A Retrospective Review of Risk Factors for Suicide in Looked After and Accommodated Children in Glasgow

Case File Analysis

Dr Jane Fuller - Specialty Registrar in Child & Adolescent Psychiatry currently working in NHS Greater Glasgow & Clyde

Dr Colm Hennessy - Specialty Registrar in Child & Adolescent Psychiatry currently working in NHS Greater Glasgow & Clyde

Dr Paul Rigby - Lecturer in Social Work, University of Stirling

The views expressed in this report are those of the authors and do not necessarily reflect those of Glasgow Child Protection Committee and partner agencies

Thanks to Moira McKinnon, Jean Herbison and Anne Greer for their guidance during the period of undertaking this work and comments on earlier drafts of the report

January 2014

CONTENTS

Summary		4
1 Introduction	1.1 Background	5
	1.2 The Scottish perspective	6
	1.3 FAI Erskine Bridge	7
	1.4 The Glasgow perspective	8
	1.5 Looked after children	8
2 Aims	2.1 Aims	10
3. Methods		11
	3.1 Ethics and confidentiality	
4 Risk factors: The Evidence Base	4.1 Social Factors	13
	4.2 Social work history	14
	4.3 Familial factors	14
	4.4 Personality / behaviour factors	15
	4.5 Mental health	16
	4.6 Health	16
	4.7 Acute life crisis	17
	4.8 Self harm	18
5 Findings	5.1 Demographics and social background	19
	5.2 Social work	19
	5.3 Family history	21
	5.4 Relationships	22
	5.5 Employment	22
	5.6 Abuse and exploitation	23
	5.7 Personality / behaviour	24
	5.8 Forensic	24
	5.9 Mental health	25
	5.10 Physical health	27
	5.11 Substance use	28
	5.12 Acute life crisis	29
	5.13 Self harm	29
	5.14 Multi-agency input and processes	30
6 Conclusions	6.1 Limitations	32
	6.2 Indicative risk factors	33
	6.3 Future work	37
7 References		39
8 Appendix	8.1 Audit tool	45

Summary

The present report was requested by the Glasgow Child Protection Committee (CPC) to complement the Significant Case Review (SCR) process in the city. The focus on young people who had taken their own lives was considered following concerns that the SCR process for individual cases is not sufficiently focussed on understanding risk factors, but instead concentrates on procedural aspects of each case as a means of future prevention and risk reduction. The five cases selected for inclusion in this report were those identified by the SCR sub-group as those young people who had committed suicide between 2006 – 2012 and were, or had been looked after and accommodated. Methodology involved a comprehensive analysis of social work case files and health files where available, and analysis of relevant documents including any SCR reports. In effect the work was a case study approach to the investigation due to the small number of cases included.

Despite limitations in the research process, which include the small number of cases and the availability of information, the work has identified a number of risk factors that were common to all the young people. These include being bullied; accommodation issues; being victims of abuse and exploitation; displaying antisocial / aggressive behaviours; absconding; mental health concerns (not necessarily diagnosis) and alcohol misuse. There were also a number of parental factors that were common to all the young people including separation, relationship problems, aggression and mental health. While it is not possible to point to any risk factors or circumstances that could have prevented or predicted the deaths of the young people it is hoped that this work will provide an indicative baseline for continued monitoring of the looked after and accommodated population and aid professional recognition and management of possible risk factors. While it is difficult to make general recommendations from such a small number of cases, looking at the above factors in combination may be a starting point for future developments to support workers in assessment and risk management.

The work has provided further evidence of the adversities and abuse that children and young people in the looked after and accommodated system have endured and which contribute to their vulnerability and risk in many areas of their life course development, in addition to the risk of suicide.

1. Introduction

1.1 Background to the Research

Self harm and suicide are important public health issues in adolescents, with suicide being the second most common cause of death in young people worldwide (Patton et al 2009). Children and young people in care are a particularly vulnerable group whose circumstances and histories may be consistent with a higher risk for self-harm and suicide.

In Glasgow, Social Work Services manage a database of children and young people who die and are known to social work at the time of their death. The circumstances of their deaths are recorded and annual reports detail child and young person deaths. While the majority of children die from natural causes often related to complex health problems or disability, there have been a small group of young people, over the age of 12, who over the last five years have taken their own lives.

