7-minute Learning Summary

Safeguarding Adult Review – Alice

Richmond and Wandsworth Safeguarding Adults Board

Case Summary

Alice was a white/British care-experienced young person who took her own life at the age of 23. She had a complex early life characterised by parental neglect and she come into local authority care at the age of 10, She was diagnosed with a mild learning disability, Autistic Spectrum Condition (ASC), Attention Deficit Hyperactivity Disorder (ADHD) and early indicators of an unstable personality disorder. She also experienced sexual assault and sexual exploitation.

As she approached adulthood there was recognition that she would need a specialist placement to address her complex needs, but this was not found and she returned home to live with her mother. She had no ongoing mental health support and was not supported to develop her independence or address the relationship difficulties with her mother. Alice's feelings of distress and rejection manifested in the misuse of alcohol, in anger and in violence. Inevitably there was a crisis and Alice moved to an adult supported living placement in East London. She was expected to have responsibility for herself and her behaviour and without support she expressed her distress which manifested in alcohol misuse, increasingly dramatic incidences of self-harm and suicidal ideation.

She attended an alcohol rehabilitation unit, but she was asked to leave because of her erratic behaviour and inability to regulate her emotions. There was a lack of clarity about her mental health needs that continued over time. Various care plans were developed by all the agencies Alice came into contact with, but they weren't coordinated and the lack of a complex response to complex needs contributed to a sense of chaos in service delivery, which echoed the chaotic nature of Alice's circumstances.

Inevitably, the supported living placement broke down and Alice was asked to leave. There were insufficient transfer arrangements in place for her move to her second placement. Consequently, the personal understandings people had of Alice were lost, and no connections were made between relationships from one placement to the next. Alice continued to use alcohol and to self-harm and had many brief hospital visits and in-patient admissions in crisis.

Alice received intensive mental health in-patient treatment in 2017 for 12 weeks and was moved to her third adult placement. This time thought was given to how to help her with this further move and the likely rejection she would feel when discharged, there was follow-up from psychology services and occupational therapy, however Alice continued to misuse alcohol and to self-harm. She was in and out of hospital for a 10-month period through 2017 and 2018 and although her supported living provider tried to support her, she received no ongoing complex therapeutic support from 2018 onwards, having moved from one health authority to another.

Alice was admitted as an in-patient to a mental health unit in March 2018 for a period of 12 weeks and during this time she was assessed as needing to be placed in a low secure setting and was placed on a waiting list. Alice returned to her supported living placement and a referral was made for therapeutic input by the local personality disorder service. Alice continued to express suicidal ideation; she had stopped using alcohol but had started to focus on drugs and in July 2018 took a drug overdose from which she died.

Summary findings

1. 'PULL' OF BIRTH FAMILY

Work with young people leaving care does not sufficiently prioritise working with them and their birth families to address the complex relationships between them, in anticipation of their transition to adulthood. Consequently care-experienced young people experience further crises and rejection when they do return home, compounding their trauma and escalating their distressed behaviours, including self-harm.

2. TRANSITIONING THE MOST VULNERABLE YOUNG PEOPLE INTO ADULTHOOD

Local authority processes for transition planning and support for young people leaving care are not set up to differentiate the level of seriousness of a young person's circumstances based on an evaluation of factors known to increase vulnerability. This means that pathway plans are usually not adequate for complex cases

where the young person needs a coherent, integrated plan across a range of adult services. Consequently the most vulnerable young people are catapulted into adulthood with a range of disparate and ineffective care plans across agencies that do not address the seriousness of their circumstances.

3. CLINICAL OWNERSHIP, PSYCHOLOGICAL FORMULATIONS AND THERAPEUTIC CARE PLANS

For young people with diagnoses of autism and co-occurring conditions, including emerging personality disorder, whose distressed behaviours of concern manifest in drug misuse, self-harm and attempts to take their own lives, there is often a mismatch between the seriousness of their situation, and the response from mental health services. This leaves young people without any experience of being understood and unqualified supported living staff trying but failing to provide the necessary support for young people who have a history of neglect, abuse and/or, exploitation and crises-driven responses by services.

