supported within the literature. Care-experienced children and young people, particularly those living in residential childcare settings, are often perceived as a societal problem and of less value than other children (Hanlon, 2007). In a qualitative study on the stigmatising impact of residential childcare, Day, et al. (2023, p. 54) found that the children who took part felt *'pushed to one side by a system that has given up on them.'* They suggested that the discourse of residential childcare as a last resort and the children as, in some way damaged or unmanageable, contributed to the stigma they experienced. Wareing and Gilroy (2021) also highlight the perverse effects of the tendering processes that underpin funding for residential childcare whereby organisations must emphasise the problems and differences that children have, to obtain sufficient resources. Some structural and systemic stigmatising processes are enacted through individual responses and practices. Brown, et al. (2020), for example, describe finding seriously judgemental and pejorative language used in their records. They also highlighted the suspicion and resistance they encountered in accessing their personal information. Moreover, they described how this experience reminded them of their attempts as children to manage the shame and stigma of their care identities through concealment and half-truths in their relationships with others. These entrenched stigmatising attitudes and practices contributed to participants' sense that young people's deaths were perceived not to matter. These feelings were amplified as many of the care-leavers whose deaths were the focus of this study not only carried the stigma of a care identity but also become part of other marginalised and ostracised groups such as homeless people, offenders or substance-users that also attract stigma.

As well as recognizing the individual experiences of participants and the difficult personal journeys of the care-leavers who died it is important to retain a broader perspective on the societal factors that contribute to the original difficulties that bring children into the care system and that create structures and attitudes that fail to prevent the negative outcomes experienced by many care-leavers. There is considerable evidence that poverty and inequality are inextricably associated with child welfare interventions (Bywaters, et al. 2015; Bywaters, et al. 2020; Featherstone, et al. 2017) and that young people's transitions from care to independence are fraught with structurally created obstacles that can cause damage in every area of their lives (Power and Raphael, 2018; Turner and Percy-Smith, 2020; Welch, et al. 2018). Nevertheless, as highlighted by participants in this study, there is a continuing professional and policy focus on individual failure and inadequacy. The work of Hoggett (2010) on the perverse social defence system and government illuminates the dynamics by which well-meaning people can become complicit in the maintenance of structures and systems that reproduce inequality and distress. He argued that the financial and political costs of recognising the suffering of marginalised or ostracised groups created a *'thick skin […] between the state, its managers and policymakers on the one hand, and the many seas of social suffering characteristic of increasingly socially polarized democracies'* (Hoggett, 2010, p. 210). When the effects of structural inequality can be recast as individual failings, then the most extreme consequences of these, such as the premature deaths of young care-leavers, become evidence of their personal flaws and less important than the deaths of other young people. It was, for example, the 2018 death in Polmont of Katie Allan, a middle-class student, that created public outrage rather than the multiple deaths of care-experienced young people in the prison system.

People bereaved by suicide often report feeling isolated from others as did many of the participants in this study (Pompili, et al. 2013; Ross, et al. 2021). This may in part be the result of the bereaved individual withdrawing from social connections, as Keith described, either because of a belief that others would be unable to understand their experience or an expectation that they might face stigma or insensitivity (Chapple, et al. 2015; Cvinar, 2005). This seems to be matched by an uncertainty from those around them about how to approach them or to address their loss (Azorina, et al. 2019; Bell, et al. 2012; Hunt, et al. 2019). Social support and connectedness, however, are consistently identified by people bereaved by suicide as important in the process of healing from their loss (Hunt, et al. 2019; McGill, et al. 2022; Ross, et al. 2021). The opportunity to talk freely about the person who died and to share their own overwhelming emotions without feeling judged are seen as particularly valuable (Hunt, et al. 2019; McGill, et al. 2022; Ross, et al. 2021). Many suicide-bereaved people also find great comfort from establishing connections with people who have been through similar experiences (Ross, et al. 2021). When social connections are absent, however, the isolating experience of being silenced, either by a process of self-censorship or through the inability of others to reach out, can contribute to the sense of people bereaved by suicide that their grief is illegitimate (Bell, et al. 2012; Maple, et al. 2010; Ratnarajah and Maple, 2011). Although most studies have concentrated on the needs of bereaved families and friends, there is evidence that professionals also need social support and benefit from people who are able to listen to their distress and confusion. Morrissey and Higgins (2021) highlighted that the lack of a supportive space for mental health nurses who had lost a client to suicide meant that many were left carrying their grief alone. In a mixed methods study examining the effects of client suicide on social workers and counsellors, Sherba, et al. (2019) found that participants reported that having the opportunity to talk about and process the difficult emotions surrounding a suicide were the most helpful support in reducing negative effects such as compassion fatigue. Several participants, however, described an uncaring agency response that failed to treat them as human beings. This echoes the experience in this research where many participants felt silenced in their grief by the responses of others or through organisational neglect of their distress.

This chapter explored the experience of disenfranchised grief among those affected by the suicide of a young care-leaver. Almost all participants in this study experienced some disenfranchisement of their grief. The chapter demonstrated that in a variety of ways their internal experience of loss was not matched by an external response that validated their grief. It showed that the residential child context is not societally recognized as one in which deep connections are made. The lack of importance accorded to relationships developed in residential childcare settings meant that the grief of participants remained unrecognized. internalization of societal norms by participants also contributed to this disenfranchisement as they often struggled to reconcile the intensity of their response with what they believed was an appropriate level of sadness. In all the accounts there were indications that the deaths of these young people were perceived by others to be of less importance than other deaths – either through the lingering stigma associated with suicide, the spoiled stigmatized identity the young people carried through their care experience and their membership of other marginalized groups or a combination of both. These devaluing responses from others often left participants unable to talk about their distress, which contributed to a sense that their grief was unimportant.

The next chapter moves on from exploring the impact of the suicides of young people on participants to a consideration of their reflections on the factors leading to the deaths and their attempts to make sense and find meaning from their losses.

Chapter Six: Making Sense and Finding Meaning

Donny's Life – The Longing to Belong

I first met Donny when his Mum appeared at the Children's Hearing with Donny's bags packed and said, "Take him! Take him away!" Donny was the youngest in the family – very much the focus of everything going wrong. Mum split up from Dad. Lots of relationships in between, Mum always felt Donny sabotaged those... There were issues within the community, out late at night, multiple exclusions from school. The way that Mum talked she didn't like Donny. She liked her two older sons, seemed to have a strong connection to them. I don't think his big brothers liked him either. It always felt like, he was the devil's child.
He went to Willow Court School. Had a very settled period. It was a very little boy environment- forest school, lots of trees. He was free to run around and be Donny. They took the wee ten-year-old and held on to him to that youngster of fourteen, but then came the inevitable move to a school for older boys. It didn't work.

He came back to The Warren, one of our units. For months it went well. He was very skilled, able to engage those around him, a cheeky wee chappy. There were issues but there was that charming lovable side to Donny – you couldn't help but forgive him. He had a thing about throwing stones. One time his target practice *happened to be my car. He chucked a stone and smashed my back window. I was furious… but I saw him standing there… all I could see was the little boy. I knew it was a big, massive mistake. I just put my arms around and cuddled him, he just collapsed into my arms and started sobbing. I had forgiven him and cuddled him rather than giving him that big lecture – something that Donny never really had, he just collapsed into me – what he really wanted was that mammy to look after him and love him regardless of what he did.*

Then he moved to Fairmead, for older young people – they did their own food shopping and cooking. On paper, the ideal resource but it didnae take account of who was there to claim Donny, who was there to love Donny? He was still a wee boy that needed the cuddles and the love and affection. In Willow Court and The Warren – the young people were younger, so it was about hot chocolates and bubble bath and cuddles. But we, on two occasions, moved him into resources where it was more distant, it was more hands off. What is important is relationships, attachments. If those things were at the centre of planning, we'd get a lot more right. We're still guided by, or driven by, outcomes and where people should be, as opposed to who the person truly is. There's still this magical notion that, you know, they're young adults, and they need to be doing young adult things *whereas he was just a kid. He had to move because he reached that magical age.*

His behaviour at Fairmead wasn't safe. Spiralled even further out of control. Demonised within that community – they were out to get him. Landed up near Aviemore, three months up in the hills in the middle of nowhere. We went to visit him but nobody there to claim him... his family didn't visit him. Returned, age 16, no space in any of the units… next three months homeless basically, sofa-surfing, he moved from friend's house to friend's house until he had exhausted all options. A couple of occasions sleeping rough. Suicide attempt spiralled him into psychiatric hospital. Settled month up to seventeenth birthday. He phoned. I said I would come to visit on his birthday but got caught up in stuff within the units… none of his family went either. Just turned seventeen and nowhere to go – nobody's child in every sense.

He managed to steal an NHS car and break out two other kids… they went joy riding. Hospital decided to end placement. Before we could visit him, he'd hung himself in the grounds of the hospital. So, within hours of going to be homeless once again... he was dead. He wanted to be loved. That was the core of it. And he didn't feel loved. He didn't feel he belonged anywhere. The two significant places that he did feel loved, and he did feel there were people fighting his corner, were Willow Court and The Warren. And they were taken away from him. Donny had only… had only just turned 17, when he took his own life. He was dead a week after his 17th birthday.

(Lesley, CW)

Introduction

This story of Donny’s life was constructed from the words used in her interview by Lesley, the residential manager who knew him throughout his care journey. It was the most fully developed account of the life and death of a young person that emerged in the interviews. Lesley described Donny’s experience in his family, his care journey, and his struggles once he left care. She not only provided Donny’s biographical details she also shared her own analysis of factors contributing to his ultimate death. Although many participants did not have the same detailed biographical knowledge about individual young people that Lesley had about Donny, they all used their interviews as a space to share and explore their interpretations of why the deaths had occurred and convey their attempts to find meaning in them. Dransart (2013) identifies the importance for those bereaved by suicide of finding a good enough explanation for the death or, if that is impossible, to achieve acceptance that a more complete understanding might always elude them. She also distinguishes between this ‘sense-making’ and another important emotional task of ‘meaning-making’ – the struggle to find significance in the death.

> *Sense-making is seeking comprehensibility and consists of rebuilding the path which led to suicide and the figure of the person who died… Meaning-making allows the survivor to journey towards an existential significance of the loss (Dransart, 2013, p. 317).*

The first part of this chapter focuses on participants’ attempts to understand and make sense of how the young people came to die. It begins with an exploration of the diverging pathways for care-experienced people that seem evident in the accounts of participants. The incongruence between the public face of competence and success and the internal experience of personal pain and insecurity in care-experienced participants accounts, will also be highlighted. The various factors that participants identified as contributing to the care-leavers deaths will be examined. All participants used their personal and professional understanding to try and identify why some care-experienced people died but others appeared to thrive despite an apparently similar burden of trauma and neglect. Care-experienced participants drew on their own histories to identify potentially protective factors that had supported them in their journeys. Participants focused mainly on individual biographical detail and the immediate relational context in their reflections about the deaths. However, they also regularly referred to a variety of organisational, professional, and societal factors they believed had contributed to young people’s deaths. Finally, the chapter will explore the different ways in which participants attempted to reconfigure their distress to find meaning in the deaths on both a personal level and as a driver for social change.

Diverging pathways

Even among “at-risk” populations such as veterans or care-leavers, suicide remains a relatively rare event (Pokorny, 1983). Care-experienced participants in this study shared some very distressing and traumatic experiences from their own histories, described difficult journeys through the care system and told how they had faced many challenges in their transitions out of care – they all had many risk factors for suicide. Despite these adversities, when interviewed they were succeeding in many areas of their lives. This appeared to be in stark contrast to the catastrophic trajectories of the care-leavers who died, although they seemed to have experienced similar levels of trauma. Although this divergence was identifiable across all the accounts, it was most obvious when comparing the different outcomes between siblings. For example, Keith had been exposed to many of the same adversities as his brothers, yet they died in their teens, desperate and alone, whereas he had had a successful and distinguished career and in his personal life had sustained a marital relationship and become a father.

The story of Brian and Kristy as recounted by Kate (FM), Kristy’s adoptive mother, helped to unpick some underlying processes that may have contributed to such different outcomes. As well as providing the factual background of their lives and her sense of their different internal worlds, Kate used the interview to reflect on their different outcomes. The children had shared their earliest life experiences including being subject to extreme violence:

> *His mum was violent, she broke his nose, it was a very violent thing to do. She was violent, very violent (Kate, FM).*

Kate explained that they were not separated until Brian moved into residential care when he was eleven. Although Brian seemed to feel cared for and made good relationships in this home, Kate felt his life rapidly deteriorated after he left care. She explained that he spent the remainder of his life bouncing between prison and homeless accommodation. She recounted that he seemed isolated and lonely with few connections to people who had been important to him in childhood. He seemed to manage his loneliness and distress through alcohol and drugs and when intoxicated was capable of serious violence. He died of a massive drug overdose in homeless accommodation, just days after leaving prison. In her interview, Kate (FM), began to identify that the superficial similarities in Brian and Kristy's childhood stories concealed some profound differences. Perhaps most importantly, when Kristy joined Kate's family, she seemed to become involved in a process of reciprocal claiming that, over time, gave her a more secure sense of herself and her position in the world – a degree of ontological security (Giddens, 1991) – which her brother seemed to lack. Although the usual underlying foundations of ontological security such as trusting relationships and secure attachments (Giddens, 1991) were absent for both children in their earliest years, Kristy had the opportunity to develop these in the family she joined. Moreover, Kate strove to ensure that Kristy had the opportunity to become embedded in a wider network of family and friends that might provide a lifelong experience of belonging. She and her two children appeared firmly ensconced in a mutually supportive family network that is expected to continue to exist beyond Kate's lifetime. Importantly Kate also ensured that belonging to this family did not require Kristy to abandon connections to her birth family. She described encouraging Kristy's relationship with Brian, regularly inviting him to visit whilst he was still in care and writing to him when he was in prison. She talked about actively creating a warm and genuine connection to Kristy's grandmother which helped Kristy to retain a sense of her origins. In contrast, Kate believed that Brian experienced a continual loss of important relationships and was exposed to the damaging effects of policies and practices that failed to buffer the challenges of moving out of care and into independent leaving. Further she felt that this was compounded by the unequal distribution of resources at a societal level that affected Brian's access to the material requirements of life as well as his capacity to exercise meaningful control over his life-path.

For Kate, the interview had brought to the surface aspects of Kristy and Brian's lives that had not previously been in her conscious awareness.

> *We've touched on a lot of things that I hadn't thought of and I think the contrast between their care experience has really startled me. It's incredible and it's all the things really that we can't invent - families for looked after children, but we could,*

> *surely we could do something. Or could we not make them a community for each other? (Kate FM).*

Kate's reflections highlight that differences in the pathways of care-experienced people cannot be explained simply by the presence or absence of individual resilience. Drawing on Layder's (2005) theory of social domains, it becomes clear that while experiences in the domains of psychobiography and situated activity may exercise considerable influence over an individual care-leaver's life trajectory, systemic power, located in the domains of social settings and cultural context, is also strongly implicated in the differing outcomes they may experience. Interestingly, the idea of creating a community of care-experienced people, that Kate alluded to, seems to be in the process of becoming a reality. This seems to be acting as a source of belonging as well as a site for the exercise of collective power to challenge and change entrenched institutional attitudes, assumptions, and practices (Milligan, 2021; Roesch-Marsh, et al. 2023).

The interviews with care-experienced participants also cast a different light on what initially could be construed as stories of individual resilience or despair. Although many care-experienced participants had achieved considerable success, in some accounts there was evidence that beneath the surface they had experienced considerable emotional turmoil and a precarious sense of control over their lives. Only one participant who had lived in residential care did not describe times of active suicidality since leaving care, and some still struggled with suicidal ideation daily. They described practical challenges around finding and retaining safe accommodation, struggling with debt, and sustaining education and employment as well as turbulent family and romantic relationships. Their continuing struggle to develop and hold on to a securely grounded identity became apparent in their descriptions of the challenge they faced in managing and presenting the conflicting aspects of themselves. Despite their evident success in many areas of their lives, in their reflections, they acknowledged how close they too had come to dying by suicide.

This echoes the findings of Duncalf (2011) in her work on the life course of adult care-leavers, which points to the life-time implications of being in care and the ontological insecurity that can accompany a care identity. Some adult care-leavers she interviewed, many of whom were objectively successful, described the absence of a secure emotional space to retreat to and a lack of confidence in locating a coherent identity.

The following sections outline in greater detail the various factors that participants drew on to help them understand and make sense of the deaths of the young care-leavers they had known.

Belonging

The theme of belonging and not belonging permeated the accounts of all participants. In her reflections Lesley highlights her belief that the persistent thread that organised Donny's life and ultimately led to his death was a desperation to belong that was thwarted by factors beyond his control. She felt that his family experience of being the problem, the unwanted one, was compounded by his experiences in care and beyond. In Willow Court he found a place where, for a time, he fitted, with people who loved him – 'he was free to be Donny'. Jillian (CW) who knew him at Willow Court was also interviewed and she spoke of his fear of returning to the local area where he did not feel safe and which he associated with rejection and abuse. She echoed the sense that Willow Court had given Donny relationships, positive experiences, and a place where he belonged. She also highlighted the helpless inexorability of him moving into unknown spaces with the inevitable rupture of relationships and the potential destruction of that fragile sense of belonging.

> *You hope that when kids move on that somebody else is going to give them the same things that have kind of got them through that period of time - highs and lows. But the reality is that's not how it happened for him* (Jillian CM).

Lesley believed that at Willow Court and the Warren Donny experienced unconditional acceptance; his distress, and the behaviour through which it was communicated, was seen and understood. She described his behaviour as still troubling – climbing on roofs, running away, causing damage – but that was not what ended his placements. She believed that professionals moved him, based on a generic care pathway that failed to recognise Donny as an individual. Lesley felt that not only did he lose places where he was at ease and fitted, he lost the people who reflected back to him an image of himself as a valuable person who mattered to them. In these places he was not perceived as the 'devil child' rejected by family and community but the young man who had talents and potential as Jillian recalled:

> *He was a cracking kid, a real ambassador - see when he was, he was on his game this kid would, he would be the one that you would, you know, get to interview staff he was perceptive he was, um, charming. A lovely, lovely kid (Jillian, CW).*

From their perspective these moves proved to be catastrophic for Donny; eventually there was no space for him at all in any system – care, housing, health – until his attempted suicide precipitated entry into psychiatric inpatient care. His final days, where it seemed his yearning to belong was thwarted yet again by the absence of significant people on his birthday, completed the pattern. Lesley thinks his distress led to extremely dangerous behaviour and the loss of his place at the hospital where she believed he had a sense of basic safety if not belonging.

Jillian and Lesley felt Donny's psychobiography made him vulnerable to suicide. Nevertheless, it is clear from their accounts of his life that the power of the entrenched assumptions and practices of the care system - the domain of social settings, (Layder, 2005) - created the inflexible decision-making that interrupted his embryonic sense of belonging.

Donny's story was not unique in participants' accounts. The combined perspectives of Lesley and Jillian as well as contributions from a care-experienced peer who knew him well, however, made it possible to construct a coherent timeline and catch glimpses of his internal world and his growing despair at ever finding a place to belong. Like Donny, most young people who died had experienced rejection in his family and had multiple placements that involved moving all over Scotland.

Most children spend their whole childhood in the same family, where stories are told to them, and about them, that create a sense of who they are and where, and to whom, they belong (May, 2013; Smart, 2007). Children may move home or school, but this is usually with others whom they know, and who know them. They develop an autobiographical narrative located within a shared familial and wider cultural story. This process is abruptly interrupted by the admission of a child to care. People, places, and culture are unfamiliar and alienating (Ward, 2011). Given time and care, children can pick up the threads of their own story and incorporate them into a new and expanded narrative that connects past and current experiences. This can allow a sense of belonging to develop that encompasses their new relationships and home without having to abandon membership of their family and community of origin (Oke, et al. 2011).

This is more difficult when the break with family is irretrievable or a child is continually moved, with consequent ruptures of relationships, perpetual confusion about expectations and cultural dislocation. Robbie emphasised that such moves are completely different from those experienced by other young people and cause far greater stress and disruption.

> *In our presentations we say 68% of young people in care have had more than three moves. That's conservative - you'd be better off picking something like ten. That's, nearer the average of what folk have moved. I've only moved five times in my lifetime, and I'm forty-two, and those moves were with family - everything comes with you. I moved with my family, my twin brother and my sister, my mum, and my dad, and even the dog, we all moved. It is classed as one of the most stressful things to do in life, we do that as a family and it's still stressful. Yet, we expect young people to do that, at the drop of a hat, at somebody else's decision, on that day, and walk away with just a suitcase, possibly never see them again, or have to fight to get to see them at any point or have them supervised when you're seeing them (Robbie, AW).*

Some participants talked about young people ejected from the family because of offending behaviour that brought harm, shame, or disgrace to other family members. Not only did they experience a loss of belonging, but they were also viewed as pariahs - no one ever contacted or visited them. George (CW) described how Peter, whose offence against a member of his family had caused just such disgust, killed himself days before leaving his secure placement. George believed that the tenuous sense of belonging Peter had attained over three years of predictable routines and knowing his place in the system, could not survive the anticipated loss of safety and connection.