Following the death of a looked after and accommodated young person in October 2011 an internal review of the case was undertaken which raised the wider issue of adolescent suicides. While the number of such deaths is relatively small, it was considered that a broader piece of work would look at a number of cases and any learning from such cases would be disseminated across all partner agencies to inform future practice.

The Child Protection Committee Significant Case Review Sub-Group gave consideration to undertaking a formal review of those young people who were or had been looked after and accommodated, where suicide was given as the cause of death between 2006 and mid-2012. This work follows on from previous research completed by Glasgow Looked After and Accommodated Children Joint Planning Group (Cowan 2006). This report reviewed all deaths of young people with experience of care who had died in Glasgow, and in which suicidal behaviour was implied or clearly present. It aimed to identify common risk factors which retrospectively suggested the young people were at an increased risk of suicidal behaviour and points to where interventions could be applied in future cases. It involved a thorough case file analysis of 12 young people. The current 2006 – mid-2012 research builds on the 2006 report but has some significant differences with a more specific remit to look at

deaths only attributed to probable suicide and also involves a dual agency case file analysis of health and social work files.

1.2 The Scottish Perspective

Data spanning up until 2010 shows that Scotland has the highest overall mortality rates from all causes in younger working adults aged 15-44 years, since 2002 in women and 2004 in men, when compared with other Western European countries (Whyte and Ajetunmobi 2012). The main cause of death varies with age and gender. Suicide is the leading cause of deaths in Scotland in males aged 15 – 34 and the second most common cause of death in females in this age range (General Register Office 2010). Suicide rates in Scotland are now significantly higher than in England and Wales, though are comparable with Northern Ireland. This is a change that has occurred over recent decades. In 2010 the suicide rate among working age Scottish men was 73% higher than in England and Wales compared with 1968 when the rate in Scotland was just 6% higher than England and Wales (Whyte and Ajetunmobi 2012). Scottish suicide rates for women in 2010 were almost double that of England Wales. It is not just a discrepancy within the UK. Scotland's suicide rate has been above the Western European mean since 1993 for both sexes. Data from the period of 2001 to 2005 shows Scotland to have the third highest suicide rate for men and the fourth highest suicide rate for women out of 16 Western European countries (Whyte and Ajetunmobi 2012).

Within Scotland mortality from suicide in men climbed dramatically from the mid-1970s to peak in 1993 (Information Services Division Scotland, 2012). There has been a slight decline from 2003 onwards. Despite this the incidence of male suicide in 2010 was 50% higher than in 1968. In contrast the suicide rate in working age women peaked in 1978 and then reduced and has remained stable since the early 1980s (Whyte and Ajetunmobi 2012). In 2010 the female suicide rate was 26% lower than in 1968, though remains still above the Western European average (Whyte and Ajetunmobi 2012). Platt et al (2007) identified that male suicide rates were approximately three times higher than females, and that male suicide rates decline with age.

The National Records for Scotland (2012) define probable suicides as deaths resulting from intentional self harm (codes X60–X84, Y87.0 of the International Classification of Diseases,

Tenth Revision (ICD10)); and events of undetermined intent (ICD10 codes Y10-Y34, Y87.2). In 2011 there were 889 deaths in Scotland attributed to intentional self harm or "event of undetermined intent". However there was a change of coding of deaths implemented by the National Records of Scotland in 2011 following the World Health Organisation update to the International Statistical Classification of Diseases and Related Health Problems, which now classifies drug abuse deaths from acute intoxication as poisoning, resulting in some of these being classified as suicides. Prior to 2011 these deaths would have been classified under mental and behavioural disorders. For comparison with previous years, under the old coding system 772 deaths in Scotland in 2011 would have been attributed to self harm or "event of undetermined intent". Under the old coding system the rate of suicide in Scotland between 2007 and 2011 was 15.3 deaths per 100,000 population. In 2006 to 2011 there were 223 deaths of young people aged between 10 and 19 in Scotland from intentional self harm or "event of undetermined intent". 154 of those were classified as intentional self harm (General Register Office for Scotland, 2013).

1.3 FAI Erskine Bridge

As part of the literature review for this report the authors were requested to reference, and indicate any learning, from the recently published Fatal Accident Inquiry into the suicide of two young women at the Erskine Bridge (Anderson 2012). While it is difficult to incorporate case specific recommendations into an aggregated research study it is worth noting a number of points that were made in the FAI.