4. VICTIM BLAMING

The absence of functioning local authority leaving care processes for complex cases and/or effective mental health interventions creates fertile ground for victim blaming that sees young people with unregulated emotional behaviour, including violence to others and property, drug and alcohol misuse and concerted self-harm, held individually accountable for their behaviours. This risks inadvertently blaming the young people when a trauma-informed approach that acknowledges the young person's history is more appropriate. It creates the conditions where self-harm and increasingly determined efforts to take their own lives become normalised.

5. CREATING STABILITY AND IDENTITY DESPITE REACTIVE SERVICES.

For extremely vulnerable young care leavers who experience a pattern of reactive, crisis-led responses, which do not necessarily recognise or meet their needs as vulnerable people, there are inadequate mechanisms to forge continuity in relationships over time. This deeps the young person's sense of being continually rejected, of being unlovable and of being totally alone. It makes it less likely that a holistic life story is pulled together over time that travels with the young person or that the young person is helped to build a non-professional support network, including identifying a person beyond their parent(s) who could be more permanent for them.

Lessons

LESSONS

1. Betrayal of the parental role to love, care and meet the needs of children creates attachment and relationship difficulties and cause changes in the brain architecture which can lead to mental health difficulties and struggles with everyday life in adulthood. In order for this sense of identity or belonging to be addressed and outcomes improved, it is important that when a child is in the care of the local authority, work is undertaken to ensure that ***family and parental relationships are healed*** and wider family and friendship links are maintained. Care leavers need to be enabled to maintain links with the past and connect together their life story.
2. The effectiveness of making a positive transitions to adulthood include factors such as the quality of the care provided, the stability of the placements and caregivers, access to appropriate services to address trauma, mental health and disability. The most vulnerable young people leaving care need ***therapeutic care placements*** that actively develop emotional wellbeing, address psychological trauma and help them develop resilient and positive relationships.
3. Young people leaving care are more likely to have poor educational outcomes, be unemployed, in contact with criminal justice processes, have poor housing/inappropriate care placements/be homeless and not have access to support for impaired mental health. The likelihood of these negative outcomes is connected to the level and extent of the harm they experienced and the context in which they grew up. Young people with complex needs (including disability, Autistic Spectrum Conditions and poor mental health) will need ***more support*** to make the transition successfully.
4. Care experienced young people feel marginalised, stigmatised and questioning their own self-worth. When young people with complex needs, come into contact with adult services, there is a danger that these childhood risk factors get lost and there is a focus on the individual and they are blamed for their failure to negotiate the transition to adulthood. Care-experienced young people with complex needs and traumatic backgrounds should have ***comprehensive and multi-faceted and coordinated care plans, with one key professional consistently overseeing them***.

5. Autistic people are at greater risk of co-occurring psychiatric disorder (especially anxiety and depression). The association with psychiatric disorder may stem partly from an adolescence characterised by victimisation and bullying, affecting the development of self-esteem, social confidence and identity, and the potential to live independently. The risk of suicide by an autistic person is substantially greater than for the general population, particularly for women and in the presence of ADHD. Risk markers include the number of unmet support needs and the use of camouflaging, as well as depression, isolation, and unemployment. Autistic young people find it difficult to access services and are ill-served by unfamiliar staff and time limited case management. They require a co-ordinated approach which knits mental health support into the wider, multiagency network including education, social services and the voluntary and independent sectors.

6. There remains a reluctance to ***diagnose personality disorder***, particularly in young people where a diagnosis would provide an opportunity for early intervention. There is inconsistent adherence to the NICE guidance, limited access to psychological therapies, and no clear pathway for effective treatments. Without a timely and sustained engagement from mental health services, young people diagnosed with personality disorder and co-existing vulnerabilities such as ASC, ADHD and early trauma, end up in a Catch-22 where their complex needs go unresolved and unaddressed, leading to changes in placement and relationships causing more crises and more complexity. This is not cost-effective for commissioners and the human cost for the person could not be higher.

Useful Resources

Please find below some useful resources linked to findings from this case:

Useful information around trauma Informed practice and Adverse Childhood Experiences

NHS Autism resources

NHS Safeguarding Conference – for health professionals, includes information on trauma and working with whole life histories

Summary of recommendations from Childrens charities - Recovery Plan – Children in care and care leavers

Statutory guidance for local authorities (February 2018) Applying corporate parenting principles to looked-after children and care leavers -

Care leavers' transition to adulthood – National Audit Office