Some young people who died were unable to allow themselves to find a fully secure narrative of belonging despite the attempts of carers and professionals. Wren (CW) described how Jennie's adoptive placement broke down when her behaviour deteriorated dramatically after contacting her birth family. She entered residential care and despite her initial anger and violence developed good relationships and seemed to feel she belonged there. Wren felt Jennie struggled to find a coherent identity that could integrate her different stories. She believed that Jennie's search for her birth family left her dismayed and appalled by their lifestyle and attitudes, but feeling she no longer belonged in her adoptive home. Wren recounts that her post-care journey was marked by a series of abusive relationships, substance misuse and the loss of her own children to the care system. During the months before her death, Wren knew Jennie was in crisis, in an extremely violent relationship which she refused to leave. There were signs of her trying to regain connections and find somewhere she could belong in a less self-destructive way. Wren described a process by which:

> *… for about the two or three weeks preceding her death, all of her actual stuff slowly came back to the house… like she'd bring back stuff, so in a big cupboard there, we acquire a case and then a bag and then she'd bring back some of her stuff.* (Wren, CW)

Wren was unclear whether Jennie was trying to leave her abusive relationship and build a different future or was already planning her own death. One night she appeared at the home asking for support and comfort. She fell asleep in the early hours, holding the hand of a member of staff, in the morning, she was dead. Wren felt that the importance of the residential setting and the safety and belonging it symbolised was emphasised when her adoptive father said at her funeral that:

> *he felt that she had come home to die and that he was really, really grateful that it had happened there and not in the street* (Wren CW).

This preoccupation with belonging was not only apparent in the descriptions of care-leavers who died. Care-experienced participants shared powerful examples of the people and places that contributed to their sense of belonging but also described moments that destabilised that sense of security and connection.

Patrena gave the strongest account of a secure sense of belonging. She vividly described her continuing relationship to the place where she spent the last twelve years of her childhood and the key people who had cared for her. Her earliest years had been traumatic, involving multiple placement changes and ruptured relationships. She described reciprocal relationships with residential workers, talking of them as ‘family’ and being confident that her involvement with them had moved beyond the professional and would endure over time. Her transition from care had been a shared journey of joy, discovery and hope tinged with sadness at the change in daily contact. Despite this powerful story of belonging two experiences showed that this achievement was still precarious. The first occurred when the expectation that she would move on became more emphatic.

> *When I was like eighteen or nineteen they started telling me like “ok we’ll need to think about you moving out and signing up to the housing association.” I remember I clung onto the pool table in the living room and cried like a baby on the floor. Like it totally reverted me back (Patrena, CEA).*

The prospect of moving evoked an anxiety that she recognized as disproportionate and was probably fueled by previous experiences of catastrophic loss. The second took place only weeks before the interview. Her through-care worker informed her that since she was now twenty-one, he would no longer be working with her.

> *I remember sitting there crying and I was like “so what happens now?” and he was like “bye” basically. He was trying to say like in a funny way - I know he meant no malice, but it was the wrong way. And it wasn’t really explained to me what would happen in my case… it never once crossed my mind “I’m going to lose a worker” (Patrena, CEA).*

The shock at the realization that the relationship, which was so important to her, did not have equal weight for her through-care worker was profound. Fortunately, her relationships with her previous residential workers had a different quality and intensity which enabled her to preserve her sense of belonging.

As previously described, Keith’s disappointment about the lack of reciprocity in the relationship with his favourite member of staff was profoundly destabilising and has never really left him. He also made a strong connection to staff who were temporarily seconded to his unit. The plan was that they would return to their original setting which they described in glowing terms. Keith used his considerable understanding of the system to engineer a move to that house but they did not return, and the house was in chaos. He summed up his learning from the experience*:*

> *I tried to follow the relationship, because the relationship never followed me, but it doesn't work. So, when you try and follow the relationship in care, it can't work (Keith, FM).*

Keith was, however, able to find a multi-faceted sense of belonging through other areas of his life. He formed close bonds with his brothers' foster carers and would stay overnight and go on holidays with them. The foster mother was one of only seven guests at his wedding. He also was a talented sportsman and felt included through belonging to sports teams. He volunteered for a national advocacy organisation where he not only developed strong personal bonds, fulfilling his need for belonging, but also found a shared culture and community where he could fit in, rather than experience exclusion and stigma. The opportunity to achieve unconditional belonging by being part of a community was reinforced by Robbie who believed it could protect against the isolation and despair underlying the choice to die by suicide.

> *Not just kids in care, everyone is looking for relationships, everybody wants attachments, you need to belong to something and someone. And that's a benefit of our organization - we now have a membership; we've got families and we've got friends- that's a community. They can be part of something that they don't need to do anything for - they automatically belong because of their experiences (Robbie, AW).*

Although Keith's trust in relationships within the residential care setting had been compromised, he understood the systems and processes of care. This enabled him to operate with ease and fluency, prolonging his stay till he was eighteen and organising his transition to suit his needs and timescales. He described knowing the 'rules of the game' and at this instrumental level had developed some degree of belonging. Keith explained that as a young teenager he had resisted being returned to his mother's care and argued to remain in the system, even though he could see its flaws, because he recognized that being at home was dangerous for him. He contrasted this with his brother Patrick's desperate desire to return to his mother and his inability to find belonging other than through his relationship with her:

> *Patrick always from a young age had always wanted to be home with my mum. He was always focused on that and really intent on that that was what he would want. His journey was similar to mine, but this constant desire to go home. He was the first and that connection and that bond - they could, you know, cling on to each other… he was very protective both verbally, physically (Keith, FM).*

Some care-experienced participants had found belonging through joining other families which revealed the possibility of new ways of relating and different aspirations. Daniel, for example, identified his relationship with his future wife Sally as a key turning point in his life. Even though he went through very difficult times in his early twenties, this relationship marked a revival of hope and a re-engagement with education.

> *But then I had Sally, I met her when I was sixteen and she showed me this whole different world… If I hadn't met Sally, I genuinely don't know if I'd have been here honestly, because I think I had that ability to just keep going, keep pushing it because aye, there was nothing to lose (Daniel, CEA).*

Within this research there is evidence that some strongly entrenched established practices and attitudes not only failed to promote a sense of belonging but actively disrupted connections when they were emerging. In contrast, the extraordinary power of simple human interactions to interrupt feelings of disconnection and burdensomeness is illustrated by Declan's account of his brother's intervention that prevented him killing himself:

> *Just three years ago I was in a relationship that broke down. I drove myself to "I can't do it anymore." I think I was about a mile and a half out from the Erskine Bridge… then my brother phoned, and I heard my nephew on the phone in the background greeting and my brother said, "Declan come to mine" because I was going to be staying alone in the house, so he was like "Declan, come to mine, your nephew needs you." I broke down (Declan CEA).*

Although single experiences such as this cannot overturn years of feeling disconnected, Declan's account demonstrates that, in that moment, a sense that he mattered to somebody else and was needed, was sufficient to interrupt his desire to die and prevent him from killing himself. Other participants had recognized the impact that their death would have on those around them and had made conscious decisions not to act on their continuing suicidal ideation. Hamish, for example, describes the commitment he made to a close friend:

> *She knew that I was in a really bad place - she basically guilt tripped me "Make me a promise you'll never do that. Because I wouldn't go to your funeral" … And I think it's, it's a mixture between that and I know how I felt with Millie. I don't want to do that to people. As much as some days I'm gut-wrenchingly drawn to that… I feel like even people I don't see very often I make strong bonds with and if they were to hear that I killed myself (Hamish CEA).*

Throughout participants' accounts there was a sense, however, that they felt that most young people who died did not believe that they mattered enough to other people to counterbalance their desire to escape their situation. Participants linked this lack of belonging directly to the suicides they discussed. Tommy, for example, highlighted the massive impact that rejection had had on both him and his younger brother, Jack.

> *My wee brother felt rejection as well, you really really need to - that's something all members of staff need to take on board about how they go about situations like that because weans pick up things - it is, it's rejection, you feel rejection and that's the stuff that that later on in life come back to haunt me (Tommy, CEA).*

In Jack's case Tommy felt that the experience of having his desperate pleas to return to care rejected was directly connected to his death.

Lack of connections to others and to society has long been associated with an increased likelihood of suicide. Durkheim (1951 [1897]) argues that the degree of social integration in any given society affects the rate of suicide that occurs. Too little social integration leads to an increase in 'egoistic' suicides where individuals experience a lack of connection with society that can provide meaning and belonging. At a more micro-level several theorists identify the role of thwarted belongingness in developing the desire to die (Joiner, 2005; van Orden, et al. 2010; O'Connor, et al. 2018). They also suggest that if an individual feels expendable or burdensome they may develop a belief that others would be better off if they died. They argue that rather than focusing solely on more distal risk factors which would be difficult to change, the most effective form of suicide prevention may be to support the development of social connectedness and belonging.

Cumulative effects of trauma and loss

All participants recognized that most children and young people enter residential care carrying a heavy burden of loss, neglect, and trauma. They often have a family background that includes chaos, substance misuse, violence, and extreme poverty. Moreover, as Pauline suggested, the experience of the care system can contribute to suffering further loss.

> *Loss is part of being in care. Once you're in care you can expect to lose a lot. It's not an easy ticket (Pauline, CEA).*

Participants from all groups identified several negative aspects of the care system that they felt exacerbated children's trauma and highlighted the lack of therapeutic interventions to support their recovery. Several pointed out the continuing distressing effects of family fragmentation and fractious relationships on children throughout their care journey and felt that there was little effort to support families even when children were returned to their care. A strong thread of violence was also identified as affecting young people throughout their childhood which for many continued into their adulthood. The cumulative impact of adverse experiences formed the permanent backdrop to all the reflections that participants shared in their struggles to understand how young people came to die. In the following sections these adversities are explored at depth.

Childhood trauma

Keith's and his brothers' experiences while living with their mother were typical of the early childhoods of both care-experienced participants and young people who died.

> *Home was dysfunctional, it was different men, different houses, different communities, different schools. So, I might be rehabilitated and go from a care environment I was in, back home, or it would be in a different area, with a different person. My mum was a constant and her lifestyle at the time was just alcohol, abusive men and poverty. So that's what home looked and felt like. It didn't feel safe a lot of the time because there was a lot of different people in and out and there was violence (Keith, FM).*

Although these pre-care experiences were considered important by all participants and they believed they had a continuing impact on young people's lives, they rarely considered them to be a sufficient explanation of the suicides. It was only when a trauma was so overwhelming that its direct impact was still apparent in adulthood, that it was perceived as a primary cause of suicide. Lesley, for example, related Aaron's suicide directly to the trauma of seeing his father murder his mother.

> *How could you ever come to terms with that? It is so huge, and it haunted Aaron, all of that haunted Aaron. He was always in pain, he was a boy who was always in pain, and the pain was so immense. At times, it was like you were with him and talking to him and, and he glazed over (Lesley, CW).*

Although Wren's explanation of Jennie's death was not rooted solely in the damaging early experiences she suffered before she was adopted, she did wonder how their continuing impact affected the ultimate outcome.

> *tThese kids can move on to tragedy, even with that kind of support - is the damage really done by the time you're three or by the time you're five? - in spite of all the efforts and all the really positive relationships, we weren't able to stop her wanting to hurt herself and that can feel really upsetting and powerless - real downer when that happens because you just think, whatever we do, these poor people just have their lives written out for them, they're just young people, it's horrible (Wren, CW).*

Wren's reflections demonstrate that participants drew on a range of underlying concepts to help them understand why young people died. Implicit in Wren's comments is an awareness of the interacting factors from every systemic level that can affect the development of self-destructive behaviours. The diathesis-stress model (Brodsky, 2016; O'Connor, et al. 2018) of suicide suggests that early adversity can interact with genetic factors at a neuro-biological level to increase the likelihood of developing traits such as impulsivity and emotional dysregulation which increase the possibility of suicide. Even in her despondency at the apparent intractability of Jennie's difficulties, however, Wren recognised that there were many others who had recovered from their early difficulties through experiencing more positive relationships and opportunities. Later in her interview she also drew on concepts such as identity and belonging to explore how

Jennie's life began to unravel once she left care, as well as highlighting the damaging effects of unsupportive policies and structural inequality.

Whilst children entering residential childcare all have unique histories, the early lives of care-experienced participants showed the same type of neglect and trauma as young people who died. Arguably, the purpose of residential childcare is to mitigate the impact of such adversities and provide a safe space for children to grow up. Indeed Macdonald, et al. (2012) argue that all residential care should be 'therapeutic' for young people. The reflections from some participants in all groups suggested that this was not always achieved and that some practices exacerbated existing trauma and distress.

Participants had a variety of experiences with residential childcare, whether as young people or practitioners. Their accounts spanned a period of over thirty years and showed that policy and practice had changed dramatically during that time. Most residential care workers believed the homes they currently worked in had evolved into caring environments where positive relationships flourished, and young people were understood, supported, and loved.

> *it is definitely evolving. From the point of view of how we talk, how we feel about the kids we work with nowadays. It's much more open and a real emphasis on relationships and connection. That's where things have changed. We talk about structures and boundaries. And that's great… but we match that with love and empathy. I think we're doing much better (Jillian CW).*

Some care-experienced participants, such as Patrena, also recognised these characteristics in the homes they had lived in, though they questioned whether all their peers received the same quality of care and relationships. They also shared memories of intense fun and excitement, particularly through the opportunities to engage in outdoor activities they were afforded in residential care. Declan, for example, recounted his warm memories of outdoor experiences and the importance of this in his relationship with Donny:

> *You know the thing that was good about that school is that there was a lot of activities. There was an adventure playground, there was go-karts, there was a big massive gym, you know. Outdoor education, me and my full life, outdoors is*

> *my learning place… whenever it was a case of a canoeing trip or kayaking trip or mountain climbing trip. That's another thing me and Donny had was outdoors. We always used to run away. Where did you find us? Forest school - just down the drive a bit. Sitting round eating a sausage off the campfire (Declan, CEA).*

There were also, however, some disturbing accounts of practice from care-experienced participants which appear to have compounded previous trauma that young people had experienced, rather than contributing to their recovery. Pauline gave a vivid description of the abuse she suffered in her care home.

> *I didn't want to get into the minibus - the officer in charge pulled me into the house Took me in by my hair, by the scruff of my neck. I managed to pull away - he grabbed my leg - I was only about eight at the time - pulled me along the corridor. I was kicking and nearly kicked a glass panel out - he was going to give me the belt. I was scared of getting the belt, that's why I was reacting like that. I was petrified. It was used regularly. It even had a name; it was called Charlie. The belt had a name, Charlie (Pauline CEA).*

She not only depicted a regime of brutal corporal punishment she also described the insidious emotional abuse that undermined children's sense of self and connection to their own families.

> *She was a cruel person, very cruel. She used to sit in the bunker and say things to me like "your dad doesn't love you; your parents have no time for you." I found out later, that it wasn't just me she done that to. She done it to everybody who was on their own (Pauline, CEA).*

Pauline grew up in residential care over thirty years ago and the kind of practices she described are currently being investigated by The Scottish Child Abuse Inquiry. Pauline was quite clear in her views that the care system directly contributed to the many suicides she described and to her own continuing suicidal ideation.

> *When I find out where they are, they've got problems with their mental health or they're dead or they're in prison, or they've got serious drug problems. It's just a really crazy waste of a generation that was brought up in care. I'm glad the child abuse investigation is going on, I know you have to learn from the past to make the future better, but I don't think it's enough, I really don't. I mean it's a whole generation that's been failed. I mean I still feel failed (Pauline CEA).*

Although no participants described such an extreme type of abusive culture existing in the more recent experiences of residential care, there were examples of individually abusive staff members as well as institutional practices that exacerbated the difficulties that children had when they entered care.

Several care-experienced participants gave vivid accounts of the ubiquitous use of physical restraint to enforce compliance and explained the impact this had on the culture of homes. Their descriptions suggest that in some places, the dynamics of the home could slip into a confrontation between two mutually hostile groups engaged in a battle for control. Rather than developing connection and trust, such environments confirmed for young people that adults were dangerous and that they could impose coercive control on children with impunity. Traumatic events can have long-term effects such as hyperarousal, where a person is constantly looking for threats or danger (Van der Kolk, 2014). Daniel described how the continual fear of physical restraint exacerbated this already heightened response.

> *You were just getting ready for them to jump on you. That's honestly what it was like. Aye we were just always on high alert (Daniel, CEA).*

Smith and Bowman (2009) found that young people who had experienced physical restraint not only found it very painful but also described serious psychological and emotional consequences such as reactivating memories of trauma or believing that adults did not like them and that they enjoyed hurting them.

An alternative way of managing difficult behaviour described by participants was to move a child out of the place where they were living. Daisy explained the simplistic individual-blaming thinking that underpinned many moves within and out of the residential care system and reflected on the shared failure to recognise the more complex dynamics in operation:

> *It was like scapegoating within a family. "If we can just... Things will settle down if we can just get him out" "rather than a sense of "this is actually the job and we've got to contain them" and that really strong sense of nobody challenging, including me, nobody challenging that narrative (Daisy, CW).*

Declan reflected on the different responses to his distressed behaviour that he encountered while in care. He described being moved from one placement when still a young child because he displayed suicidal behaviour and was seen as a problem. Shaw (2017) argues that multiple placement moves not only have direct negative effects on children's wellbeing, but that they also contribute more indirectly to children's difficulties, as they are closely associated with the criminalization of children in residential care. This type of reaction to children's distress was also described by Declan:

> *It's not a case of, if you kick off, the staff deal with it. The police get called. Then because you're of an age you can get charged as a juvenile, you just get taken down the cell.(Declan, CEA)*

Multiple placements, the criminalisation of children and the widespread misuse of physical restraint, can all be considered examples of system abuse as defined by Stein (2006a) where children are left unprotected by failures in policies and practices. It was clear from participants that these drastic and controlling interventions, designed to manage children's difficult behaviour, reflected a wider failure to develop and resource more effective and sensitive approaches that could enable children to address their earlier adversity and help them forge a positive future.

Participants in every group repeatedly mentioned the absence of direct work addressing young people's trauma and directly linked this with the deaths. Kate (FM), for example, recounted the events leading up to the death of Brian's and Kristy's mother when Brian was only ten.

> *He had said to mother, you know, "if you come next time and you've been drinking then I won't come back. She had been drinking again and he refused to go back and of course she dies within three weeks – so he always thought it was his fault… my guess is nothing much was done about the death of his mother and what he'd said. And he shouldn't have been allowed to say it, the worker should have stopped it (Kate, FM).*

From Kate's perspective, the failure of social workers to exercise appropriate authority around contact arrangements or address his traumatic bereavement, both contributed to Brian's overwhelming sense of guilt and consequent chaotic descent into substance misuse, criminality, and homelessness and ultimately his death. Robbie also linked the failure to work directly with young people's family losses and personal trauma with later difficulties such as excessive drinking that are known to link to suicide (Makhija and Sher, 2007).

> *… these young people are dealing with grief, loss and separation, because they were removed from their families, which isn't really looked at and you're in care for years and that's just left to grow and fester. Along with any other additional issues that you may have on top, like trauma, sexual abuse, neglect. It's a recipe for disaster. The work's not done with them to learn how to regulate behaviour - you're just told "no" and told "this is the reason why" and then that's it. But there's no therapeutic input. Then you get young people who want to drink -the level that's done within care, it's not normal. Scott, for example, although 90% of the time, he was a placid big lad - when he kicked off, he kicked off. Then when he introduced alcohol into his life, and other substances then kicked in, he was on a spiral down, and he went from placement to placement. And then again, he died of an overdose as well (Robbie AW).*

Declan, however, also described a very different response to his distress and anger, demonstrating that there are alternative ways to support young people in their pain. He recognised that the deep-rooted nature of his own and others' sadness cannot simply be fixed, but he shared the effect of having his pain accepted and witnessed despite the challenging way he expressed it.

> *Nobody can fix sadness. Nobody can. It's all in your mind, you know. It's how you are. You can get sent to counselling and all your groups. None of it will fix the pain, the anger, that's going through your head. It can maybe calm it down, but it won't fix it. It affects everyone differently but with me, the way to calm me down, I'll talk about - I've still got these letters by the way - I can prove this. There was one day I was absolutely smashing my room about - barricading myself in - every time somebody was talking to me, I was telling them to fuck off - did not want anyone speaking to me. I barricaded myself in. The staff knew exactly what I done and they started feeding letters through the door. Jillian (CW) was writing stuff, Lorna (CW) was writing stuff as well and shoving it under my door. And some of the letters back were saying "fuck you" and then you seen how they progressed and got a resolution out of it. It may sound stupid, but it worked (Declan, CEA).*

The two workers were able to remain present and attuned without reacting to Declan's hostility and the meaning of this apparently simple intervention was profound. As Declan said, he had the letters several years later and is still in contact with both workers. This intervention not only required an understanding of pain-based behaviour and communication (Anglin, 2002) and the creativity to respond effectively in the moment, it also needed an organization that supported such practice through training and reflection.

