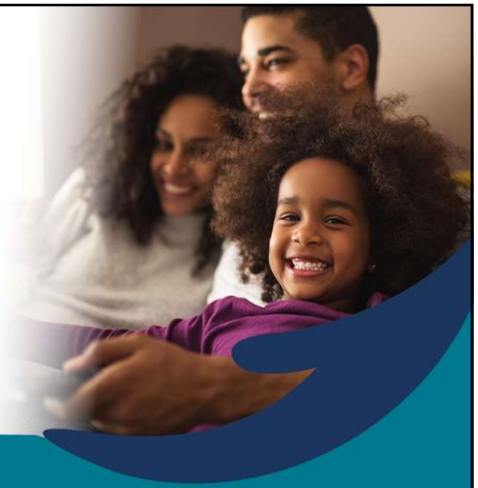
Preventing Suicide in Adolescents Event



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Case 1

- **Male, 15** years old when they took their life
- **Known to social care since age of 8,** previously on a CPP and a CIN when they died
- **Referred to CAMHS aged 9** and prescribed anti-depressants but not collected by family and not followed up by professionals
- **Confirmed** autism diagnosis
- **Disclosed** physical abuse by father and grandfather
- Following a settled period of time behaviours became 'difficult and challenging' at age 12 – **WHY? WAS THIS FURTHER ASSESSED?**
- Various missing episodes linked to injuries and/or drug misuse

Case 2

- **Male, 16** years old when they took their life
- **Child in Care since age 5** and subject to Care Order (S31 Children Act 1989) since 2008, and was in a residential home at time of their death
- **Psychotherapeutic assessment aged 4** showed a child who was anxious and insecure and thought to be linked to past life experiences
- Further assessments showed that they were suffering from complex social, behavioural and emotional difficulties which were having a major impact on their ability to function 'normally' on a day to day basis
- Sudden death of a close relative compounded these emotions

Case 3

- **Male, 15** years old at time of their death
- **Referred by CAMHS to CSC at aged 5** due to concerns of emotional abuse and neglect by mother and new partner
- **Parents did not always engage** with requests to support
- **Became a child in care 2016** moving from foster care to residential setting
- School attendance was good
- School suspected **they had autistic and OCD traits** which were being assessed at time of death
- At a CIC review the YP comment that they were **not bothered about contact with mum** as the mother had failed to attend reviews and return the child's call

Case 4

- **Female, 14** years old when attempted to take own life but not completed
- **Child in care since age of 8** and children services involved from 2007 until time of incident
- Parents had intensive support over a 7 year period with regular meetings – WHY WAS THERE A NEED TO KEEP THIS FAMILY AT EH FOR THIS AMOUNT OF TIME. DID THE INTERVENTIONS OFFERED WORK?
- Experienced physical chastisement and verbal and emotional abuse by parents
- **2021 diagnosed with a learning disability**
- Moved to residential home from settled foster placement following an assault. The move coincided with their birthday. So a significant event on the child's life

Emerging themes in the cases

- Dysfunctional families
- Mental health or anxiety were a factor
- Adverse childhood experiences from an early age – were they recognised and acted upon?
- Missing episodes – were they linked or seen in a silo?
- Exploitation
- Late diagnosis in one case of a learning disability – would this have led to a different assessment and or approach?
- Unstable placements and the impact of the uncertainty of these moves
- Lack of information sharing to support assessment was evident
- Absent OR dominant fathers/significant males

Key learning identified

It is important professionals consider how childhood experiences can impact on the behaviour and vulnerabilities of troubled adolescents so work focuses not only on presenting issues but also addresses the visible and hidden complexities of childhood trauma.
Possible lack of understanding of the impact of familial sexual abuse on the child

The need for greater oversight and supervision of cases from experienced colleagues and more multi-agency decision making to prevent drift and develop SMART care planning – FOR EXAMPLE CHRONOLOGIES AND GENOGRAMS

Is it possible more might have been achieved had professionals been better supported to understand the impact of early life experiences and how these impact on the child's overall wellbeing?

Does this require more thought? Does this then become the focus diverting practitioners away from the additional presenting risk factors increasing the harm to the child/young person? Would this be helpful? What support is currently available to support you?

The risks to children become much greater if there are other problems and stresses facing the family (Sidebottom et al 2016)

South Tees Safeguarding Children Partnership

Hartlepool & Stockton-on-Tees SAFEGUARDING CHILDREN PARTNERSHIP

Key learning continued….