Evidence from an expert witness indicted that children in care are at increased risk of suicide, from the fact that they are in care, and that risk increases where there are additional factors. The additional risk factors, distilled from the available evidence, are highlighted later in the report and these should contribute to an individualised risk assessment, and raise concerns amongst professionals. The self-harming behaviour and threats of suicide were two factors that repeatedly re-occurred throughout the document as particular risk concerns in the two young women. Perhaps most importantly, and despite a number of concerns around practice and management issues, the expert witness indicated that the suicides probably could not have been predicted.

1.4 The Glasgow perspective

Almost half of Glasgow's residents, 283,000 people live in the 20% of most deprived areas in Scotland and the city as a whole has one of the poorest health profiles of any Scottish or UK city. Glasgow City had has the highest rate of suicide in relation to neighbouring local authorities and the major urban centres in Scotland. Suicide rates for Glasgow, along with Dundee, are higher than the national average (www.understandingglasgow.com).

1.5 Looked After Children

As of 31st July 2012 there were 3740 children in Glasgow looked after by the local authority (Scottish Government, 2013). This equates to 3.8% of Glasgow's population of children (National Records for Scotland, 2012) compared to total Scottish figures for looked after children being 1.47% of the population (Care Inspectorate, 2013). In Glasgow 977 of looked after children were living at home with parents and 1277 were living with friends or relatives. 1203 were in foster care, 18 in "other community placement" and the remaining 265 were in residential accommodation.

Looked after children are a vulnerable group, particularly those in the care system who are known to have a higher rate of psychiatric disorders (McCann et al., 1996, Dimegen et al., 1999). A surveillance study comparing looked after children with controls found the risk of psychiatric disorder to be increased by more than four fold in the looked after group (Ford et al., 2007). A national study of young people in Scotland looked after by local authorities found that 45% of looked after children have a psychiatric disorder (Meltzer et al, 2004). There was no significant difference in prevalence rates with placement type i.e. with parents, foster care or residential care. In this study 22% of looked after children and young people had tried to harm, hurt or kill themselves. The rate of self-harm in Scotland was more prevalent among older children, aged 11–17 (28%) than younger children (6%) and among those in residential care (39%) compared with children placed with their birth parents (18%) or in foster care (14%).

Looked after children also have a slightly higher mortality rate from all causes than the general population of children (Care Inspectorate Report, 2013). Between 2009 and 2011 30

looked after children in Scotland died. Five of these deaths were attributed to suicide (16%). A similar audit undertaken in 2002 found that 11 out of 50 deaths of looked after children between 1997 and 2001 were suicides (22%) (Scottish Executive 2002), suggesting a higher rate of suicide in looked after children than in the general population.

There has been a large body of research regarding risk factors for suicide in adults. In recent years there has been work undertaken to identify predisposing and precipitating factors for suicide in children and adolescents. Relatively recently attention has turned to the mental health and emotional needs of looked after children. However the focus to date has been on identifying the needs of this group in order to determine the need for targeted interventions. Further work is required to be undertaken identifying the specific risk factors for suicide in this vulnerable group of children and young people. This paper aims to address this deficit in looked after and accommodated children (LAAC) in Glasgow; who may be considered a particular group at risk as living away from parents has been identified as being associated with suicide risk (Evans 2004).

2. Aims

The primary aim of this paper is to identify themes and risk factors in cases of suicide between 2006 and mid-2012 in children and adolescents in Glasgow who were or had been looked after and accommodated and were known to social work at the time of their death. The aim is to identify potential indicators of suicide risk that workers across health and social work agencies should be aware of to try to reduce future suicides in this vulnerable group by means of an appropriate and timely intervention. The authors will identify themes and issues that impact on practice to inform the dissemination of specific learning points across agencies.

The report will provide an overview of the current research regarding risk factors for suicide. This is to inform the review and support the development of a case file data collection tool rather than to provide a comprehensive systematic review of the literature which is outwith the scope of this paper.