It was not just the lack of individual work with young people that was highlighted. Residential childcare is in essence a group-based intervention (Emond, 2003; Furnivall, 2018), however participants highlighted the absence of effective work with the group of young people. Despite strong evidence of the potentially positive relationships among young people who live together in residential care (Emond, 2000; Rose, 2002), care-experienced participants described persistent attempts by staff to disrupt peer relationships when they developed.

> *Lizzie was told "he's a bad influence on you" she told me like "I've been warned away." Even my best friend Michael was told, aye it was the manager – whom I adored by the way. So, the manager said to him "Daniel will stab you in the back as quick as. Don't trust him, he's just out for himself. He doesn't care about you." And that is so far from the truth, I was the most loyal friend in the world, and I would have always stood up for my wee group. I was a wee bit of a ringleader, but I cared about them (Daniel, CEA).*

Although Daniel acknowledged his own capacity for troublemaking, he also cared deeply about his friends and wanted the best for them. Instead of engaging with the therapeutic potential of these relationships, the response of adults in the home was to treat them as wholly damaging. Robbie also reflected on the level of control exerted over children's relationships by staff. He recalled that Alicia's friendships with other young people were disrupted by her move to another house but that contacting them, without staff knowledge, was seen as unacceptable:

> *It was just constant control, control, control. The relationships we dictate are okay, anything else is unwanted, and unnecessary, and fitted into the mischievous bracket with regards to working towards your care plan (Robbie, AW).*

Pauline believed that, although she and Abbie had engaged in a suicide pact, it would still have been possible for workers to harness the strength of their relationship to support each other rather than collude in their own self-destruction.

> *It was a very special relationship; we were really close… but nobody ever thought about putting us together to actually figure out what was going on because if they'd done that then I think she'd actually still be here today (Pauline, CEA).*

Shannon also believed that the failure of staff to actively address relationships between children in a positive way led to Ricky's involvement in serious drug taking and his ultimate death.

There was a sense from many professional participants that admission to residential care was often viewed as sufficient intervention without any further consideration of the specific needs of individual children or their families. Robbie suggested that once children were in an environment perceived to be safe, the focus of social workers shifted to others still in danger and direct work with children in residential care and their families was devalued:

> *Once they came into care, they were seen as being safer. But once you see it as being safer, you're no longer priority. And that's where the danger comes in. Because when you've got kids who are highly traumatised and are going through a very difficult period, they're not getting support (Robbie, AW).*

Fragmented and fractious family relationships

This lack of effective work with young people whilst they were in residential care was mirrored by the perceived absence of support for families once their children were removed. Despite nothing changing in the fractious family situations which precipitated their entry into care, young people were regularly returned to their families around their sixteenth birthdays. Several participants believed such decisions contributed to deaths such as Johnnie's, who died within weeks of going home.

> *Johnnie left care and went home and within a week he'd hung himself from a bridge in a public park - he was taken away because he had a hard time with his brothers. He was a small boy, a very small boy - he used to get picked on and he ran away from home a lot… why on earth did they take him out of that situation then put him right back in… from what I can pick up the bullying started again… and he took his own life (Pauline CEA).*

Other young people, having yearned to return to their parent(s), found there was no space for them. Some participants from every group described watching helplessly as young people drifted into homelessness and drugs but without support from the care system, as they did not meet the legal criteria of care-leavers. The only sense of belonging they found was through sharing drugs with others undergoing the same drift away from human connection and safety. Keith, who lost two of his brothers through premature death, witnessed this pattern, watching as their mental health deteriorated and drug habits escalated.

> *Patrick went into care when he was four and then had not been home staying in a sustained, consistent way and Antony was even longer. So, it just made no sense to me that they would be returned home at any point through decision making processes. I'd have understood if they'd left and went home – but for it to be assessed, for the last twelve years it's not been safe... I was different because when they tried to push me, I refused (Keith FM).*

Young people could still be at risk of violence or abuse when they returned home. Daniel, for example, described phoning Lizzie just after she left home and hearing her father's violent assault on her.

> *She went back to live with her dad. I could hear her dad battering her in the background. And I could hear her brother going "dad leave her alone, leave her alone." Nothing had changed - her dad hadn't changed his behaviour and it was known; they knew that her dad had been violent. So, in my mind, surely something, some type of work or something, should be put in place, so that wouldn't happen (Daniel, CEA).*

Daniel's account makes it clear that the level of violence Lizzie was returning to was known but, because she wanted to go home, social workers allowed it. Daniel recognized that Lizzie adored her father, but from watching them together he knew she had unrealistic hopes about their relationship. Although she had spent several years in care, the work that might have made this relationship safer or allowed Lizzie to give up her unrealistic hopes was never undertaken.

Milligan and Stevens (2006) recognise some young people, like Keith's brothers or Lizzie, are desperate to return home and argue for more sustained and managed contact while children are in care to support this transition. They also suggest that to help them become more realistic about what their family can offer this could include counselling to '*dispel unfounded hopes or myths about their place in the family*' (Milligan and Stevens, 2006, p. 114).

Some care-experienced adults, reflecting on their transition from care, feel it was impeded by the enduring and complex problems in their families (Andersson, 2018; Duncalf, 2010). As Boman (2022, p. 9) recognised, however, many young people turn to family members when they leave care '*for companionship, assistance, advice and a place to live. Understanding and managing relationships with various family members as part of the transition from care process, can be viewed as unfinished business for many young care-leavers.'*

Healy (2020) suggests that the caring capacities of the families of young people in residential care are generally devalued and therefore there is little focus on working to improve them. This reluctance to expend time and energy on a potential resource that could provide some level of continuing support to care-leavers heightens their vulnerability.

The importance and meaning of sibling relationships for children in residential care and a lack of support in managing and maintaining them was also mentioned by participants in this research. Sibling relationships are likely to be the most long-lasting in an individual's life and can be an important emotional and practical resource both in childhood and adulthood. Keith described how much his desire to connect to his siblings dominated his life while in care.

> *when you know you're only going to see them once a month or once a week for an hour, it's a real focus it's a really exciting thing to look forward to and the event itself is amazing even if it was just sitting in a social work department. The impact beyond that was horrible because you knew it would be a distance between the next one - it became a disproportionate part of your life, so you then become obsessed about it. It was always a big part of your life. It was unnatural completely. It felt like this constant battle because you were putting it in your review forms, your panel forms, you access your social worker to push things… so its constant. And my sister was adopted as well, I've seen her once. She was adopted when I was ten, then I did not see her until I was twenty-three… it feels that what has been done can't be undone. So, I could probably meet her in the*

> *version of who she is and I am, but not as brother and sister. And I think we both realised that very early on (Keith FM).*

Keith went into the care system as one of six siblings: within months of leaving care, he was one of only three siblings. He had to fight for contact with his siblings and was left feeling powerless and with no support as he watched his brothers fall into the despair and reckless lack of self-care that led to their deaths.

Some participants across the groups suggested that unresolved hostility between siblings was implicated in some young people's deaths. For example, both Donny and Johnnie were bullied by their brothers but there appeared to be no support given to resolve these difficulties. It seems both felt they had nowhere to belong and those who knew them well felt that this alienation from family contributed directly to their deaths. It was also suggested that in some cases familial trauma negatively affected the relationships between brothers and sisters but that this was never addressed. Robbie, for example, outlined the dynamic between Alicia and her siblings after she disclosed the sexual abuse they were suffering.

> *… she had a difficult life. She was scapegoated by her siblings for a while - she would have been eight or nine. They didn't have a sibling relationship although they had loyalty towards each other. I think that's very different. They weren't loving towards each other - though I could see they wanted to be. But there'd been so much trauma between them and angst with regards to who's to blame. It was a very dysfunctional kind of relationship. I believe they wanted to have a relationship. But Alicia was the scapegoat. As I've already mentioned Mel could not forgive her because she was removed from the house (Robbie, AW).*

This very large sibling group, whose members had experienced overwhelming trauma together, seemed to have received no support either to recover from their abuse or to address the continuing difficulties in their relationships. Two of the siblings, Alicia and Scott died by suicide and the youngest has been repeatedly hospitalised after suicide attempts.

The lack of support for developing positive sibling relationships as described by participants may have contributed to the distress and isolation of some young people who died. The potential power of sibling relationships -both negative and positive- has frequently been reported. For example, sibling bullying has been found to increase the likelihood of suicidal behaviour in young adulthood (Dantchev, et al. 2019). There is strong evidence of the importance of siblings in surviving trauma but also of the danger that parental abuse will be reenacted within a sibling group (Katz and Tener, 2021). For many young people in care, however, sibling relationships can provide considerable emotional support especially as teenagers and may represent their only safe haven (Mota, et al. 2017).

Some young care-leavers who died became parents at a very early age, including at least three young women who had left care whilst pregnant. As well as describing fractured relationships in many young people's families of origin, participants also indicated that some of those who died were separated from their own children, either through the breakdown of relationships or by state intervention. Even those who had not lost their children had struggled with the complexity of caring for children whilst dealing with the trauma inflicted on them by their own parent(s). Pauline, for example, described the difficulties Abbie faced even in such basic tasks as bathing her sons:

> *She got pregnant when she was young and she had a little boy, a beautiful little boy, then she fell pregnant again and she had another little boy… when she was bathing the children she was finding it difficult because it was bringing memories back to her and she was scared in case she was abusing her children and she was really, really confused and mixed up about it (Pauline CEA).*

Some of those who died by suicide left behind dependent children who were still living with them, including two young women who were pregnant at the time of their death. Care-experienced parents may find it difficult to ask for help when they are struggling because they fear excessive scrutiny or having their children removed as is outlined in the Promise (2020, p. 48). Lesley provided a vivid recent example of the anxiety experienced by care-experienced parents about engaging with services but also the important role that can be played by residential workers if they are encouraged to maintain relationships with young people who have left their care.

> *the health visitor's not been allowed in, the allocated social worker for the baby's not been allowed in, but they still open the door to residential services. So at least*

> *we know that they are safe and the baby's safe, and again, for me, that shows the importance residential care had in their lives, that we're the only adults that they trust (Lesley CW).*

Overcoming the taboo

Participants in all groups associated the cumulative impact of trauma and difficult family relationships with young people's deaths. They suggested, however, that exposure to suicide or other violent deaths, especially those of family members, was particularly likely to evoke suicidal ideation and behaviour, which echoes findings in the literature (Agerbo, 2003; Agerbo, 2005; Kessing, et al. 2003; McDonnell, et al. 2022). Participants mentioned three young people who died by suicide who had witnessed the murder of a family member. They also identified four pairs of siblings whose suicides occurred within two years of each other as well as one young man who died some years after his mother overdosed. Miklin, et al. (2019) found that for some people bereaved by suicide, the death overcame the taboo associated with suicide and it became incorporated into their repertoire of possible ways to deal with distress.

Several suicide theorists also argue that regardless of the level of distress and alienation individuals experience, they are unlikely to kill themselves unless they have acquired the capacity for lethal self- injury (Joiner, 2005; Van Orden, et al.; O'Connor, 2011). This can occur through experiences such as traumatic exposure to violent death or when a person uses self-harm to regulate distress. Persistent and at times extreme self-harm was common amongst the young people who died. Charlie, for example, described Demi's self-harm when she was looking after her.

> *She was one of the worst self-harmers I had ever worked with at that time which would have been for about 24 or 25 years. She was self-harming all over her face all over her body (Charlie, CW).*

Pauline recognised the connection between self-harm and suicide and was wary about it being dismissed as a cry for help:

> *I know that self-harm is a big thing with young people in care and I think that anybody that self-harms has the ability to go on and do further damage to themselves (Pauline CEA).*

Exposure to suicide and violence was also apparent, however, in care-experienced participants' accounts of their own lives. Hamish for example described the suicide of an ex-girlfriend just after he was admitted to residential care:

> *My first ever girlfriend killed herself. Someone I grew up with. She basically came to me - she'd been being bullied. She came to me and asked for help. But I was too scared to help. And three days later, she' d hung… She hung herself and then her mum hung herself. As a result, I wasn't allowed to go to the funeral or anything because the dad blamed me because I had been her friend all my life (Hamish, CEA).*

This and other traumatic experiences of violence underpinned his own suicidality and self-harm. Shannon and Pauline also described their own serious self-harm and suicide attempts which they linked with abuse and traumatic loss. Although their suicidal ideation continued, they had all found ways to stay committed to life. Hamish, for example, recognized that stopping drug use, which had increased his impulsivity and reduced inhibition, was important in controlling his suicidality.

Participants across all groups reported that many young people died as a direct result of substance misuse and, even when the specific cause of death was different, the young person had often been using alcohol or drugs. Keith was clear that drugs and alcohol were involved in Antony's death and believed that he had very little else in his life.

> *he was in this environment where they were all drinking, they were all taking drugs… this was their life... They had nothing, but they had each other. And they had this lifestyle that revolved around kind of getting drunk and taking drugs (Keith CEA).*

There is evidence that those bereaved by suicide, like Antony and some other young people who died, are more likely to use alcohol and drugs to cope with their distress (Pitman, et al. 2018). Alcohol and drugs can numb the pain of loss and loneliness as well as reduce inhibitions against self-destructive acts (Makhija and Sher, 2007). Several young people began using drugs and drinking to excess as young teenagers which also substantially increases the risk of dying by suicide compared to those whose alcohol misuse began in adulthood (Langeland, et al. 2004). Almost all the participants identified a pernicious interaction between unresolved trauma, substance misuse and homelessness that kept many young people trapped in a hopeless situation that they believed contributed to their deaths.

Transitions

Although childhood trauma may have contributed to the young people's deaths, most died only after moving into independence. The few deaths that occurred while young people were still in care, happened around a planned transition to independence. All participants felt that the process of leaving care seriously escalated the difficulties young people faced and there were accounts of several dying within weeks of their transition.

Drawing on the work of Chandler and his colleagues (Ball and Chandler, 1989; Chandler, et al. 1987; Chandler and Proulx, 2006) on the importance of developing a persistent sense of self, Ward (2011) suggests that moving into independent living may create a crisis of identity for young people whose disjointed care history has already compromised their capacity to create a coherent autobiography for themselves. Young care-leavers may *'find themselves between stages, which leaves them without a successful means of justifying their own continuity across time'* (Chandler, et al. 1987, p. 119) and consequently their risk of suicide and other self-destructive behaviour dramatically increases.

Robbie gave a graphic account of these challenges, and the lack of support care-leavers are offered. He also highlighted the process by which systemic failures are regularly reframed as the individual inadequacy and incompetence of young people, which can have the effect of discouraging them from seeking help.

> *Who can they go to when there's a problem… If your kids phone, you're either round there, or giving advice over the phone, or transferring money straight into their accounts- that's what parents are there for. These young people have nothing. And the minute they ask for support, they're seen as failures - "have you done this? have you done this? have you done this?" - "I just want to fix my front door. It's broken, you know" - they're stigmatised because they've asked for help yet again... I don't judge my kids for asking for help - I encourage them to - that's*

> *a normal relationship for a parent - we need corporate parents to act like parents (Robbie, AW).*

Some residential workers described the terror they observed in young people as their leaving drew close:

> *Now you see when people are getting near you see fear - fear etched in their faces. And they change because they don't want to leave (George, CW).*

Wren highlighted the intensity of this fear as well, but she also described a sabotaging dynamic by which young people's anger was transmuted into anger and rejection which risked damaging the relationships they were so frightened of losing.

> *While these young people are feeling the terror they're projecting all the anger and all the previous rejection on to you (Wren, CW).*

Participants from every group also expressed concern that young people left care much younger than their peers living with parents left home. When the interviews took place young people could remain in residential care until they were 21, but many local authorities were reluctant to implement this policy because of a lack of resources. Charlie was very critical of the process by which most young people she had worked with had left care and linked this directly with young people dying.

> *We take these kids, because they're not safe where they are. And we love and care for them. And then at the ripe old age of sixteen, more times than not, we move our kids after years of being with us, when their vulnerability is at its highest not its lowest. We need to stop treating our kids like adults when they're still kids, when they have had really difficult experiences in life. Do I think some of the deaths, some of the funerals I went to could have been avoided? Absolutely. Absolutely (Charlie, CW).*

There is accumulating evidence of the benefits of extended care arrangements (Mendes, et al. 2022; OECD, 2022; Peters, et al. 2006). In addition to ensuring a longer period of material and financial security for young people, such arrangements can provide a protected space for neuro-biological maturation to allow them to consolidate self-regulatory skills which help control impulsivity and reactivity to stress. Such arrangements also ease young people's journeys into the worlds of education or work and ensure that they can maintain longer relationships with supportive adults and friends.

Several care-experienced participants in this study moved into independence relatively late, whereas almost all the young people who died left care at the age of sixteen or seventeen. Hamish, for example, left aged nineteen, whereas his friend Millie, who later died, left when she was barely sixteen. Hamish explained this by his knowledge of the system and his capacity to manipulate it in his favour:

> *A phrase I use a lot is "I played the game. And people had my back." But I feel like because she was more trouble than me, she didn't. She didn't get the help to stay (Hamish, CEA).*

Most care-experienced participants gave examples of taking some control of their pathways through and out of care by using their understanding of the system and interpersonal skills to persuade social workers and residential workers to agree to their requests. They also recognized that despite the inevitable restrictions imposed on them in the care system, there were both material and emotional benefits for remaining as long as possible. In contrast, many young people who died, expressed a wish to leave as soon as they could - believing they would regain control of their lives and might be able to renew family relationships. They appeared to have little realistic appreciation of the challenges they might face until it was too late to return to care. Within weeks, for example, Jack begged to return to the secure unit, where he had been locked up, because he felt so unsafe outside:

> *My wee brother went down to social work, broke down, because my mam was in nae fit state - they should never let a young person to go and stay with somebody that's in nae fit state to look after herself. He couldn't manage life - had everything done for him, had everything cooked for him had his clothes bought for him from, took out shopping and took to the pictures everything was done for him and he got let go and into society with nothing - with a mum that was caught up in addiction, had nothing at all. Went down to the social work department, greeting, and he had blood, he'd cut himself he had blood on "Please, please take me back. Please. I beg you." They says Jack there's nothing we can do for you, your supervision order's been took off you. Couple of weeks later my wee brother died. My maw found him dead in his bed (Tommy, CEA).*

The loneliness and isolation that the young people, like Jack, may have faced at the point of leaving care was vividly evoked in care-experienced participants' accounts of their own transitions. Hamish, for example, described how his fear and loneliness meant he allowed people into his flat for company with disastrous results that eventually lost him his tenancy.

> *They got me a private let. And I was at college. I got enough support to learn how to cook and learn how to manage my front door. But I didn't know about council tax. So, I'm still in debt from eleven years ago, because I've been paying off debt. But while I've been paying off debt, more debt has been accruing - a whole cycle. When I moved in, I didn't sleep for four days. Four days. Couldn't sleep. So, the first night was, you know, it was a bit exciting, I'd finally left care at nineteen and I thought that's what I needed. So that was good. That was good. But then, within the first few hours, it just became a vacuum. I always stand by this statement… the silence was deafening. That was a real issue for me the next three nights was like, I wasn't drunk or on drugs - I was just too scared to sleep, if I'm being honest. It was a really nice area too - a nice wee flat. But basically, I was left to my own devices. And I just couldn't sleep for a few days. So, I ended up having friends who were inappropriate friends to have up and we ended up trashing the place - wasn't good (Hamish, CEA).*

The stark contrast between the busy, noisy environment of residential care where there was always someone available to talk to and the silent loneliness of their own space ran through all the care-experienced participants' descriptions of their transition out of care. The connection between loneliness and young people's deaths was also highlighted by some of the professional participants.

> *Loneliness is the killer because we don't prepare them for that loneliness. And it's the loneliness - they're in a house where there's people 24/7 with them, and all of a sudden, they're on their own (Amy, CW).*

Loneliness and social isolation are identified in research literature as some of the most serious difficulties facing care-leavers (Atkinson and Hyde, 2019; Duncalf, 2010; Sulimani-Aidan, 2014). As has already been identified in the accounts of care-experienced participants, close connections between young people in residential care are often discouraged, despite their potential to provide a continuing social network for care-leavers. Shannon wished that her relationships with her friends, particularly Demi, could have been valued and supported to be positive because:

> *then you don't feel like each other's guilty little secrets, and I suppose both of us had many guilty secrets and we just didn't need each other to be an additional one (Shannon, CEA).*

Although participants focused mainly on the transition out of care, several also talked about young people whose deaths they believed were related to moving in or out of other types of institutions. Seven young people had died either in prison or shortly after being released and three were patients in psychiatric hospitals when they died by suicide. All these deaths occurred close to the time of admission or discharge. The enhanced risk of suicide for individuals moving into or out of a variety of institutional experiences has been noted in several reports and research studies (Crawford, 2004; Frottier, et al. 2009; Hunt, et al. 2013; Radeloff, et al. 2021).