- A lack of knowledge among professionals about the evidence base related to risk factors for adolescents who die as a result their own actions, could leave them ill equipped to discuss, recognise signs, and respond accordingly
- When working with children, practitioners need to proactively assess and engage with all significant men in a child's life, recognising that some may pose risks, some may be assets to the family and some may incorporate aspects of both. Where concerns exist and there is evidence of conflict between a child/young person and significant none birth related males in a family, this should always be explored in assessments and be incorporated into ongoing work.

- Partnership have started to upskill staff on:
  - Trauma informed care
  - Adolescent neglect and
  - ACEs
  - Absent fathers and their impact on the child's life

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Key learning identified overall

It is important that professionals consider how childhood experiences can impact on the behaviour and vulnerabilities of troubled adolescents so that work focuses not only on presenting issues but also addresses the visible and hidden complexities of childhood trauma. It is possible that more might have been achieved with CS3, had professionals been better supported to understand the impact of early life experiences and how these influenced and continued to influence CS3's thoughts and behaviours.

Child Sexual Abuse in the family environment will often come to the attention of statutory and non-statutory agencies because of a secondary presenting factor, which then becomes the focus of intervention. It is worth considering, especially in light of the findings from the Children's Commissioner whether more work is needed in the local authority to increase professional understanding and awareness of familial child sexual abuse. This might be particularly helpful given the range of ways the impacts of physical and emotional neglect can mediate or set the scene for a child's increased vulnerability to Child Sexual Exploitation.

Whilst social workers and other professionals are skilled at communicating and gathering information, there is evidence that they need greater support to analyse and evaluate the data they collect, so the multi-agency analysis can support and be seen to support professional judgments and decision-making.

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Professionals need to be able to make informed decisions not only about which parents/family members are able/unable to meet their children's needs and why, but also what aspects of a parent's behaviour needs to change. Consideration also needs to be given whether parents/family members have the motivation and capability to make such changes in line with their child's needs and timeframe.

- Where CSE is suspected, it is essential that risk assessments take into account not only the presenting risk factors but also those risks, which emerge from vulnerabilities arising from past experiences such as abuse, loss and trauma.
- Given the vulnerability of children coming into the care system, it would be helpful to ensure that all assessments for adolescent thought to be at risk contain a stand-alone section which requires professionals, including health colleagues, to consider and carefully comment upon self-harm or suicide ideation. The triggers and control measures associated with these harms are distinct and require careful consideration of what steps should be taken to minimise opportunities for a young person to harm themselves.
- Curiosity and inquisitiveness should be part and parcel of professional practice. Unless professionals maintain a questioning and curious response to what they are told or what they see, opportunities for exploring the unthinkable or opening up conversations with young people will be limited and they may be left vulnerable.
- Without robust managerial oversight to ensure that work plans are in place and are regularly reviewed, the effectiveness of interventions cannot be easily determined, and work with families can drift leaving children vulnerable.
- When concerns are raised about a child, a clear chronology of significant events can show agencies where risks lie but unless practitioners are supported to identify and share significant events or incidents in a child's life, and without clear systems to gather, record and share this information, the use of chronologies to inform good assessments and decision making will not happen.
- Unless multi-agency meetings are well chaired, structured, and purposeful, work with families can drift but because the meetings take place, they can give the impression of progress.
- Unless all children's plans have SMART objectives and are regularly scrutinised, work with families will lack focus and will likely be ineffective, leaving some child vulnerable
- A lack of knowledge among professionals about the evidence base related to risk indicators for adolescents who die as a result of their own actions, could leave them ill equipped to discuss and/ or recognise signs and respond accordingly.

Fact

- Most people have thought about suicide from time to time and not all people who die by suicide have mental health problems
- Often feeling actively suicidal is temporary
- That is why getting the right support at the right time is so important

Myth

- You have to be mentally ill to think about suicide
- If a person is serious about killing themselves there is nothing you can do

Questions for Consideration

- How do you work with other agencies to build a full picture of what is happening in a child's life?
- What behavioural biases, e.g. confirmation bias, might impact upon your information sharing and seeking practice?
- Do you consistently speak to and listen to the views of family and friends who know a child well? What barriers can get in the way of you doing this?
- What assumptions might you hold relating to culture, ethnicity, gender and sexuality? In what ways might this affect your practice?
- What aspects of working with families whose engagement is reluctant and sporadic do you feel more/less confident with? What do you consider to be typical signs of parental avoidance?
- What opportunities do you have - formally or informally - to challenge decisions within your and other agencies and to consider different professionals' perspectives?