The specific personal circumstances of each case will be reviewed in an anonymised fashion, along with procedural aspects of the cases to identify areas of learning in the procedural approach to such cases which are transferable to future practice. The paper does not aim to critique management of cases or to identify mistakes or missed opportunities but rather to provide a knowledge base for identifying children and young people at risk of suicide. Another secondary aim is to identify areas for further research in this high risk group.

The overall objective of the report is to add to the current knowledge of professionals across health and social work agencies in Glasgow, regarding the early identification of risk of suicide to facilitate timely interventions in looked after and accommodated children and young people. The work does not, and cannot, replace other methods of case review, as it does not focus on individual cases, but is an anonymised overview of the selected cases.

3. Methods

The cases identified for inclusion in the study were preselected by the Child Protection Committee sub group as those young people whose death was recorded as suicide, or it was considered to be suicide, and they were looked after and accommodated at the time, or shortly before the time of death. All had some continuing contact with social work at the time of death.

The primary method of data collection was via social work and health case file analysis – both electronic and paper. Where available, Significant Case Review and other reports were also consulted. A decision was taken not to interview professionals involved in the cases; some of the deaths were a number of years old, and the analysis was not designed as a formal practice review of the cases. Additionally, many of the workers had been previously interviewed as part of formal review processes.

Drawing on previous work undertaken in Glasgow (Cowan 2006), and including the latest research findings on suicide and young people, a data capture form was designed containing identified risk factors (see appendix 1). For each case two members of the research team worked together on reviewing electronic and paper case files – social work records, followed by health.

Information was recorded in relation to three time frames where applicable – lifetime, last 12 months and last month before death. The data was collated on an Excel spreadsheet and analysed in terms of descriptive statistics. The limited number of cases available, and limited data, precluded any more sophisticated statistical analysis. The included cases have been anonymised as Case 1, Case 2 etc.

Case	Social Work Notes	GP Notes	CAMHS notes	LAAC Health Notes	Child Health Notes	Child Protection Unit files
1	Y	N	Y	Y	N	Y
2	Y	Y	Y	Y	N	Y
3	Y	N	Partial	Y	N	Y
4	Y	Y	N	Y	N	Y
5	Y	Y	Y	Y	Y	Y

Table 1: Access to case notes for each young person

- Case 1: GP notes destroyed as policy is to destroy GP notes three years after death. Child health notes destroyed as policy is to destroy child health notes three years after death.

- Case 2: Child health notes destroyed as per Case 1.

- Case 3: GP notes destroyed as per Case 1. Glasgow CAMHS notes reviewed but care was transferred to a CAMHS team in a different health board. This team was contacted, but unable to locate notes (either destroyed, or misplaced when service relocated). Child health notes destroyed as per Case 1.

- Case 4: CAMHS notes not located. Child health notes not located.

3.1 Ethics and confidentiality

As an audit of specific cases to inform child protection / safeguarding policy and practice in health and social work, full ethical research approval was not required under the guidelines for each agency. Health and social work senior managers, via their own individual processes, and under the auspices of the Child Protection Committee, provided full approval for the audit and methodology. The work was overseen by a steering group comprising of senior managers and clinicians from both agencies, who also facilitated full access to case records.

Individual names, or clearly identifying factors, were not recorded on the data capture forms and all reference to individuals, or specific areas of the city, were anonymised. The report was approved by relevant managers and the Child Protection Committee prior to publication.

4. Risk Factors: The Evidence Base

In order to facilitate comparison, with the author's permission, the risk indicators utilised in the 2006 report have been used in this review (Cowan, 2006). However following a review of the literature some additional risk factors have been added to compile a comprehensive data collection tool. It must be noted that although there is extensive literature on suicide and self harm in general, there is a lack of evidence with regards to risk factors for suicide in young people who have or were at the time of death looked after and accommodated. Therefore the evidence base from young people and adults must be drawn on to facilitate work to identify risk factors specific to young people with an experience of being looked after and accommodated. The relevant literature has been reviewed but as previously stated this paper does not aim to provide a comprehensive review of this area. However it is hoped that the following will provide the literary context for the risk indicators that were included in the data collection risk indicator tool used in this paper.

4.1 Social Factors

Several social and demographic factors have been identified as risk factors for suicide. It is known that completed suicide is more common in males than females (Platt et al 2007). Research in Scotland, comparing rural versus urban areas, found there to be higher rates of suicide in remote rural areas (Levin and Leyland, 2005). When adjusted for age and deprivation the risk in men of suicide was significantly higher in remote rural areas compared to urban areas, whereas the risk of suicide was lower for women in accessible rural areas.