Despair

Several participants across all groups believed that despair was at the root of most deaths. Some participants described becoming aware of this developing hopelessness when they observed something vital switch off inside the young people who died.

> *There's no like lust for life, there's no enjoyment - whether it be suicides or substance misuse and overdoses - you read it, when people start to go lifeless, when they laugh, there's actually no laughter in their eyes and there's no feeling (Shannon, CEA).*

Daniel recognized a similar process occurring in Lizzie, even though he had not seen her for a while before she died.

> *every time I saw her, she looked worse, she just looked miserable - she was always the life and soul of the party -she just lost her spark - just wasn't herself… it was like she just didn't care anymore - if you've not got a parent that cares what does that do to you? When you realise the person you love most in the world doesn't like you. It's just horrendous (Daniel, CEA).*

Participants across all groups drew attention to this lack of hope in the young people's lives. Although they recognised the material and emotional difficulties young people faced, participants believed that it was the feeling that nothing would ever change that underpinned this hopelessness. For example, Charlie described the response to a question she posed to a group of young women in prison.

> *“What could we do better in secure care for you when you're leaving that would stop you coming in?” Because all of them had been in breach of licence, so I asked the question, and there was a wee bit of arrogance about me because I thought I knew the answer. I thought the answer was “We need a job, we need a house, and we need money”and, almost in stereo, they said “We need hope” I remember being really humbled and embarrassed that something every human being should have a right to have is missing in a girl's life (Charlie, CW).*

Daniel described how meeting Sally and her family opened the possibility of a different pathway in his life and allowed him to resist the pressure of negative expectations. In contrast he felt that Lizzie faced a future she perceived as hopeless.

> *… and I’m like if I wasn’t in care, I would have liked to have had a life like that, you know. And it was that “maybe I could” - that wee chink of hope. It’s about hope - the minute you think “oh maybe I could do that”… and that’s the bit where when I look at Lizzie’s story she never had that chink, you know, that wee bit of light (Daniel, CEA).*

The difficulty some care-leavers face in finding hope can be compounded by encountering an inflexible system that can crush tentative dreams of a different life rather than encouraging them. Shannon, for example, thought that it was when Demi dared to believe in the possibility of change, only to have it ripped away, that she finally gave up on her life. Having decided to take control of her life and make different choices, within hours of being released from prison she had been re-arrested on an outstanding warrant.

> I *think that’s what killed her - she didn’t want that life anymore and she wanted so badly to move on from it - that’s a courageously strong thing to do and people underestimate that - it’s so much easier to just deal with the status quo and think “this is my lot” and “this is what I have, I just need to live with it.” But she made the most courageous and brave move by taking a stand and saying, “actually no I’m worth more than this and I want more than that.” What happened would have felt like a porcupine who has her spikes out, who lets her spikes go in, who’s stabbed in the chest (Shannon, CEA).*

Whilst recognising that Demi may have been unable to hold on to her hopes and aspirations if she had remained at liberty, this example illustrates that the control care-leavers exercise over their own futures can be severely constrained by the entrenched power of institutionalised practice and policy as well as the force of structural inequality.

This sense of hopelessness is closely associated with a sense of being trapped in an impossible situation with no way out. Shannon explained her own attempted suicides were to escape unbearable pain and linked this with her perceptions of others she had known who went on to die by suicide.

> *I don't think it's about not wanting to live. It's just not wanting to live with all this pain and all this hurt and all these feelings and sometimes when you're in that mindset you think that by committing suicide that it's a way to feel nothing - and feeling nothing is better than feeling that horrendous kind of storm of pain you're feeling inside at that moment (Shannon, CEA).*

Although all participants recognized that most care-leavers who died were seeking an end to their internal distress, they also highlighted the external factors which contributed to this pain. Charlie shared one young woman's powerful explanation of the cyclical process which resulted in her repeated periods of imprisonment.

> *One girl said to me "At least if I'm in prison I get my meals - I've got a bed. When I get put out of here, I've got nothing. I have absolutely nothing. So why would I not want to come back here? But", she said, "but Charlie, I absolutely hate it here, but it's so much better than freedom." So, then it was like - prison is better than liberty and death is better than life. And that was what it was like… And I think that, looking back at many suicides that I have attended, many funerals in my years, I think there is a common link there and I think that that idea of death is just much more appealing than life (Charlie, CW).*

The accounts of participants showed that several young people who died had reached the point where the only way to get their basic needs met was through admission to some form of institution by engaging in criminal or self-destructive behaviour. Although there was no doubt in Keith's mind that Patrick was experiencing serious mental health difficulties, for example, he was also clear that environmental factors were implicated in his distress. It was only when he communicated his suicidal intent, however, that he was admitted to hospital.

> *I started to see a change in the way that he was behaving, and it was kind of, you know, in terms of his mental health he started talking about the birds and talking*

> *to them and he started. And at this point I think he was dabbling with drugs and alcohol and that was the space he was in. That was literally everybody that was in every flat. And again, I think that loneliness and the environment, the environmental factors, forced him into a space where it was like become part of it or people around you will turn on you. His behaviour was worrying - so over a period of time he was talking about different things and then he started to talk about the option of hanging himself (Keith, FM).*

Not all the deaths participants mentioned were clearly classifiable as suicides. Some young people died from overdoses, and these are deaths where intent is difficult to establish. What was consistent in participants' reflections was the overwhelming sense of hopelessness they observed in most young people who died which they believed resulted in them losing their connection to life. As Staples and Widger (2012) point out, the boundary between suicide and reckless risk-taking and deliberate self-neglect is often blurred.

Whist unsure whether he had a fixed intent to die, Keith recognised the deep ambivalence Antony felt about being alive.

> *I think Antony's intent was to forget about his present moment where he was, his environment, life around him… and I think that when you're in a space where, whether it's drugs or alcohol or, or not, without any of that. Where you then start to, your mind starts to meander into a different space. So, you know, if you're using drugs and alcohol to forget about where you're at or take you to another space, that's because of the circumstances you're in. So, I think that what he was doing was taking himself into a different space. Taking risks because there was no reason not to (Keith, FM).*

This recognition of the blurred boundaries between giving up on being alive and choosing to die was apparent in several participants' accounts of young people's deaths. Wren questioned whether it was possible to distinguish between the extreme level of recklessness Jennie displayed and a deliberate choice to die.

> *it's a really, really fine line because, she was clearly just in that downward spiral and I don't know if it was absolutely deliberate or not, but she was certainly being so reckless about herself to the extent that, whether it's accidental or not, you have kind of killed yourself because you've felt so kind of fragmented that you're not able to take care of yourself anymore (Wren, CW).*

At the time that Jamie died, Daisy had accepted the simplistic narrative that was current at the time that poor outcomes were the result of young people making poor choices. Many years later her reflections led her to question this:

> *I suppose even if he didn't actually say "I'm going to take these drugs because I'm going to take my life" I think he was probably so low and so lonely that actually, that may have fed into his drug taking. Or he may have decided that "I've just had, I can't do this for the next"… (Daisy, CW).*

Several professional participants wondered if their own failure to keep a promise to contact a young person had contributed to their decision to take their own life. Davy, for example, still feels he missed an opportunity to interrupt Jordan's pathway to his suicide.

> *I got a phone call from the office – "I've got Jordan on the phone." I said, "Listen can you explain to Jordan I'm dealing with an issue - I'll give him a phone tomorrow and if he wants to phone back later on or phone me tomorrow, I'm on the early shift." I dealt with the situation. He never phoned back, I never phoned him and the next phone call I got he was dead (Davy, AW).*

Jillian reflected more broadly on the disrupted connections that are built into the residential care system and wondered whether this meant young people felt unable to reach out to people who had cared for them when they were in despair.

> *I think I reflect that, when somebody takes their life, they've run out of hope. And what if we were that one grain of hope, you know, what if we were that to them, but it was just too hard to grasp, to grab it? (Jillian, CW).*

This pervasive sense among participants from every group that those who died experienced despair and a sense that nothing would change in their lives echoes wider suicide literature. Hopelessness has been associated with suicidal behaviour separately from the impact of depression in several studies (Costanza, et al. 2022; Li, et al. 2020; Speckens and Hawton, 2005). The idea of escape from the unendurable has also informed understandings of the motivation for suicide since classical times (Montesquieu, 1973[1721]; Seneca, 2004 [65]; Shneidman, 1993). Several current theories of suicide emphasise the feeling of entrapment in the development of suicidal ideation and intent (O'Connor and Kirtley, 2018; Williams, 1997; Williams and Pollock, 2001).

There were also indications from participants that the negative discourse around residential care may have also contributed to the despair and sense of entrapment experienced by the young people who died. The professional and public preoccupation with poor outcomes may contribute to a sense of hopelessness for many care-leavers. Although it is necessary to recognise the difficulties care-leavers face it is also important that they are framed as barriers not as destiny. Negative labelling can have a destructive impact on some care-leavers' attempts to construct a positive identity and a hopeful future (Duncalf, 2011; Ferguson, 2018).

Systemic and societal issues

Although participants recognised the influence of individual psychobiography and everyday experiences on young people's deaths, they also identified systemic or wider structural factors that they felt constrained the control young people had over their own lives or limited professionals' opportunities to provide appropriate support. They believed these factors were strongly implicated in almost all these deaths.

The Hidden Costs of Professional boundaries

Participants across all groups believed that, until very recently, the loss of place, relationships and belonging young people experienced as they left residential care was exacerbated by a pervasive belief that continued contact was unprofessional and damaging to them. As Daisy pointed out this was how practitioners were trained:

> *There was a very strong narrative at the time… about the personal and the professional. I remember somebody saying to me "oh we've been told if we see a young person on the street who we've supported we should ignore them." To support independence… that was a narrative that we were actually training and supporting people around (Daisy, CW).*

Some professional participants made conscious decisions to continue relationships, despite this being perceived as transgressive, because they worried young people had no one else. Amy, for example, maintained contact with Craig, whom she had looked after in care, despite being told to stop the relationship. She felt that this connection helped him through some very difficult experiences he had during his transition from care and wondered whether lack of such a relationship contributed to the premature deaths of many young people she had known.

> *I was taken into an office and told to disengage. Sorry - I was all that wee boy had… how could I disengage… I chose not to: I was there at his eighteenth - the only person who sent him a card at his eighteenth, the only person who sent him a card for his twenty-first. I was there when his kids were born, there with presents - the daft granny… [There during the awful times - including traumatic death of his brother and his own suicidal feelings] He's came through the other end, he's an inspirational guy, works with guys coming out of jail… I am dead proud of him. He says "I know you are always going to be there - I can always talk to you. You know what happened to me, you know me." Maybe, if these other guys had someone to turn to, they wouldn't have killed themselves (Amy, CW).*

Interestingly, this attempt to disrupt an important relationship and the implicit assumptions about its inappropriateness echo many care-experienced participants' accounts of their disrupted friendships with other young people. In both situations professional anxiety about potential problems pushed those involved into conducting their relationships covertly.

An important debate about the distinction between boundary crossing and boundary violation exists that originated in psychotherapy literature (Zur, 2004). In the context of residential childcare, boundary violations occur when a worker misuses their power to exploit a young person or members of the young person's family for their own benefit. Amy's description of her relationship with Craig does not fit this definition of boundary violation despite the disapproval of some colleagues and, arguably, it helped him stay alive during a volatile and dangerous period of his life. Lazarus (1994) argues that allowing organisational risk management principles to interfere with such relational interventions is itself an ethical problem.

Although professional participants stated that the total break in connection, described by Daisy was no longer expected, there was still some degree of hesitancy about continuing relationships. Robbie's explanation about how such contacts are initiated hints at ongoing suspicion about workers' motivation for maintaining relationships.

> *… there are continuing connections but it's at the young person's pace. It's nothing to do with what I want - it's not about what I am looking for from a relationship (Robbie, AW).*

Daniel, however, explained how harmful not reaching out to them can be for young people. He reflected on his own experience of staying in contact with the home he grew up in, as well as his awareness of the impact on Lizzie of the abrupt disruption of connection she suffered when she went home.

> *There was no support round her at all. The horrible thing is the residential house we were in, she had a great relationship with her keyworker, but he never kept in touch. It's still a bit like that actually - the relationship's very much one way. So, I keep in touch with them. Because that's my home, that's where, you know I take the bairns back to show them where mum lived. They never, ever pick up the phone to me. And that's fine… I don't really need them, whereas I think someone like Lizzie needed them. She needed someone to check in on her. Somebody to be like "are you alright?"… She needed someone to look after her (Daniel, CEA).*

Jillian shared a recent example suggesting that the inhibitory power of professional boundaries can leave some young people feeling that the affection and warmth they feel towards people who looked after them are somehow inappropriate. She described a conversation with a young care-leaver reflecting on his relationship with Betty, a former residential manager, whom he had known for years.

> *There's one young person who messaged my team last week, and said, "I'm still, I'm still missing my, my wee Betty" And he asked, "Do you think that that's, do you think that's wrong, that I still miss her and think about her?" So, these kids feel that too. They feel the, the… what are they allowed to do? And in some ways, I feel like we have a responsibility to make that feel genuine for them (Jillian, CW).*

The important indicators to Patrena, that her relationship with adults in her former home was genuine included the fact that they proactively contacted her rather than waiting for her to phone them and that her relationship was becoming progressively more reciprocal. Although Robbie stated his belief that continuing connections with young people should be solely for the young person's benefit, he provided one of the few descriptions of a clearly reciprocal relationship which was positive for both him and Keith.

> *I'm no longer Keith's worker, I'm just now his colleague and his friend. He knows should he need anything he just has to ask. And you know, I can just do the same for him Because it is about the fact that that now, that relationship - it was a dependency at the start off - very quickly has become interdependent. It's about having a relationship (Robbie, AW).*

Jillian had reflected deeply about the nuanced nature of relationships with young people leaving care. She was worried that one young man who died had failed to contact her when he was distressed because he did not want to disappoint her.

> *I reflected a wee bit about that because I suppose - it's nice to know the success stories. I wonder did I praise him too much that actually it was like I can't, I can't sustain that level of… I don't want to disappoint her so I'm only gonna phone her when it's good stuff. And I'm much more mindful of that now and realistic about celebrating the successes at a level that matches the affect but at the same time is mindful that look you know, you know... we're here for you. We provide that reassurance that it's great you're doing well but you know you can lift the phone up to me and I'm always here for an ear and a shoulder. But I do. I think I reflected a whole lot that maybe he felt he couldn't sustain that level of success. And I hope, I hope I didn't create that. But I probably did if I am being honest. Without intention, of course, but just… yeah (Jillian, CW).*

Arguably, expecting care-leavers to initiate contact fails to recognise the difficulty they experience in asking for help and their wish to prove to themselves and others that they can succeed on their own as reported by Adley and Jupp Kina (2017). The same authors emphasise the importance of proactively reaching out to young people, even when they have previously refused contact or support, as their perspectives about what they need may shift after experiencing the reality of independence, though shame or pride may prevent them seeking help. Moreover, trust is a key factor in young people accepting help and as indicated by some participants in this research, relationships with residential workers are often more valued than those with social workers or throughcare workers.

Flawed decision making

A frequent source of anger and confusion among participants across all groups, was decision making that was perceived as flawed and driven by resource considerations rather than children’s needs. Young people leaving care just before their sixteenth birthday and returning to home situations that were still unsafe and hostile, was seen as a direct contributor to several deaths. When care-experienced participants, such as Casey and Keith, reflected on the factors that led to suicides or other premature deaths they gave numerous examples of young people returning to unchanged family situations which made no sense to them.

> *Off his supervision order, save a wee bit of money. So, then his mum - obviously the reason he went into care was because of his mum- she hasn't changed when he's moved back, so she's still quite nuts so keeps kicking him out (Casey, CEA).*

> *Antony was fifteen and a half I think when he left and again, they just transitioned him back to my mum because it meant that - well a couple of things. It meant that they didn't have to pay and at this point I was thinking - well I knew what would happen because it happened with Patrick when they put Patrick back with my mum. He was there for a couple of years then he went homeless and then it was the exact same with Antony (Keith, FM).*

This was echoed by professional participants who often drew on many years of experience working with young care-leavers and who believed that they discerned a common pattern in decision making that they felt was due to the inadequacy of resources available.

> *The link to all my stories will be poor decision making on leaving care. Because it's the easy decision to go with the one that uses least resources and impact on their workload least… that is genuinely my feeling with regards to the fact that when you've got an overstretched service, and lots and lots and lots of strong messages coming from management, with regards to resources, you do start taking shortcuts. And the shortcuts lead to premature deaths. If you, if you're not aware of why you're making a decision, that's going to lead to harm for someone. Ultimately, death (Robbie, AW).*

Charlie also expressed her belief that resource considerations drove the planning for many young people leaving care and she too felt that this prioritization was directly implicated in the deaths of young care-leavers.

> *They let our care-leavers down, our care-leavers are going out and experiencing an adult world when they are not equipped to do it, at often very young ages and they're let down, and they're let down because money becomes more important than their life and resources become more important than their life (Charlie, CW).*

The level of loss and professional abandonment that these decisions often entailed was powerfully described by Daniel when talking about Lizzie who had been his closest friend in care and with whom he had his first romantic relationship.

> *… you've already been abandoned by your parent, and then the state does that... its replicating all the trauma again... Like for Lizzie to have lost both her parents, you know, through whatever circumstances, that is just horrendous. Then the state disappears, her relationship with her key worker is gone, the relationship that I had with her is gone, I don't think that her best friend had seen her for a long time because she didn't take drugs so she couldn't fit into that world with her. So, she was on her own (Daniel, CEA).*

Although the 2014 Children (Scotland) Act provides the legal basis for young people to remain in their placements till they are 21, few additional resources have been allocated to achieve this. Professional participants were unconvinced that all young people would be supported in this way. Lesley, for example, described the pressure she still experienced to move children into independence.

> *The pressure does come still as they reach 16 years of age, if there's a referral for a 12-year-old it is still about moving young people on to create space. And there is greater pressure now than there was five years ago. So, if I had somebody who was sitting in here who I feel wasnae appropriate to move on, would I put forward that argument? Yes, would I be successful in that argument? Probably not if it was felt there was a need there for a younger person to, to have that bed (Lesley, CW).*

Although there is a legal and policy framework that provides for later and more supportive transitions from care some research literature echoes the difficulties identified by participants. The inflexible and inadequate support available to many young people who leave care has been consistently recognised in research literature. In their recent review of the enablers and barriers of successful transition from care, Prendergast, et al. (2024) found some young people still felt rushed into leaving care and felt that their experience of pathway planning was a futile tick box exercise. Some experienced extreme social isolation and were unsure how to access help or were put off by the contractual nature of the services they were offered. Insufficient resources, excessive workloads and frequent changes of worker also contributed to young people feeling that they had little control over decisions made about them and that they were treated as just a case. In contrast, other young people had identified the importance of the consistent availability of warm, personalised and proactive support in creating a positive transition.

Lack of accountability

Linked to this perception of flawed decision making was the feeling that there was no accountability for the effects of such decisions. Professional participants often identified a widespread tendency to blame individual care-leavers for failing to manage their independence rather than exploring the systemic factors that contributed to these catastrophic outcomes. When Daisy reflected on the death of 16-year-old Jamie within weeks of leaving care to live in a homeless hostel, she could recognise how problematic such a move was, but she felt that there was no capacity from anyone within the system to even question the decision let alone actively challenge it.

> *The system was not in a place of being able to reflect and think about what it had done… Nope, it was just, it happened. And when I look back now, I think there was a strong narrative about… "Jamie began to make really dangerous choices." We just didn't have the analysis. I didn't have the analysis. The residential workers didn't have the analysis. But there were social workers and external managers - people who I admired who didn't seem to have that analysis. We were a team of social care workers and that's not to say that they weren't doing a great job. They were doing a great job at the caring element, but we didn't have the language or the analysis to be able to challenge what was happening. We didn't (Daisy, CW).*

Although this death had occurred almost 20 years earlier, Daisy also provided a very recent example where a dispute between local authorities left a vulnerable young man homeless and without support.

> *The system, it feels like the system just propels you - it just normalises it; I think. I mean Katy [one of Daisy's colleagues] and I were talking about a young man… who ended up being homeless because two local authorities fell out about who was paying for his placement (Daisy, CW).*

Robbie felt that the lack of an automatic review of every death of a care-experienced young person meant that not only was there no accountability there was also no opportunity to learn from the deaths and potentially create systemic change.

> *Where's the accountability? Who's looking after these young people? Just because you've reached a chronological age does not mean you're an adult… They don't even have case reviews in substance misuse they're not seen as a failure of somebody else. Yeah, no one's held accountable for it. Because theoretically, you just blame the young person yet again. Why change the habit of a lifetime? If it's. If it's child abuse, or if there's neglect, and it's all over the papers there's always going to be a case review. Due to the death. If anyone dies in care, it should be reviewed. So, it's noted, so their voices aren't lost, the experience isn't lost, it can still change things (Robbie, AW).*

Although all the professionals talked about their own and some colleagues' personal guilt and distress about the deaths of young people, they identified that the lack of a structured feedback mechanism in the system meant that the wider implications of young people's deaths could effectively be ignored. As Davy points out this risks undermining the effectiveness of a system that is intended to protect children and young people.

> *Nothing really happens to you, you don't get in trouble for being terrible at providing care... while you actually make the trauma just as… not as bad, because they probably felt safe, they don't get battered as much - this is a different type of trauma and it's worse because that was meant to be the bit that saved you (Davy, AW).*

Participants in this research were profoundly affected by the personal loss of one or more young people and this, perhaps inevitably, led them to focus on the lack of accountability for the deaths. Johnson, et al. (2024), however, identified tensions that exist around the concept of accountability when considering outcomes for young people leaving care. They argue that policymakers, organisations and care-leavers have very different criteria for measuring success. Economically driven outcome measures that often drive policy development can fail to focus on less tangible factors that may have higher priority for young people's sense of well-being or success. Similarly, the desire for standardisation fails to recognise the heterogeneity of the care-leaver population. Turner and Percy-Smith (2020) also describe the reification of accountability when performance becomes linked to standardised assessment and planning documentation which may not provide a nuanced account of individual lives or needs. In designing any change process to reduce the possibility of premature deaths among young care-leavers these different pressures may need to be considered.

Poverty and inequality

In addition to the problems that all participants identified in the operation of the childcare system, they also highlighted the crushing impact of poverty and inequality of opportunity that affected young care-leavers. Most young people in the care system come from families and communities that experience extreme economic and social disadvantage, and the perception of participants was that for many care-leavers the transition out of care returned them to similarly hostile environments. Some care-experienced participants gave vivid accounts of their own struggles with this, as well as sharing their reflections on the way poverty was connected to the deaths of young people. Keith, for example, who had worked hard to prepare for his move into independence, described his forceful recognition of the circularity of poverty that he was experiencing when on his first day as an independent adult he woke up with no food.

> *I'd had three offers of houses, and they were all in the worst areas. Even the third was, you know, it wasn't a great area, but it was the best out of a bad bunch. I was told if you don't take this, you'll be back at the bottom of the list, so I took it anyway. And I had everything sorted and then I woke up this day and I had no food, and I didn't have money to have food and that was the one thing I'd forgot to get. It was that realisation that actually I was born into poverty and had no food and actually I was out at the other end, in poverty with no food. So, it was this realisation that it had went full circle again (Keith, FM).*

He reflected that this was even more damaging for him and his brothers than their original exposure to poverty because the rupture of relationships in their family meant there was even less protection than they had had as small children.

> *So, where care had nourished us – in terms of food and needs and happy times at moments in time – it was literally you know, again, coming out of poverty as a child and being placed back into it but ten times worse. Because, even when we were with our mum, she was a protective factor. Although she exposed us to risk, when Patrick and Antony were in homeless accommodation they had no protective factor, they were there themselves. And they didn't have the capacity or the tools to, or the support to work their way out of it (Keith, FM).*

This sense of the impact of poverty was echoed by Pauline, reflecting on her own experiences as well as those of some young people who went on to die.

> *One of the craziest things somebody said to me when I was leaving care, she turned round to me and said, "At least you'll be able to eat what you want when you want." I thought "That's crazy where am I going to get the money for food?" (Pauline, CEA).*

She believed that it was the terror of facing this poverty that contributed to the death of Angus who killed himself days before he was due to leave care.

> *He was that scared of having to fend for himself because in those days you really got nothing, you just had to go, yeh, and he had nowhere to go (Pauline, CEA).*

Casey, however, who was in kinship care and had remained in her own community, provided an important perspective on how damaging and pervasive the effects of poverty could be for many young people, even without having been in care. Although she talked about three care-experienced young men who died she described an environment where violence and involvement with drugs was normalised.

> *It's kind of, the norm around there… that culture as well where I live. It's now the most deprived area in the UK so drugs is just everywhere. You can walk down the street and it's just everywhere. A lot of young people struggled, and a lot ended up staying with their girlfriends, mainly young males in particular. It was kind of the norm and the only way to get through was selling drugs and taking drugs and that's pretty much what they did. And it left them vulnerable really, vulnerable in their aggression and the way they are and the way young men feel they have to be (Casey, CEA).*

Despite the level of community disadvantages she described, Casey also recognized the additional struggles faced by care-leavers who lacked any type of social network to seek informal support from.

> *Like we all have a safety net, like even in kinship care you've got somebody to fall back on, you have your mum and dad, you have everybody. You can go and ask for a loan of money you can go and get your own flat. They have nobody and then when they go and ask for help it's kind of like well, you've spent your money, that's it, and they don't get anything (Casey, CEA).*

She contrasted this sense of a rudimentary safety net with the experience of one young man who had died. He had experienced several placements including residential and secure care but seemed to have no continuing connections to anyone.

> *He didn't really have anyone at all. He was himself in a flat. He never really had any family either, he never had any contact with his mum or anything. I think he had a gran who stayed over at the airport but that's about it. Never really seen her and he kind of just got left to grow up himself since he was about 16. I think he got his own accommodation and then from there it went downhill (Casey, CEA).*

Although most professional participants focused mainly on the deficits they perceived in the care system, they also recognized the damaging effects of poverty and inequality and connected them to the premature deaths of young people they had known. Amy, for example, highlighted the multiple challenges faced by young care-leavers just to survive.

> *Maybe some of these kids would have survived if they had more support, as I say, are we setting kids up to fail? By giving them the dream, and then, the reality is, taking it away from them. They don't have money for clothing, they don't have money for electricity they don't have the support and the friendships - they're out there on their own (Amy, CW).*

Robbie also suggested that resource allocation policies exacerbated the difficulties faced by young people who were already dealing with multiple challenges because of family and care experiences.

> *they're always placed in the most difficult places -vulnerable young people who have had a vulnerable upbringing - who have been through the care system - set free in the world and expected to function as normal adults or young people: get a job, pay your bills, have a real relationship (Robbie, AW).*

These vivid descriptions of the impact of poverty on young care-leavers provided by participants demonstrate yet again the material and practical difficulties that care-leavers have been shown to face in their compressed and accelerated route to independence (Stein, 2012; Ward, 2011). Most policy and practice responses to these difficulties have involved developing programmes for acquiring independence skills for young people before they leave care (Turner and Percy-Smith, 2019). This approach, however, inadvertently contributes to a perception of individual deficit when care-leavers struggle to manage the multiplicity of demands that most young people in the non-care population are protected from through extended parental support (Palmer, et al. 2022). This stigmatising approach is challenged by Power and Raphael (2018), who argue that Britain's neo-liberal welfare state impacts negatively on the most vulnerable groups in society including care-leavers. They suggest that professionals supporting care-leavers' transition, whilst continuing to provide immediate support, must also raise broader issues of resource distribution and argue for policies that address these inequities.

Finding meaning

So far, this chapter has focused on the ways participants tried to understand young people's pathways to death. They also, however, shared their personal attempts to find meaning and significance in the deaths. Finding meaning was not an easy task and almost all participants experienced an overwhelming sense that these were deaths that were somehow out of place and revealed a huge cost of wasted lives. Daisy, for example, spoke of the rapid deterioration in Jamie's life when he was moved out of care.

> *What a waste. I mean it's a waste for any young person we look after but he was so full of life and it was just like within weeks that had got sucked out of him, you know. He was actually still a really young person who needed looked after (Daisy, CW).*

Several people reflected on the youth of those who had died and how time passes on, leaving them behind. Patrena struggled with the realization that she is now older than Lewis and that, although he will never reach twenty, she continues to grow older and further away from him.

> *I think it was just before his twentieth birthday. So, I'm a bit older than him, when he was a year older than me (Patrena, CEA).*

Charlie's statement that '*their three ages added up to younger than my one life is a startling, startling fact'* seems to highlight her continuing struggle to find meaning in the deaths of three young women she had cared for deeply. She, and others, questioned the purpose of a system that they believe spends time, emotion and resources on traumatized children only to cut them off when they are still vulnerable and dependent with very little support. Keith was furious at the lost potential of his brothers and other young people he knew who had died.

> *At that age, I mean they were eighteen they literally could have done anything, they could have been anything (Keith, FM).*

Most participants in every group, however, were able to find meaning or significance in the deaths they described despite continuing anger about the young lives that had been lost.

A few people, especially those who had a personal faith, were able to find comfort with the idea that a young person was no longer in pain but in a better place.

> *She was a tortured soul, a person who deserved to be in a place of peace and for her, that place of peace was going to be wherever your beliefs are, for me that's heaven, and I believe that that she was very much at peace (Charlie, CW).*

Kate believed that her daughter not only felt comforted that Brian was now at peace but that his eventual death gave her a relief from continual anxiety about him.

> *So, I mean I think she had a sense of he was at peace, and she was at peace really when he went in the end (Kate, FM).*

Some people described finding comfort through a continuing bond to the young person who died. Shannon for example explained that Demi was always in her thoughts and that she did not yet want to let go of this connection.

> *She's the first person that I think about when I wake up in the morning, she's the first face that I see. And she's the last thing I think about before I go to bed at night and I don't want that to change right now, I deliberately abstain from full on relationships for that reason, because I'm not ready to let her go (Shannon, CEA).*

Kate describes a less intense continuation in the bond with Brian but one that she believes is important not just for her but for her grandchildren who never met him.

> *He’s there and he will remain there as long as I’m there. He’s in the family photograph album which the children like looking at so, oh no, he’s very much there, they know who he is, and they’ve seen him and everything (Kate, FM).*

Although Charlie described a process of gradual recovery from the trauma of the deaths of young people she had loved, she was clear that it was important for her that they were still held in her mind and that her loss and grief were easily triggered.

> *You get stronger, you do get stronger but there is not a time or an anniversary or a certain thing I see that I'll remember, and I'll think about them. It may be a song for instance - I mean the song that was played at Demi's funeral when I hear it on the radio is my moment to cry - and I cry over and over again when I hear it (Charlie, CW).*

Almost all participants stated that the deaths of the young care-leavers they had known had strengthened their determination to strive for changes that might prevent future deaths. Shannon, for example, shared her determination that Demi’s death would not be wasted.

> *There’s two ways to look at that isn’t there. So, there’s the way where I feel like shite and it’s like “Oh well why did I live and why is it me?” and then the other way is "Well, you know, she did die but I’m going to make sure that it wasn’t in vain and I’m going to make sure people know her name and know” (Shannon, CEA).*

Casey described the effects on her of the deaths of the three young men she knew but also shared her sense that her young brother’s journey through adolescence could have ended in a similar tragedy. She too felt that this fueled her commitment to working for systemic change that reduced the risk of premature death among young care-leavers.

> *It’s just really kind of hard hitting and it’s motivating me kind of in this job, to make stuff change. I want to make sure people don’t slip through the net. A lot of them are folk that were in the position that I was, or they just relate to my wee brother so much. It’s shocking because I know firsthand, from experience, what goes on and it’s not right and it motivates you to want to change things (Casey, CEA).*

Although the realistic limits to the impact of any research study had been explained to them, several professional participants stated that they were involved in this research because they hoped their experience could help inform changes in policy and practice. They felt they owed it to the young people who died as well as to the care-leavers and practitioners of the future as Jillian, for example, explained.

> *You've got a responsibility to share and be vulnerable, and be open about experience – because how else do people learn, grow, or develop? And also, I think I owe that reflection, like that space and reflection for the kids who are no longer with us. That's a bit of a legacy, isn't it - it's like a legacy for professionals to do a better job (Jillian, CW).*

Charlie was also clear about her hope that tangible benefits might emerge from the research.

> *I jumped at the chance of being part of this. And I think it is an incredibly important piece of work that's never ever been looked at and the only thing I ask is a training programme, or a workshop or a conference, a paper something else has to come out (Charlie, CW).*

As well as sharing their wish to be part of creating change whether through their own work or through participating in this research, several participants also expressed their sense that the young people who died deserve to be remembered and their stories not be forgotten. Robbie shared his passionate belief in the importance of such storytelling but also his frustration that nobody, including himself, ever seemed able to take responsibility for doing this in a systematic way.

> *This sounds really bizarre but because death is final, it's an ending - it doesn't seem to matter anymore. Not the fact someone's died. It doesn't… these deaths don't matter because no one's, no one's claiming this information. I've already had so many chats with managers with regards to where's, where's, where's the voice of young people who have died who will never get a chance. And they've all thought about it, and they come back to the advocate – "You're the person who knew them best, you have to write the case study, or you have to write the story" and you're going "We don't have the time to reflect and do all that… we don't have time…" It's work so you always throw yourself back into it, so you don't have to think about how you just said that you don't have the time to, to, to write the story, to give them a voice. It's shocking because you're not honouring them at all because they don't have the time anymore either. No one takes the time, no one takes the time. That's not right for me to sit there and say no one's got the time to do it. It's shocking (Robbie, AW).*

Keith also welcomed the focus of this study and hoped that it might provide a platform for the stories of the young people he had known and others who had died.

> *like even this research, thank goodness that it's happening. There is, you know there's a narrative about what we need to celebrate and appreciate - approaches to practice and a whole range of things - but there seems to be a fear of telling stories of people who are not here to tell their story or understand this and the impact and what we can do as a result. So, this for me has been long overdue (Keith, FM).*

Most participants were able to describe ways in which they had found some form of meaning and significance in the deaths despite the grief and sadness they still experienced. For some care-experienced adults and family members this may have taken many years to achieve. Participants across all groups described a strong commitment to doing what they could to prevent future deaths and ensuring that young people's stories were shared and honoured.

Key Findings and Discussion

This chapter explored the ways in which participants explained the deaths of young people and also how they personally were able to extract meaning and significance from the experience. Their explanations of the deaths drew on personal and professional experiences as well as some theoretical knowledge. Interestingly, despite the hegemony of the psychiatric model of suicide, nobody explained the deaths through a mental illness model. They certainly recognized that many young people struggled with their mental health but viewed that as a reaction to the various adversities that they had experienced. Rather than mental health problems being the cause of the suicides they saw the combination of family difficulties, trauma, system failure and structural inequalities as contributors both to young people's emotional distress and to their deaths.

The accounts and reflections of participants made clear that they believed that factors contributing to young people's deaths interacted in complex ways. Although most young people had suffered neglect and trauma before they entered care, participants focused their attention on their later experiences and emotional states. They highlighted the lack of connection and belonging and believed that the rupture of relationships particularly around the transition from care underpinned the sense of isolation and despair that contributed to the deaths of the young people. They also emphasised that aspects of the care system had exacerbated young people's distress and made it more difficult to trust relationships and services. Lack of focused family work whilst in care meant that young people found themselves returning to an unchanged family dynamic. Many participants described entrenched systemic and structural factors that prevented young people from accessing emotional and social support and placed unmanageable practical demands on them. Most young people who died were said to have difficulties with alcohol and drugs and many self-harmed. Participants believed that these may have reduced the inhibition and taboo around suicide.

The descriptions provided by participants of young people's pathways towards death align with many current models of suicide (Joiner, 2005; O'Connor and Kirtley, 2018; Williams,1997) which suggest that as well as experiencing some kind of adversity individuals need to overcome the inhibitions against lethal self-harm and be unable to see any escape from their distress. Exposure to traumatic violence and a history of self-harming behaviour which can reduce the taboo against suicide were frequently described by participants in their accounts of young people's experiences. They also believed that despair and a lack of hope left young people feeling trapped.

As well as trying to understand what had happened to the young people who died, almost all participants also described their own journeys through grief to finding meaning and significance in the deaths. While this did not diminish their distress at the lives they believed to have been wasted, some described finding comfort through a belief that the young person was no longer suffering or through a sense that they had a continuing bond with the young person who died. Most described a fierce determination to use their loss to build a legacy of change to prevent future suicides of young care-leavers and to improve support for all those affected by these deaths.

The final chapter will draw together findings from the study and consider the potential implications for policy and practice as well as identifying the strengths and limitations of the research.

Chapter 7 Conclusions

> *The disadvantage faced by the care-experienced community should be the civil rights issue of our time. Children in care are powerless, are often invisible and they face some of the greatest inequalities that exist… (MacAlister, 2022, p. 24).*

Making the invisible visible

This research project set out to make visible an unacknowledged group of young people, and those who once cared for them and now mourn them. The individuals who are the focus of this thesis are young people who died by suicide after leaving residential care. They are perhaps the most invisible of an already invisible group. They faced the ultimate injustice of losing their life on the threshold of adulthood with no recognition from the state that was responsible for their care. Those who accompanied me on this difficult journey exploring the meaning and impact of these young people's deaths are care-experienced adults who knew them, some family members and professionals who worked with them. Their memories, reflections, emotions and, sometimes, tears are the data this thesis is built on. Like the young care-leavers' who died, those who mourn them have been largely invisible. Undertaking this research has made much more visible to me than I anticipated or perhaps wanted. I discovered limits to my emotional capacity and have had to look below the surface of my professional world. The focus of interest has, however, remained on the research questions that explored how participants made sense of and found meaning in the suicides of young care-leavers they knew and what impact these losses had on them.

This chapter highlights the most surprising and troubling findings from the research and considers the implications of these for policy and practice. It reflects on the process of the research, identifies some strengths and limitations of the study, and makes suggestions for future research.

Key Findings and Implications for Policy and Practice

Several factors believed by participants to contribute to young people's deaths echo those identified in previous research including childhood loss and violence, a thwarted sense of belonging, a lack of hope and feeling trapped. They also described their own emotions and reactions to the loss of young people that mirror those described in other studies. These included overwhelming and enduring painful emotions as well as feeling socially isolated in their grief. Some also described the type of post-traumatic resilience that fuelled both personal change and community activism that was found among others bereaved by suicide. There were, however, some findings that appeared different or were exacerbated by the context of the residential childcare and care-leaving sectors. These will be discussed further and policy and practice implications explored.

Disenfranchised grief -who do you think you are?

The question 'who do you think you are?' can be understood as an invitation to explore identity but it can also be imbued with scorn and used to attack a person' s value and worth. Identity and value pervaded the experience of disenfranchised grief as described by participants. The value and meaning of relationships many participants had with young people who died were contested and complicated. Most felt that their grief was unacknowledged or devalued in some way.

Some professionals described grieving like a parent, but this level of distress was not acknowledged or welcome. Funerals became sites for a covert power struggle over who really knew the young person. Family members decided how funerals were conducted and who should speak about the young person and care workers' presence was rarely acknowledged. Many managers and social workers also disallowed this grief and diminished the meaning of the relationship as they perceived such involvement as unprofessional. Participants described wrestling with their own sense of who they were in relation to young people because there is no adequate theorisation of a role that combines a sophisticated skill and value base with a deep, committed, and enduring relationship.

The grief of care-experienced adults was sometimes disenfranchised in even more disturbing ways. Several described lack of trust leading to sustained attempts to disrupt and prevent relationships between young people in residential care. This could mean there was no recognition of the loss because it was assumed no relationship existed. Whereas relationships between professionals and young people were recognised but their significance unacknowledged, those between young people were often not even recognised, meaning that care-experienced adults might not learn of the deaths for many years or in casual, inappropriate ways.

Participants felt their grief was devalued in other ways. Some encountered responses suggesting that the person who had died was less important than others, not quite human. Disenfranchised grief is common among the suicide-bereaved because the lingering stigma associated with suicide exacerbates more general difficulties people have in acknowledging and supporting those dealing with loss. Within this study, however, multiple intersecting and stigmatising factors meant many participants experienced an unusually strong sense that their grief was inappropriate and unworthy of consideration. Almost all participants from every group, however, described receiving little support or recognition of their loss.

Organisational and professional practice seemed to minimise the meaning of these deaths and suppress expression of grief. Workers are increasingly expected to create a relational and loving environment in residential childcare- this is unsustainable if the pain of losing a young person through suicide or other premature death remains unnoticed. In particular, the concept of being ‘professional’ needs to be decoupled from the suppression of emotion. Managers need to avoid organisationally defensive responses and ensure that those bereaved by the deaths receive the same time and space to grieve as that afforded to family members.

Many educational and health organisations now have well-developed postvention plans designed to ensure that the those affected are informed sensitively about traumatic deaths. These plans lay out processes to ensure that timely support is available for all those affected by the deaths. There was no evidence of such planning in the accounts of participants. The sense that emerged from the accounts was of a chaotic sharing of information and a denial of the meaning of the events rather than provision of support. This suggests that such plans should be developed for all residential childcare providers. They should also ensure that where possible people who lived or worked with young people but are no longer directly involved in the organisation should have the option to be informed about any death.