Unemployment has been a well researched risk factor for suicide (Neelemann, 2001). Poverty and deprivation have also been linked to suicide (Neelemann, 2001; Rehkopf and Buka, 2006). Neelemann (2001) reviewed results from three cohorts finding that the unemployed and those with lower socio-economic status are 2.2 times more likely to die by suicide than those employed or from higher socio-economic groups.

Marriage can be a protective factor against suicide (McLean et al., 2008) and high levels of social support from friends, school and family are thought to also reduce the risk of suicide. Therefore evidence was sought of romantic relationships as well as evidence of networks of

friends. An abusive relationship was hypothesised as potentially diminishing the protective element of having social supports and has been found in adults to increase the risk of suicide attempts and mental health problems (Campbell, 2002). Both victims and perpetrators of bullying in adolescents have been associated with an increased risk of suicide attempts (Klomek et al, 2007).

The literature is unclear as to whether exposure to a friend who has attempted or committed suicide has any association with attempted or completed suicide (Bridge et al., 2006). Therefore it was felt that this would be a useful area to review in these cases.

4.2 Social Work History

Information was sought to identify any common factors within social work histories that might be indicators of risk of suicide. Information regarding processes that were thought to possibly be protective for suicide, by means of identifying and addressing areas of risk, were sought such as if the young person had a key worker identified in the files and a documented care plan review within the last six months prior to death. Of interest was the age and reason the young people first became Looked After and Accommodated; child protection and vulnerable young person procedures; how long they were looked after; age on leaving care; number of care placements and the predominated care placement. Multiple placement moves has been linked to a poorer outcome in terms of unemployment and social exclusion in adulthood (Dixon and Stein, 2006), both which are risk factors themselves for suicide. Significant accommodation issues such as homelessness, use of refuges, multiple house moves and issues in the community related to housing were identified as life stressors and as a proxy for socioeconomic disadvantage. Interventions used to address areas of concern were collected to compare across the group.

4.3 Familial Factors

Parental mental illness is known to be a risk factor for suicide in adolescents (Brent et al., 1993, Qin et al., 2002). A family history of completed suicide has also been well documented as significantly increasing the risk of suicide (Qin et al., 2002). Bridge et al. (2006) reviews the literature on loss of a parent through bereavement, divorce or separation.

Several studies show that loss of a parent increases the risk of suicide. Family discord is also a risk factor for suicide (Bridge et al., 2006). Childhood sexual and physical abuse has been found to be positively correlated with self harm, suicidal ideation and completed suicide in adults (Santa Mina and Gallop, 1998).

Positive parental relationships have been found to be a protective factor for suicide and also can be a mitigating factor of risk of suicide for other risk factors such as childhood sexual abuse, where the parent is not the perpetrator (McLean et al., 2008). As social connectedness has been found to be a protective factor for suicide, it was speculated that an ongoing relationship with biological siblings may also be protective and thus was included as an indicator to gather information from case files.

4.4 Personality/Behaviour Factors

A review of the literature commissioned by the Scottish Government in 2008 found that robust research regarding personality factors as risk factors for suicide is lacking due to heterogeneity between reviews and studies within individual reviews (McLean et al., 2008). There are a wide range of personality and behavioural factors which have been linked with an increased risk of suicide such as hopelessness, extroversion, impulsivity, anger, aggression, irritability and anxiety. Due to the lack of definitive evidence in this area it was decided to collect data on the factors that were thought to most likely be documented in case files. Indicators such as hopelessness, low self-esteem and introversion were gathered from records of direct reports from the young people themselves or from subjective reports from professionals. The subjective nature of this was felt to be an unavoidable necessity in order to gather information on these areas and hopefully add to the evidence base. It was decided that some of the personality/behavioural indicators used in the 2006 paper (Cowan, 2006) i.e. recklessness, impulsivity and risk taking behaviour, were highly subjective as these would rarely be reported directly by young people and that proxy information could be gathered through a variety of indicators such as absconding, risky sexual behaviours, substance use, criminal convictions etc. It was hoped that this would provide a more objective account indicative of such personality and behavioural factors.