For some professional participants the exclusion they experienced at funerals exacerbated their grief and anger. The lack of memorialisation, at both an individual and collective level, for young people who died by suicide also caused some care-experienced participants to connect with their own profound anxiety about being forgotten. There was a desire for alternative ways of remembering young people and celebrating the positive aspects of their lives, including some relationships they developed in care. As well as organisations developing their own ways of remembering individual young people, annual shared memorial events could be organised at local or national level that acknowledged the loss of young lives from the care community. This would provide meaning and significance for the deaths and reassure those bereaved by the premature deaths of young people that those they had cared about would not be forgotten.

The hidden costs of professional boundaries

Social work, and in consequence, residential childcare, adopted a professional identity modelled on more traditional professions where emotional distance and objectivity were highly valued (Coady, 2014). As accounts of historical abuse emerged these professional assumptions hardened as they served to protect organisations from the potential damage caused by allegations of inappropriate relationships. This created a risk-averse and sterile culture in many homes, where physical touch was severely limited, close relationships viewed with suspicion and continued contact with care-leavers forbidden. A recent resurgence of relational practice in social work, mirrored in residential childcare, has challenged the sterile professionalism that could prevent the development of genuine warmth and meaningful connections in residential childcare (Ruch, et al. 2010; Coady, 2014; Steckley, 2020). Indeed Coady (2014) suggests that residential childcare should create its own professional identity - effectively reversing previous assumptions.

> *There appears to be no reason why it might not be considered unprofessional, from a care perspective, to fail to provide children who grow up in our care with the significant, flexible and enduring care relationships that other children take for granted (Coady, 2014, p. 89).*

Almost all professional participants believed that continued contact with care-leavers was now acceptable in their organisations, but framed this by insisting it was on care-leavers' terms. This leaves the onus on young people to initiate contact with adults. The genuine motivation of professionals was to respect the autonomy and privacy of young people and to avoid being intrusive. This seemed to create a potentially dangerous miscommunication, however, as it was clear from care-experienced participants that they interpreted this as a lack of interest and concern.

This research suggests that residential workers and care-leavers can struggle to negotiate a reciprocal interdependent relationship. Their shared history, the dominant professional discourses and uncertainty about the meaning of their new relationship easily combine to push care-leavers into one of two polarised positions. Either they must present a picture of success which guarantees that people will be proud of them, but which erects substantial barriers to asking for help, or place themselves in a position of incompetence and failure which may enable them to access practical help, but which creates shame and erodes their self-esteem. Such a simplistic split in no way reflects the complex multifaceted identities of care-leavers. Shifting such a dynamic is likely to require reflection and conscious effort from residential workers as they hold greater power to define the nature of relationships than care-leavers who may feel their only real power is to refuse to engage in any relationship at all. Several care-experienced participants linked this dilemma to the despair and sense of being trapped that they felt underlay many suicides.

Lack of belonging

Thwarted belonging is identified as a key factor underpinning many suicides and participants clearly believed that negative effects of aspects of the care system had left the young people who died isolated and disconnected from others. They highlighted the fragmentation of families, multiple placements, and the deliberate disruption of relationships with peers and carers as practices that undermined a sense of belonging and created a mistrust of relationships. Although care-experienced participants identified positive experiences and relationships in their own care journeys that had enabled them to succeed, they all identified times when their sense of belonging was rocked by policies or procedures that disrupted important connections. Loss and change are inevitable in all children's routes to adulthood but the deliberate or unthinking rupture of relationships described by participants seems unique to this environment.

Whilst the factors that participants believed undermined belonging are already identified in the care literature, the cumulative impact of such experiences on the suicidality of young care-leavers has not been recognised so clearly. What was also apparent was that many of these problems could be alleviated by changes in policy and practice. Many care-experienced participants recounted examples where individuals or organisations had created experiences that had supported their sense of belonging through continuing important relationships or enabling them develop interests or talents that connected them to a community. Although it is impossible to change their history of adversity, a sustained focus on children in care developing an enduring sense of belonging and creating conditions that enable rather than prevent this could be protective against future suicidality among care-leavers.

Many participants felt that with real connections to others and knowing that their death would matter, some young people would still be alive. Indeed, some care-experienced adults gave examples of a sense of connection and reciprocal need helping them to overcome their own suicidality. Unfortunately, this thesis gives a picture of relationships in the care system being time-limited, conditional and in some cases viewed primarily with suspicion. A shift to all relationships being cherished and supported would support children to develop a sense of ontological security that might protect them with future difficulties. This requires more than adults making individual commitments to young people it includes strenuous efforts to maintain and improve important relationships within families, acknowledging and supporting the positive potential of peer relationships within residential care rather than treating them as inevitably damaging, reframing codes of practice to ensure that transparently conducted positive relationships between carers and workers can be enduring and potentially lifelong, and shifting the discourse around professionalism in residential child care to include the expectation that workers make deep connections to those they look after.

Linked to belonging is the importance of enabling young people to find communities of interest or identity where they can find support and self-esteem. This requires a strength-based approach where children and young people are encouraged to find their talents and they are unconditionally supported to flourish in these spaces. Too often when children enjoy or excel in an activity it is used to exercise control over more difficult behaviours. Recently there have been several examples of groups or communities developed to support children and young people in care to engage in care activism or creative pursuits with others in the care community.

Problems within the care system

Although participants across all groups were able to identify many examples of sustained and healing relationships and experiences, they also suggested that some aspects of the residential childcare system intensified distress for children. Rupture of relationships, particularly because of multiple placements, but also through failure to honour existing connections, prevented the development of trust and belonging. Some practices employed to manage difficult behaviour such as inappropriate use of physical restraint and the criminalisation of children exacerbated the trauma children had experienced prior to reception into care. These factors were seen as contributing the distress and despair of those who died by suicide.

It also became clear from participants that there was little or no effective therapeutic work offered to young people or their families whilst they were in residential care which was linked to young people's eventual deaths by some participants. Although some children can overcome their early adversity through having a warm, caring, and predictable environment, others, because of their traumatic background, may require focused work to help manage their emotions and behaviour. There also seemed to be little focus on supporting families once children were removed, meaning that continuing contact or rehabilitation could reactivate trauma for children and helplessness for parents. The emotional environment of any residential childcare setting can either contribute to children's recovery or create added toxicity. Some care-experienced participants highlighted the difficult relationships that could exist among young people, but none described active work undertaken to develop more positive and supportive relationships among the resident group. Although many teenagers are resistant to formal therapeutic work they can be easily engaged opportunistically, and residential workers are well placed to take advantages of such moments.

It was evident from this study that the care-experienced participants generally left care much later than the young people who died. Many described leaving at their own pace with considerable control over the process. This was in stark contrast to the transitions of those who died which were often abrupt, unplanned, and out of their control. Many young people across Scotland are now in continuing-care placements but this requires local authority agreement and is not guaranteed, even when the young person wishes to remain. There is accumulating evidence that smoother transitions to adulthood are associated with later transitions from care (Mendes and Rogers, 2020). Rather than each continuing-care placement being individually negotiated, the default position should become that young people remain in their placement until they are 21 and explanations sought if this does not happen. Although this would be resource-intensive initially, reductions in longer-term costs to all care, health and criminal justice agencies are likely. Where children wish to leave earlier, their place should be held for several months to facilitate an easy and shame-free return mirroring the experience of their non-care peers.

In general, participants were scathing about the quality and level of throughcare and aftercare support experienced by the young people who died. Young people were made to feel mad or incompetent when they sought help, and many were turned away because they did not meet necessary criteria. Participants believed that all young people deserved consistent, reliable, and non-judgemental support. Interestingly, in an example of the inverse-care law, the young people who received the most support in and beyond their transitions were those who were already successfully negotiating their route to independence. Several participants questioned the practice of throughcare being delivered by a separate team rather than in continued relationships with people who already knew the care-leaver. Some described effective models where incorporating aftercare into residential houses benefited both care-leavers and young people still living in the houses. While a range of different models may work, it is essential that they are relationship-based rather than simply task-focused, and that workers proactively remain in touch with care-leavers rather than leaving them to seek help in emergency situations.

Finally, the overwhelming impact of poverty and deprivation on young people's capacity to manage their transition was apparent from participants' accounts. Many young people who died were trapped by homelessness, unemployment or debt and their inability to escape added to the despair and hopelessness which led to their deaths. Some policy initiatives provide targeted interventions to younger care-experienced adults helping to increase their financial security, but sudden catastrophic changes in circumstances leave them vulnerable to homelessness, criminal activity, or suicidality. In most families the responsibilities of parenthood continue well into adulthood often including unconditional and shame-free practical support, shelter, and financial aid at moments of crisis. Many challenges faced by young care-leavers, including those resulting in suicide, might be avoided if a safety-net like that provided by parents and family could be created. A sustained attempt is required to identify the most common crisis points faced by young care-leavers and develop a creative, flexible, and appropriate range of responses.

The power of the negative discourse

The identification of poor outcomes for many care-leavers has influenced the development of a negative discourse about care that can contribute to care-experienced people's pessimism about their futures (Gilligan, 2019). Similarly, the focus on psychiatric disorder as the underlying cause of suicide has removed the consideration of different explanations located in the interpersonal or structural domains.

The way this research was conceptualised, organised and conducted was intended to avoid reproducing the negative discourse around suicide and care. These serve to stigmatise and demean people who die by suicide and care-experienced people, as well as those close to them. It was therefore disconcerting to realise how difficult it was to avoid the many polarisations that so easily split the thinking and emotional responses to these subjects. Perhaps the challenges they face us with are so hard that it is easy to seek simple explanations or solutions rather than wrestle with the complexity of the intersecting issues. Within the interviews, in developing themes, in writing up my data simplistic language and fatalistic assumptions kept appearing. The subject of the research to some extent invites this as it is perhaps the most extreme evidence of the failure of the 'system', the most conclusive example of the irretrievably 'damaged' young person. Its continual appearance in spaces devoted to reflection and complexity emphasises its power.

Many young people who died were caught up in the criminal justice system or mental health services. Several had experience of substance misuse or homelessness, a few had lost their children to the care system. Despite their complicated backgrounds and forced early entry to adulthood, participants suggested that any difficulties young people experienced were treated as evidence of individual incompetence or poor choices. To receive help they had to present themselves as inadequate - not only were they casualties of this negative discourse but their 'failures' were then co-opted to strengthen the representation of the care- experienced as damaged and unhelpable.

In making sense of the deaths, participants avoided easy explanations that framed young people as ill or incompetent. While acknowledging that many young people who died were struggling with their mental health, they believed that the same factors that caused them to take their life also led to their mental distress. Participants drew on complex interacting factors and recognised the importance of personal history and immediate interpersonal context. They were also clear about the damaging nature of some policy and practice as well as pointing to the constraining effects of poverty and inequality on their life choices. It was most difficult to resist the narrative of a young person overwhelmed by unstoppable forces but that too risks strengthening the very discourse that maintains the problem. Recognising the agency of the young person who died is to recognise their choice and the power they exercised over their own body.

Reflections on the research

Strengths and limitations of the study

A strength of this study is that it was undertaken at the end of a career immersed in residential childcare with considerable awareness and knowledge about the research topic. This meant that it was possible to confidently engage gatekeepers in the process of recruitment and to connect quickly and easily with participants, despite the sensitivity of the subject. This insider position seemed to enable participants to reflect at depth about the difficult experiences they, and the young people who died, had endured. However, it may have skewed the findings towards pre-existing assumptions, as I may have unconsciously influenced participants during their interviews or privileged particular information within the analysis. The rigorously reflexive position I adopted will to some extent, have mitigated those risks but the findings from this study must be viewed from this context.

The strength of the data from the interviews allowed the development of several important themes that provide new insights into the experiences and needs of those bereaved by the suicides of care-leavers as well as highlighting several intersecting factors that may contribute to the deaths themselves. Although conducted with a small number of participants and therefore not generalisable, the congruence in most of the findings between different groups was remarkable. This overall congruence also strengthened the reliability of those findings that were located predominantly among only one group.

The design of the study was intended to ensure that those interviewed were emotionally safe and able to reflect at depth about some very sensitive and painful issues. This meant that the group of participants was composed of individuals from specific subsets of the population I sought to interview. Most care-experienced participants were highly successful and articulate individuals and whilst they had struggled at points during their transition to independence were now managing their lives and relationships well. The professional participants were all very experienced and committed and could draw on their extensive knowledge of the sector as well as their understanding of individual young people. A recruitment process that increased the heterogeneity of participants might have produced different results. Some voices were noticeably absent from the research such as birth parents, senior managers and policymakers who might all have provided different perspectives on the issues examined in this study. Despite considerable effort it proved impossible to recruit any birth parents who had been affected by the suicide of one of their children after they left care. A study undertaken in partnership with a local authority might be more successful in engaging participants from this group.

The participants were largely self-selected, and no timeframe was placed around when the suicides had taken place. Some participants described events that occurred many years earlier whilst others talked about very recent deaths. This disparity may also have affected the findings, but it is not clear in what way. The passage of time may have made clear recollection difficult, and participants' memories may have been influenced by more recent events, experiences, and perspectives. On the other hand, temporal distance from a traumatic event may have provided opportunities to process the experience more effectively, enabling greater depth of reflection. A more constricted timeframe may have reduced this potentially confounding aspect of the research.

Participants were also referring to an evolving care system that was very different in the 1980s. This breadth of experience was helpful in that it demonstrated that suicide and premature death have caused concern throughout this period and that systemic failures remain in the transition out of care. It might, however, have strengthened the study if there had been a more purposive approach to recruitment that could have made it possible to trace changes in attitudes and practice over time.

Future research

This study deliberately adopted an interview-based qualitative approach designed to illuminate lived experience. Whilst this provided very rich fine-grained data that highlighted important issues about current policy and practice, these would benefit from further exploration using a wider range of qualitative methods including, for example, documentary analysis of records or case studies around particular young people who died. Examination of social media accounts of young people who died more recently might also give a more direct insight into their emotional state and intentions.

Some of the findings in this research would benefit from more detailed examination. A deeper exploration of the complex dynamics apparent in the funerals of young care-leavers might provide insight into the most effective way to provide immediate support to all affected by these suicides as well as possibly developing alternative care-specific remembrance rituals. Similarly, further investigation of the ways in which policy and practice contribute to the disenfranchised grief of professionals and care-experienced individuals may lead to greater understanding of how to meet the needs of those bereaved by the suicide of a care-leaver.

Many of the adversities identified as contributing to the suicides are already known to influence poor outcomes for care-leavers. Further research into the longer-term impact of different approaches and cultures in residential care settings, however, might help clarify what factors reduce the likelihood of suicide as well as other negative outcomes among care-leavers. Exploration with care-experienced people of what enables the development of a secure sense of belonging that survives the transition from care might give insight into effective suicide reduction measures.

One area that is totally missing from this thesis is how neurodiversity interacts with other adversities as a risk for suicide. It was only as I was finishing writing that I came across figures suggesting that autism increases the risk of suicide in young people sevenfold (Hirvikoski, et al. 2016). There is emerging evidence that children in residential care are more likely to experience a range of neurodevelopmental conditions such as autism than their peers and that these can interact with familial trauma and neglect in complex ways (Gajwani and Minnis, 2023). Although nothing emerged within the data about neurodiversity, this may, in itself, be an important indicator that the focus on trauma within practice may mask other important factors that may contribute to premature deaths in young people.

Research process

The motivation for undertaking this research was both personal and professional. I am aware of several young people who died by suicide shortly after leaving care, including one whom I worked with closely for six years. I also have personal friendships with care-experienced people who came close to dying by suicide. In my role as a consultant and trainer, suicide and self- harm have been part of my area of expertise. I could not have undertaken this work from anything but an insider position. I was convinced that with appropriate levels of reflexivity and supervisory support I would manage the emotional and intellectual demands this would place on me.

The subject of the research demanded a qualitative approach as the research questions were posed to explore meaning and impact. Bringing together people's pain-riddled experiences of the care system with a focus on the premature death of young people was always going to be hazardous. I felt confident in creating emotionally containing spaces for participants and ensuring sufficient supports for them beyond the actual interview. That judgement was accurate – some participants were distressed during the interviews, but all said they were glad to have taken part. What I underestimated was the impact on me of constantly revisiting the data with all the pain and outrage of participants, many of whom had never talked about their loss at such depth. I had also not realised that participants would talk about so many young people who had died. For six years I have carried them all around in my head – some I know almost nothing about except their names, but I now have a detailed knowledge of some young people's lives and deaths. I also still hear the voices of my participants as they talk about some of the hardest times of their lives. This has complicated the writing process for this thesis as I have struggled to keep within the required limits as I fear silencing the very voices, I want the world to hear. The other intrusive factor I failed to predict was two years of limited social contact and a pandemic which created a global preoccupation with premature death, which uncomfortably mirrored the work of this research.

The emotional costs of the research were predictable though exacerbated by conditions in the external world. What was more difficult to manage was some of what was revealed in the data analysis and writing process which forced me to question my optimistic professional assumptions and shook my sense of myself and the professional sphere I have worked in for more than forty years. It has left me asking myself how far anyone can be prepared before they undertake this type of insider research on a painful subject in a complex and contested space such as the residential childcare sector. The research was important and interesting, I am glad I have done it. The cost remains to be counted.

Final thoughts

This is the first qualitative study to explore the meaning and impact of the suicide of care-leavers and the findings, whilst tentative, suggest that young care-leavers who died by suicide and those who mourn for them constitute groups that are currently neglected in research, policy, and practice. This thesis has identified that there is still insufficient focus on providing safe and connected transitions from care that reduce the risk of young people dying. It highlights problems within the residential care sector that may have contributed to care-leavers' deaths and points to some changes that could potentially reduce the risk of future suicides. It has also highlighted the widespread failure to recognise the impact that any suicide of a care-leaver can have on those who once lived or worked with them. It identifies ways to improve support for bereaved individuals and mitigate some of the disenfranchising nature of the grief experienced after such deaths. Some of these suggestions are resource-intensive, but others can be achieved by attitudinal shifts and a reallocation of existing resources.

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Appendix I: Paperwork

Consent form for participants.

Exploring the Meaning and Impact of Completed Suicide by Young Care Leavers – An Interpretative Phenomenological Analysis.

Consent form for participants

This research explores the attempted or completed suicide of young care leavers and how those affected make sense of these actions and their impact. It is being undertaken by Judy Furnivall for a PhD undertaken at the University of Stirling in the School of Social Sciences.

I confirm that I have read and understood the participant information sheet for this study. I have had the opportunity to consider the implications of the research for me and to ask questions of the researcher.	
I understand that my participation is voluntary and that there will be no adverse consequences for me if I decide not to take part.	
I agree to my interview with the researcher being audio recorded	
I know that I can withdraw fully or partially during the interview at any point with no explanation and the relevant parts of the recording will be deleted	
I understand that the researcher will transcribe the audio recording of my interview and share the contents with me. At this point I can ask for all or part of my information to be withdrawn from the study.	
I understand that my information will be kept confidential between the researcher and her supervisors unless she is worried about the safety and wellbeing of me or other people.	
I understand that the researcher will store all my information in a safe and secure location.	
I agree that the researcher can use quotes from my interview in work that may be published, teaching or conference presentations as long as the extracts are anonymised.	
I have chosen another first name I wish to be known by in the write up of this research.	
I understand that the researcher will endeavour to represent what I tell her fairly and honestly in her writing and talking about this research	
I understand that the researcher will give me a copy of her final PhD if I wish to have one and also provide me with a summary of the main findings of the research	
I agree to take part in this research study	

Signature of participant ....

Name of participant .... Date…./……./……

Signature of researcher ....

Name of researcher .... Date…./……./……

Information sheet for participants

Research project: Exploring the meaning and impact of attempted and completed suicide by young care leavers

Researcher Details: Judy Furnivall, Part time PhD Student, School of Social Science, University of Stirling

Email: j.m.furnivall@stir.ac.uk

I would like to invite you to take place in this research. Please read this carefully and think about it before deciding whether you wish to take part. If you need to talk about it with other people that is OK and I am available for a discussion if there is anything you do not understand.

The Research Study: What is it?

We know that too many young care leavers choose to take their own life but we don't know what makes them want to die. We also know very little about the effects of their suicides on the people closest to them. This study aims to begin filling these gaps in our understanding. I want to listen to and record the thoughts of people who were close to a young person who killed themselves within the first few years after leaving care.

Why have you been approached to take part?

You have been invited to take part because of your close personal involvement with a young care leaver who killed themselves. Your experience and understanding would help us make sense of these very difficult matters. You have been approached by a professional who knows you well and with whom you can discuss the research and whether you wish to take part.

Do you have to take part?

No. You definitely do not have to take part unless it is what you want to do. If you decide not to take part, there will be no negative consequences of any kind.

What about changing your mind?

Even though you have already shown some interest you still do not have to take part. If you do decide to participate and then change your mind, you can withdraw from the interviews at any time. I will accept your decision without question and, if you wish, I will destroy any information that has already been recorded.

What will happen if you decide to take part?

We will have a telephone conversation to make sure that you understand what the study is about and what taking part involves. If you still want to proceed then we will arrange an interview time that suits you in a place of your choice that will feel safe and confidential for you. When we meet we will go through the consent form and make sure that we are clear what we have both agreed to. If you are still sure you want to take part, then we will both sign it and the interview will begin.

Your interview will be recorded using a digital voice recorder. The interview will probably last between one and two hours. If at the end of two hours you still have more you wish to share we can negotiate another time to meet. At the end of the interview we will spend a few minutes together to make sure you are all right to face the rest of your day and to discuss any questions or worries you may have.

After the first interview I will make a written copy of everything you have said – this is called a transcript. You can read this and if there is anything you would like me to remove, I will. I will contact you within a month to arrange another shorter interview to discuss this transcript and any thoughts either of us may have had since the first interview. If you would rather do this on the phone we can arrange that instead.

What happens to your information after the interviews?

All your information will be kept safely either in locked cupboards or in password protected files. Any details that may identify you (such as your name) will be changed to make it anonymous. The only other people who might read the anonymised transcripts will be my research supervisors, Ruth Emond and Fiona Harris.

Although confidentiality is of primary importance, if something you said made me worried about the safety or wellbeing of you or somebody else I might have to pass this on.

It is possible that I may want to use some of the information in future training materials, publications, or presentations, in anonymised form, and I would like to get your permission for this now.

As I am undertaking my PhD on a part time basis I am unlikely to complete it before 2020, at that point I will provide you with a copy of my thesis to keep if you are interested. I will also prepare a summary of the main findings that I will send to you. When I finish the first stage of this research (in about two years from now), I will send you a short account of the early findings.

Are there any risks in taking part?

Previous research studies with people about completed suicide have shown that the experience of talking to a researcher can be positive. There is no doubt, however, that you will be revisiting painful experiences and this may cause you distress, during the interview or later. We will identify together somebody whom I can contact if I am worried about you as a result of the interview, and their name and contact details will be included in the consent form. We will also discuss your support networks, when we speak for the first time. At the end of the interview I will give you details of organisations providing support and advice.

Will you benefit directly from this research study?

You will not benefit directly from this study, however, I hope that the information gained from this study may help me and others to better understand both the experiences of suicidal young care leavers and the needs of those close to a young person who has died in this way.

Who is organising and funding the research?

The research is being undertaken for the purpose of PhD at the University of Stirling. I am being funded by my employer, the University of Strathclyde and no other organisation is involved.

What should I do if I am unhappy about any aspect of this research?

If you have a problem or complaint about any aspect of the research that you do not wish to discuss with me, please contact my supervisor Ruth Emond at The University of Stirling, University Road West, Stirling, FK9 4LA. Ruth's contact details are: Email: h.r.emond@stir.ac.uk negotiate another time to meet. At the end of the interview we will spend a few minutes together to make sure you are all right to face the rest of your day and to discuss any questions or worries you may have.

What happens to your information after the interviews?

All your information will be kept safely either in locked cupboards or in password protected files. Any details that may identify you (such as your name) will be changed to make it anonymous. The only other people who might read the anonymised transcripts will be my research supervisors, Ruth Emond and Fiona Harris.

Although confidentiality is of primary importance, if something you said made me worried about the safety or wellbeing of you or somebody else I might have to pass this on.

It is possible that I may want to use some of the information in future training materials, publications, or presentations, in anonymised form, and I would like to get your permission for this now.

As I am undertaking my PhD on a part time basis I am unlikely to complete it before 2020, at that point I will provide you with a copy of my thesis to keep if you are interested.

Are there any risks in taking part?

Previous research studies with people about completed suicide have shown that the experience of talking to a researcher can be positive. There is no doubt, however, that you will be revisiting painful experiences and this may cause you distress, during the interview or later. We will identify together somebody whom I can contact if I am worried about you as a result of the interview. We will also discuss your support networks, when we speak for the first time. At the end of the interview I will give you details of organisations providing support and advice.

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Topic Guide

The main topics likely to be explored will include:

The young person’s experience and suicide

If they know, what brought the young person into care?

As far as they know, what was the young person’s experience like in residential care?

As far as they know or remember, what was happening for the young person around the time of the suicide–relationships; accommodation; work; education; health; involvement with social work or criminal justice?

If they know, what happened at the time of the event and in the immediate aftermath?

Looking back what sense do they make of what happened?

Impact

When and how did they find out about the death?

What were their feelings soon after the death?

What support, if any, was available to them (family, friends, colleagues, professionals, other young people)?

What effects were there on relationships with others (family, friends, colleagues, professionals, other young people)?

Were there any other effects of the death?

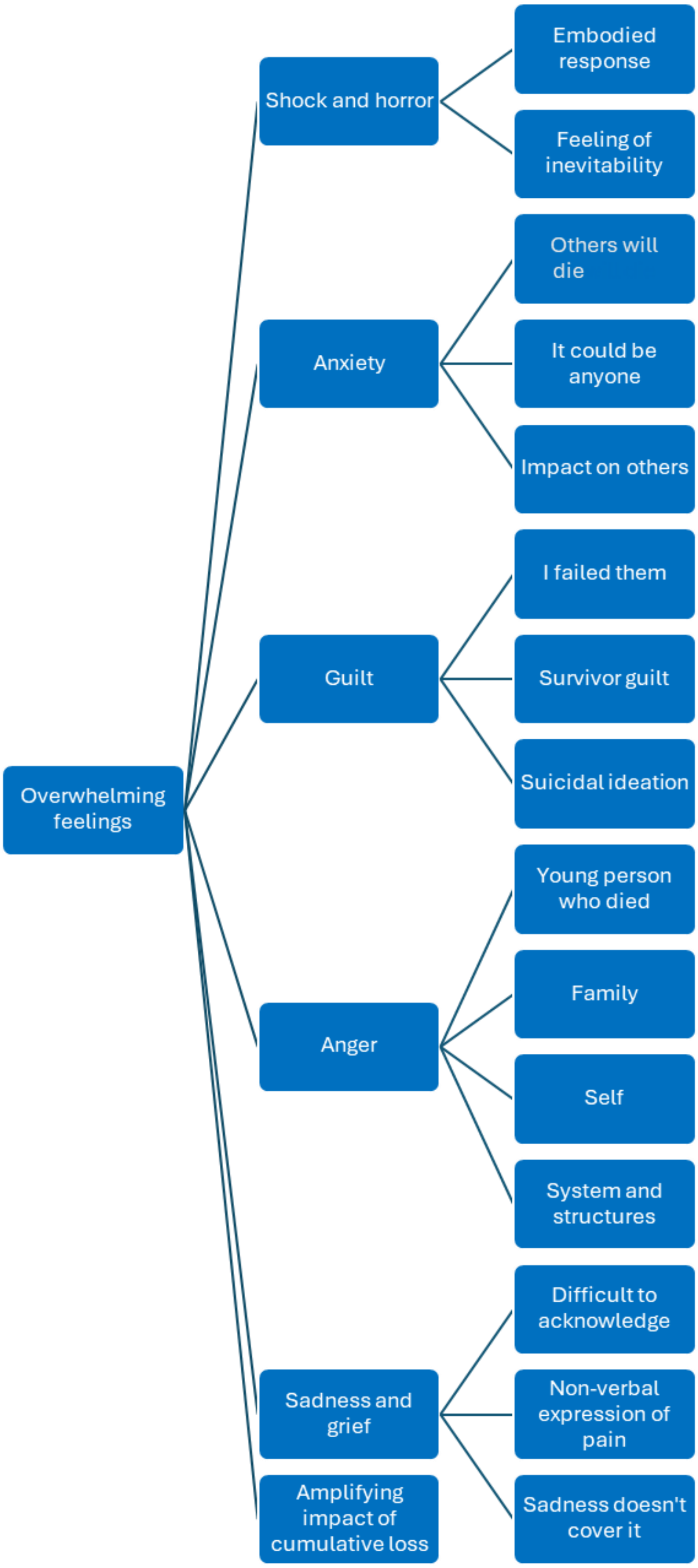
What are their feelings now about the death?

What could have helped them after the death?

Have they been able to find any meaning in the death and its impact on them.

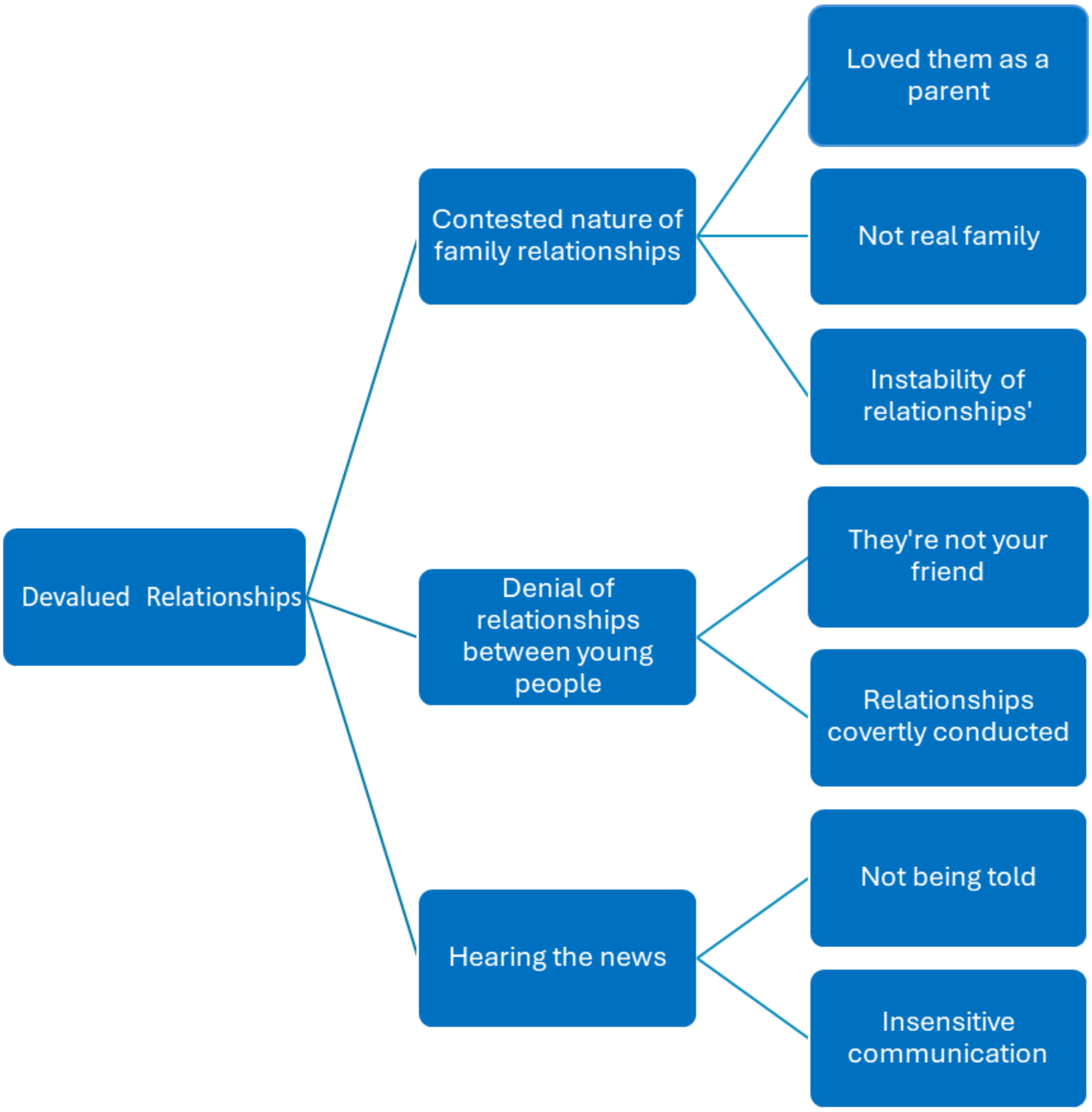
Appendix Two: Themes and subthemes

Overwhelming feelings

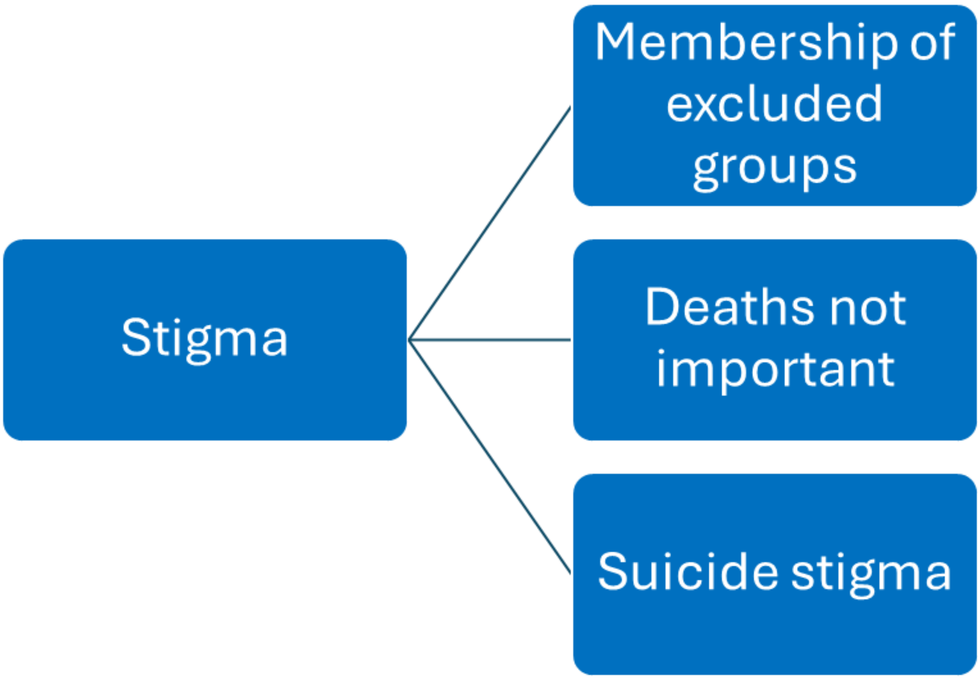


Social effects

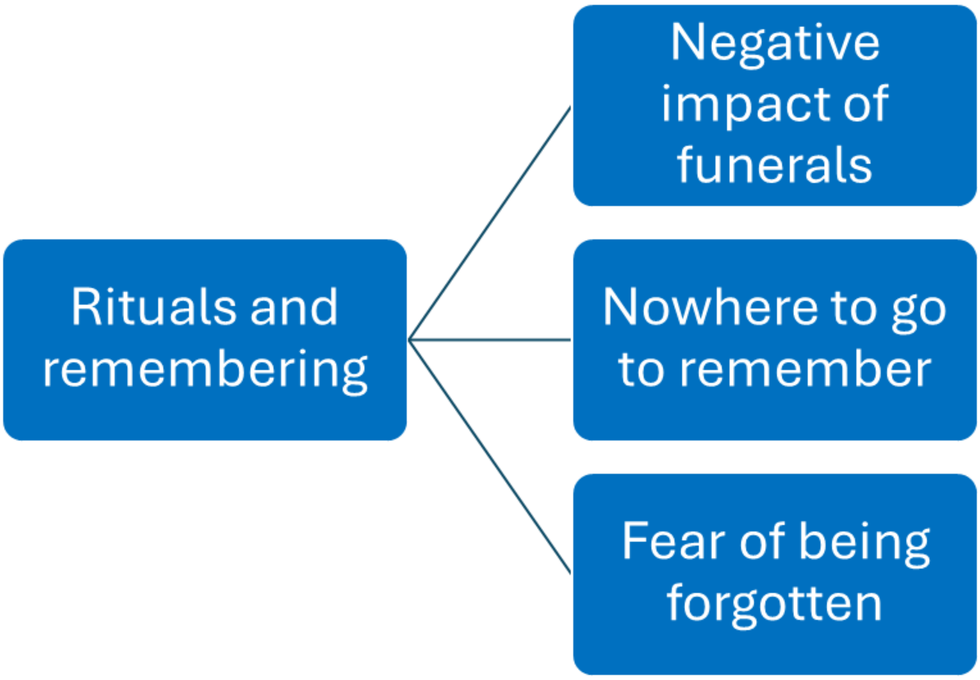
Devalued relationships



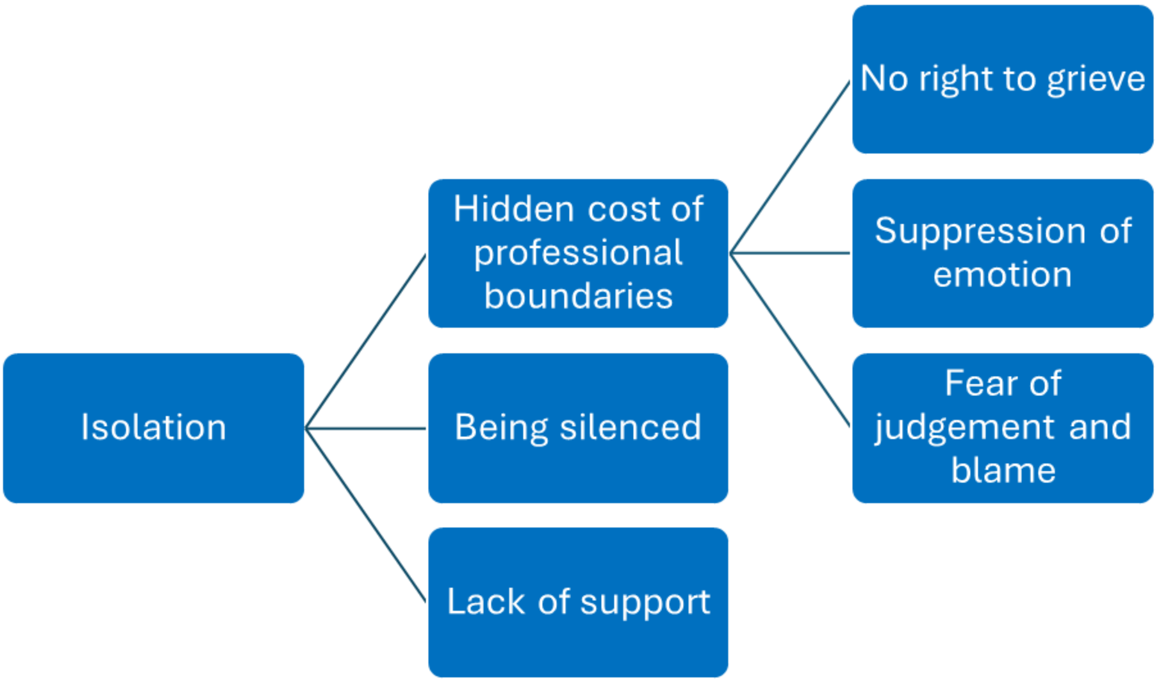
Stigma


Stigma
Membership of excluded groups
Deaths not important
Suicide stigma

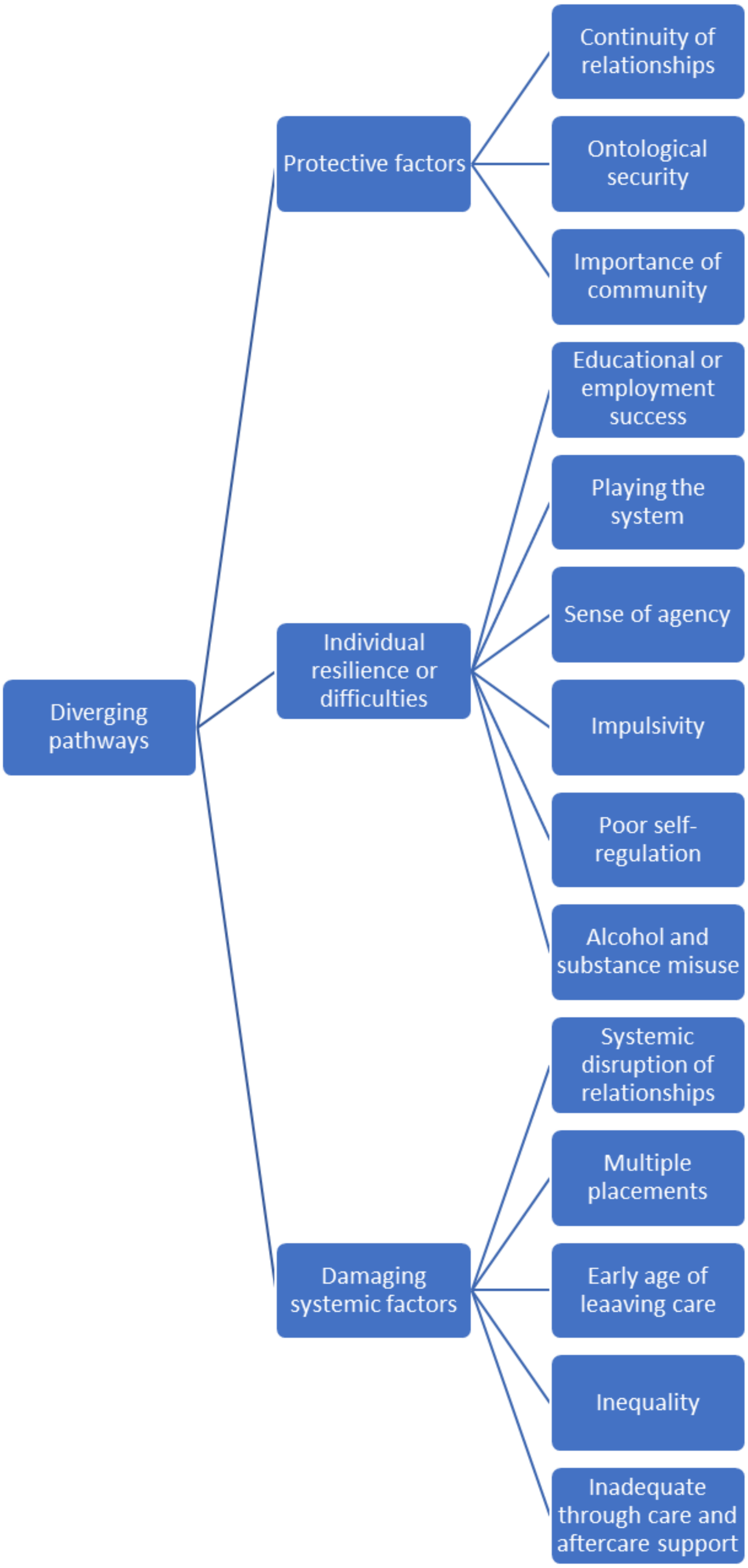
Rituals and remembering



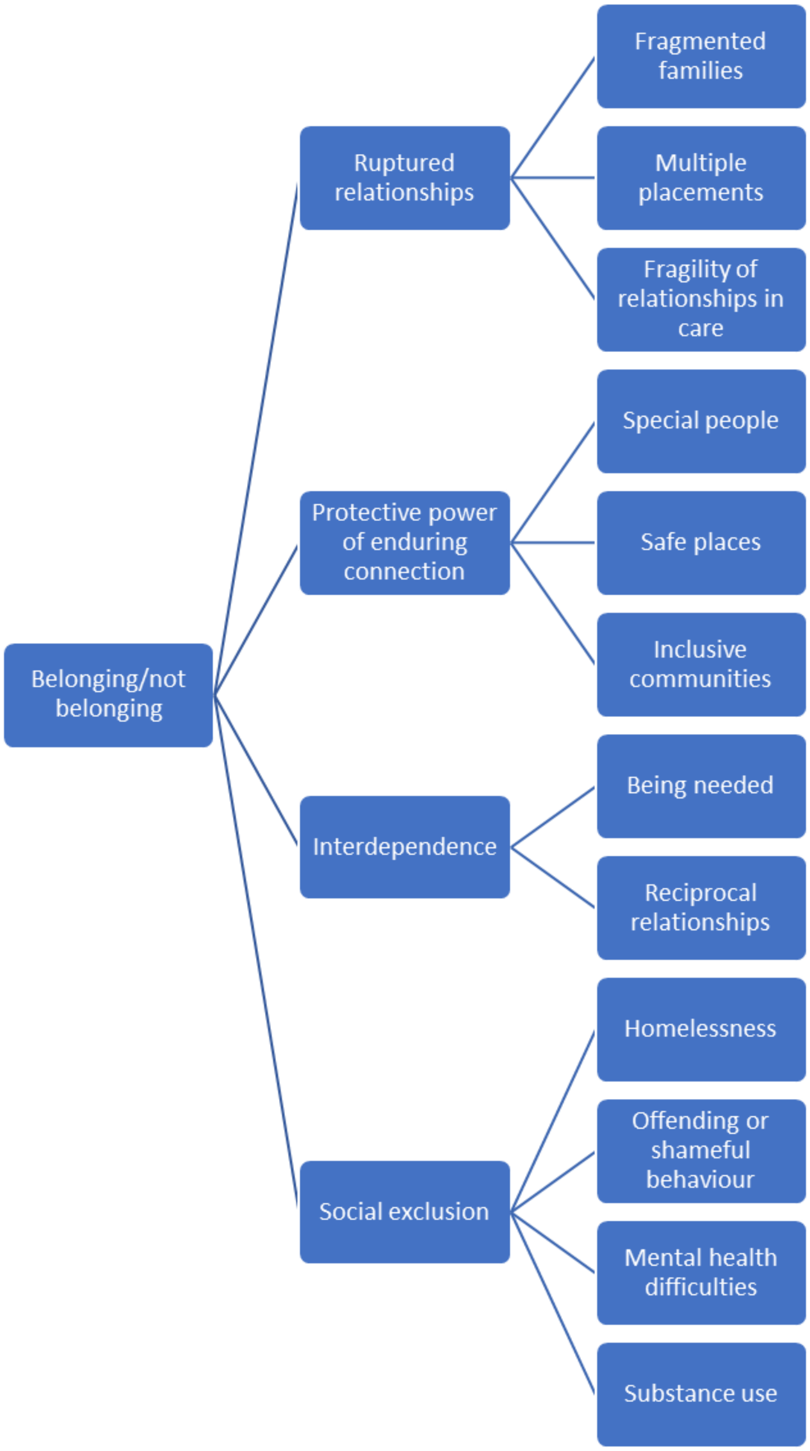
Isolation


Isolation
Hidden cost of professional boundaries
Being silenced
Lack of support
No right to grieve
Suppression of emotion
Fear of judgement and blame

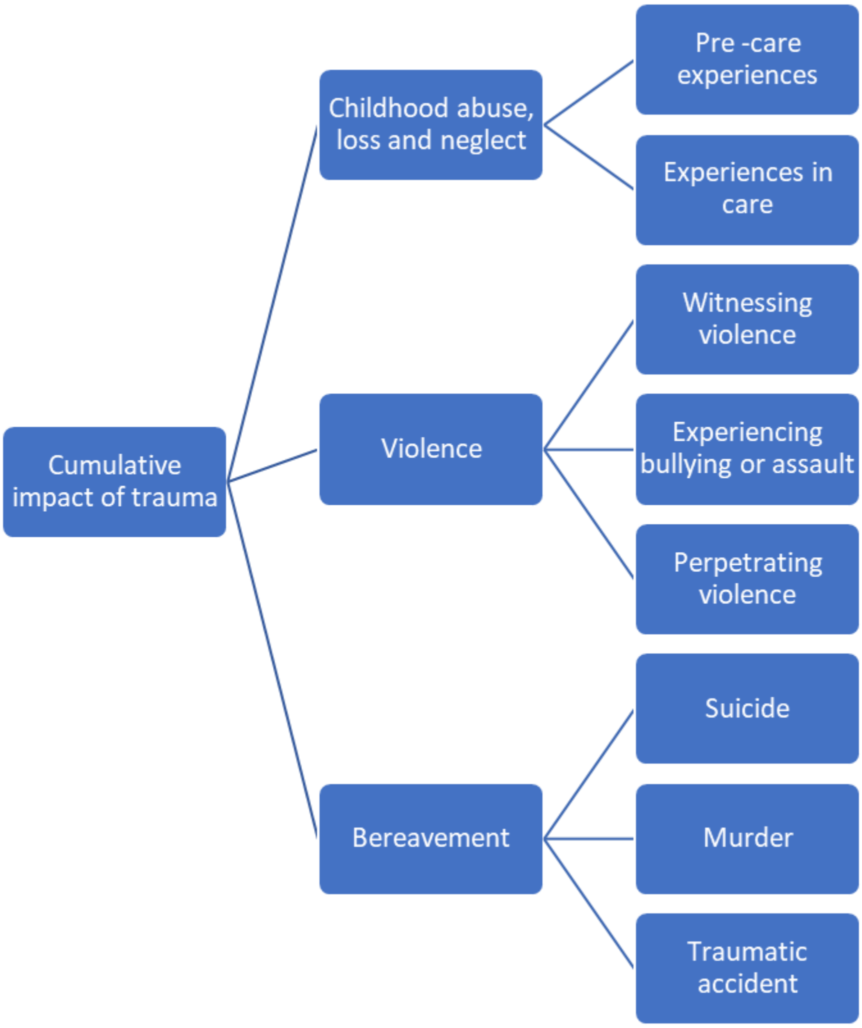
Diverging pathways



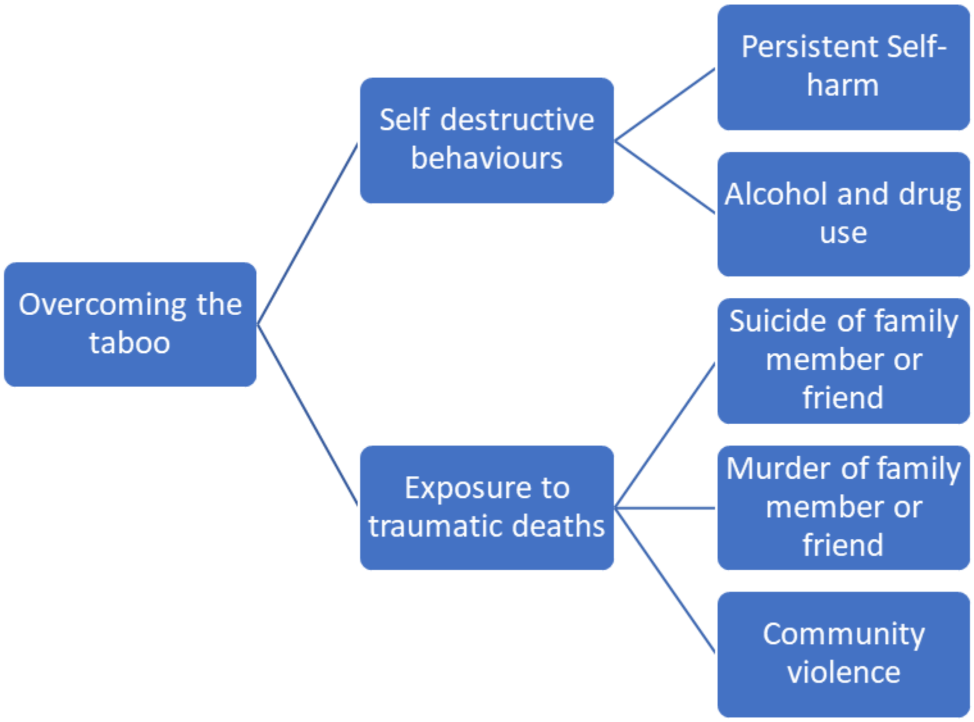
Belonging and not belonging



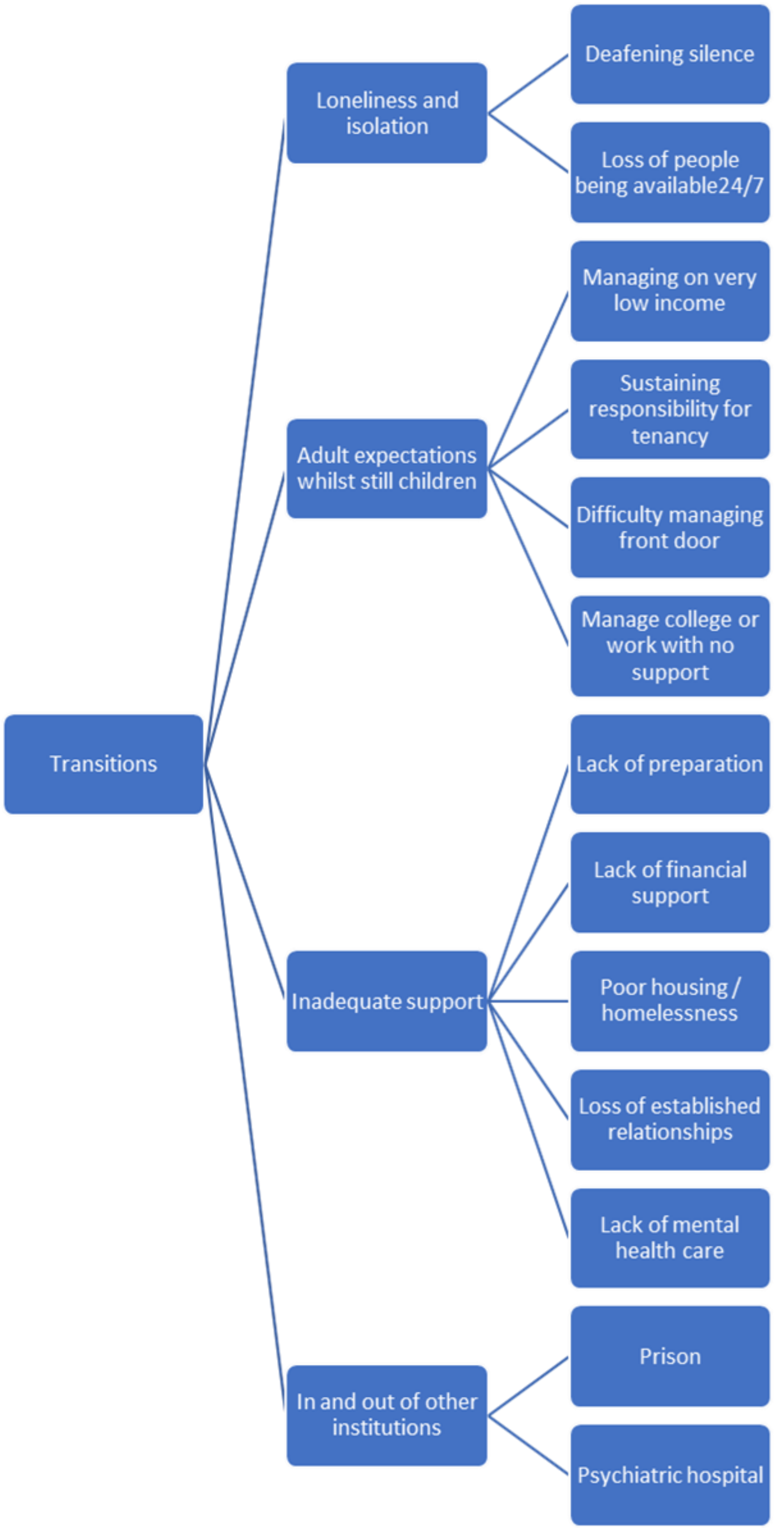
Cumulative impact of trauma



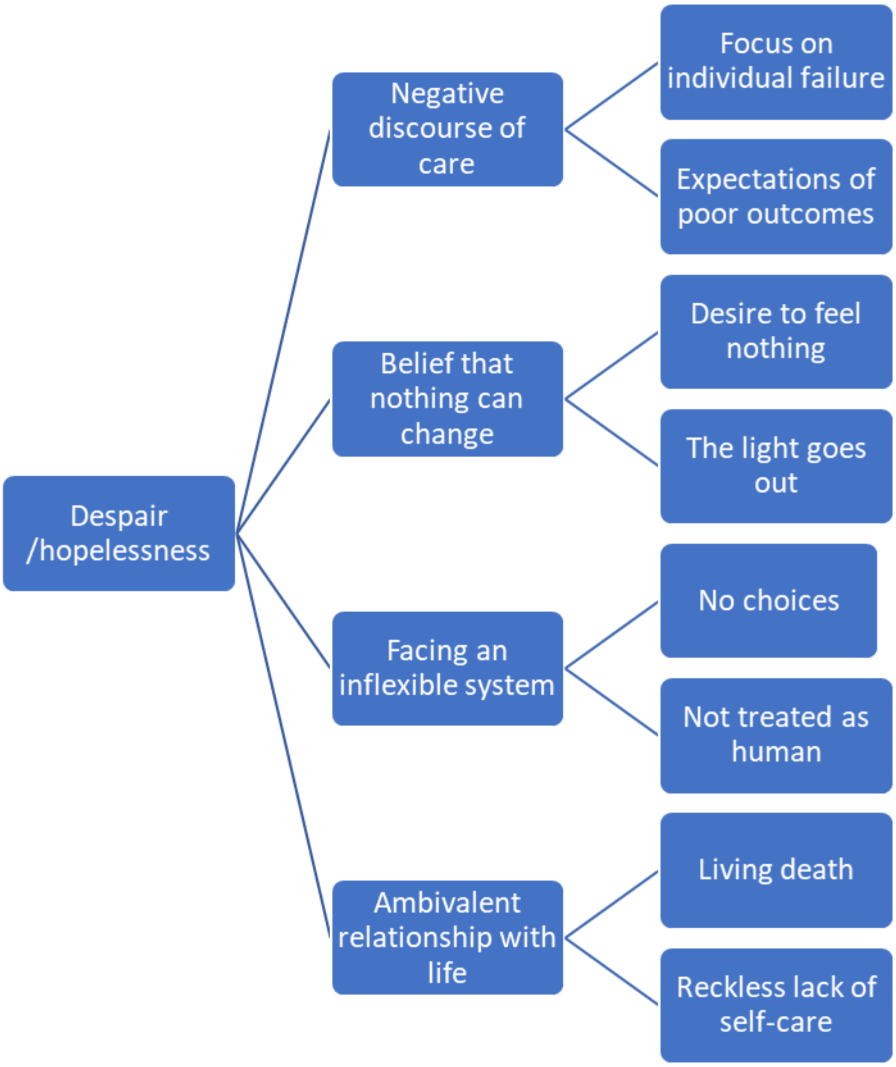
Overcoming the taboo



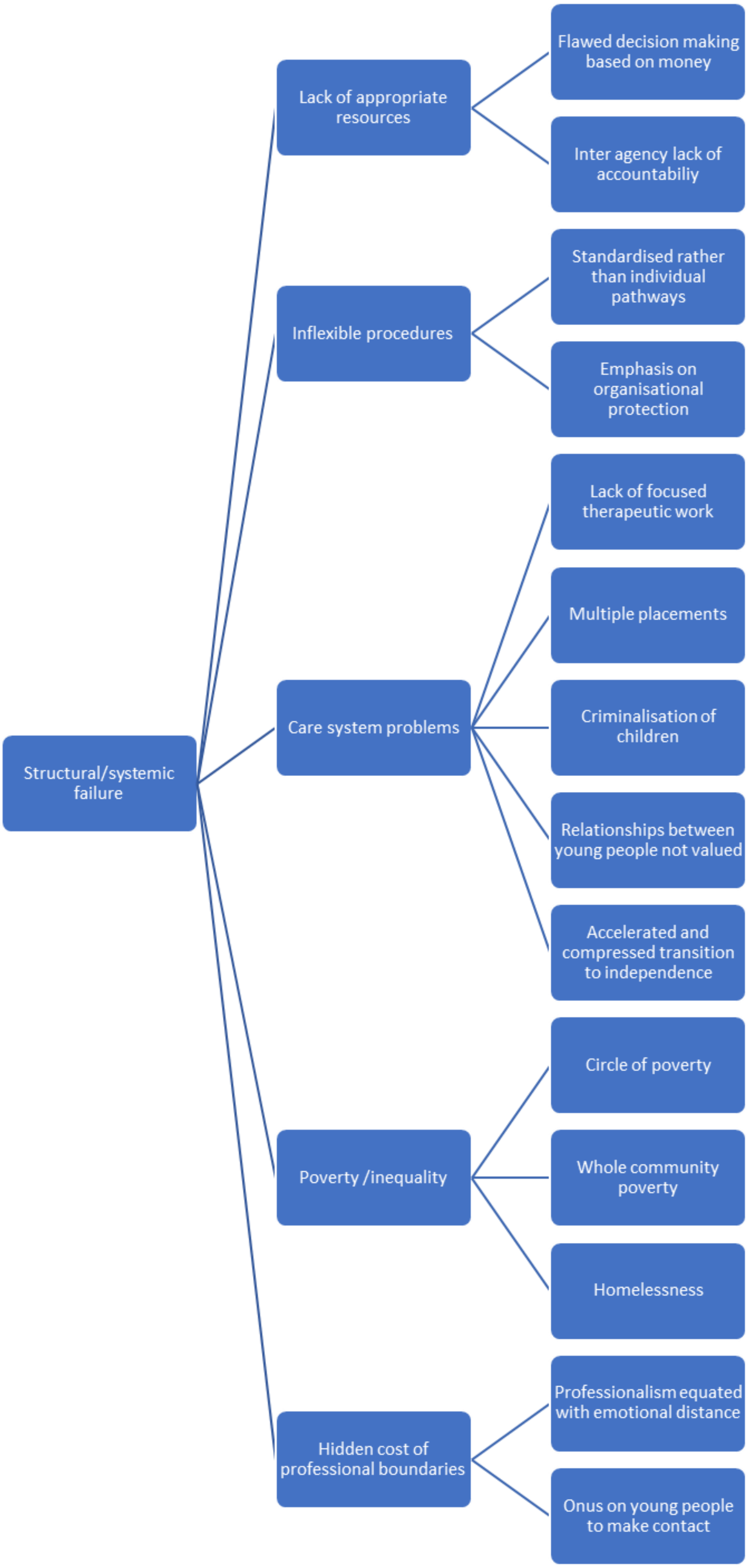
Transitions



Despair/hopelessness.



Structural/systemic failure



Finding Meaning