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Redbridge Safeguarding Adults Board

Safeguarding Adult Review "Alice"

Lead Reviewers:

Jane Wiffin and Sheila Fish

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Written by Jane Wiffin & Dr. Sheila Fish

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Social Care Institute for Excellence
54 Baker Street, London W1U 7EX

www.scie.org.uk

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1 INTRODUCTION

1.1 WHY THIS CASE WAS CHOSEN TO BE REVIEWED

1.1.1 This case was chosen to be reviewed because it met the statutory criteria for a Safeguarding Adult Review (SAR) under section 44 of the Care Act 2014. Alice lived in Redbridge only briefly before she died, but the Redbridge Safeguarding Adults Board commendably agreed to commission a review because of the importance of learning from Alice's case for all London boroughs: to explore what is supporting and what is getting in the way of delivering effective care for individuals with complex and multiple behavioural, mental health and drug dependency needs, across multiple agencies and geographical boundaries.

1.2 SUCCINCT SUMMARY OF THE CASE

1.2.1 This SAR is about Alice, 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 her mother asked that she come into local authority care at the age of 10 because of reported behavioural difficulties. She remained in care until she was 18 and during this time, 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.

1.2.2 In the run up to her 18th birthday there was recognition that she would need a specialist placement to address her complex needs, but this was not found, and it was agreed that she would move home to live with her mother. She had no ongoing mental health support and there was insufficient focus on starting to develop her independence or addressing the relationship difficulties between her and her mother. Alice's feelings of distress and rejection manifested in the misuse of alcohol, in anger and in violence. There was no plan at this time to help her make sense of this distress. It is not surprising there was a crisis which led to Alice being moved at short notice to an adult residential placement in east London.

1.2.3 With this move she was catapulted into adulthood and adult services, where she was expected to have responsibility for herself and her behaviour without any preparation or support. She remained in Placement 1 for two years and this time was characterised by continued distress, manifested in alcohol misuse, increasingly dramatic incidences of self-harm and suicidal ideation.

1.2.4 She attended an alcohol rehabilitation unit, but she was asked to leave because of lack of adherence to the rules, her distress and inability to regulate her emotions.

1.2.5 There was a lack of clarity about her mental health needs that continued over time; she was diagnosed with a personality disorder, but often described as having no underlying mental health needs. There were various care plans developed by all the agencies Alice came into contact with, but none of these were 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.

1.2.6 There was an escalation of Alice's distress, self-harm and alcohol misuse and Alice was asked to leave her first adult placement. There followed two further adult placements. There were insufficient transfer arrangements in place which meant there were no connections made between the relationships in one placement and another, and the personal understandings people had of Alice were lost. There was an escalation in her alcohol use and self-harming behaviour, which meant many brief hospital visits and in-patient admissions in a crisis.

1.2.7 Alice received intensive mental health in-patient treatment in 2017 for 12 weeks and she was then moved to adult Placement 3. 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. 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 Placement 3 tried to support her, she received no ongoing complex therapeutic support from 2018 onwards, having moved from one health authority to another.

1.2.8 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; she was placed on a waiting list. Alice returned to Placement 3 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.

1.3 METHODOLOGY, PERIOD UNDER REVIEW AND THE RESEARCH QUESTIONS

1.3.1 The purpose of an SAR is:

- To promote effective learning and improvement to services and how they work together.
- To learn lessons about how the local safeguarding system works that will help to reduce the likelihood of future harm.
- To understand what happened and why.

1.3.2 The SAB decided to use a Learning Together review approach (Fish, Munro & Bairstow 2010). This approach supports learning and improvement in safeguarding adults. The aim of this is to support involved staff, managers and strategic staff to use systems thinking to develop an understanding of practice in the case and to promote a culture of learning between involved partners.

1.3.3 Learning Together provides the analytic tools to support both rigour and transparency in the analysis of practice in the case and identification of systems learning. This creates a two-stage process:

- We broke the timeline down into Key Practice episodes. The quality of practice in each episode was analysed and contributory factors identified.
- From the case analysis we drew out underlying systemic issues that help or hinder good practice more widely. The Learning Together findings structure requires the provision of evidence about the generalisability of issues that were identified in the case.

1.3.4 The approach has involved two distinct groups of participants:

Case Group - Practitioners with direct case involvement and their line managers.

Review Team - Senior managers with no case involvement who have a role in helping to develop system learnings and supporting the case group's representatives if needed. They play an important role in bringing wider intelligence to ascertain which issues are case specific and which represent wider trends locally.

1.3.5 We also sought to engage with family members to talk through the analysis, answer any queries and gain their perspectives.

TIME PERIOD

1.3.6 It was agreed that the main focus of the review would be on the most recent four-year period of Alice's life, from when she was first placed outside her home borough, seeing this time in the context of transition work from children's to adult services.

RESEARCH QUESTIONS

1.3.7 The use of research questions in a Learning Together systems review is equivalent to Terms of Reference. The research questions identify the key lines of enquiry that the SAB want the review to pursue and are framed in such a way that make them applicable to casework more generally, as is the nature of systems findings. The research questions provide a systemic focus for the review, seeking generalisable learning from the single case. The research questions agreed for this SAR were:

a) What is supporting and what getting in the way of delivering effective care for an individual with complex and multiple behavioural, mental health and drug dependency needs, across multiple agencies and geographical boundaries?

b) What can we learn about what is helping and hindering practitioners to manage these kinds of situation so that citizens receive as timely and effective help as possible?

c) How do we understand the needs of care-experienced young people who are not adults but at age 18 will be in contact with adult services?

1.4 INVOLVEMENT AND PERSPECTIVES OF THE FAMILY

1.4.1 The SAB and reviewers worked hard to enable Alice's mother, Mary, to contribute to the review, which she wanted to do. This was facilitated by her current Community Psychiatric Nurse and mental health support worker. Mary found it extremely painful to meet and to talk about Alice, whom she misses. Mary said that she had struggled to parent Alice but had not received help or support from professionals. She felt that it had been the best thing for Alice to come into care, but this had not been a happy experience for Alice. She also believed that once Alice was 18, she should have received more help, should not have returned to live with her and should have been offered mental health services locally. She said that Alice had been lonely and isolated when she moved to Newham, and that her alcohol misuse and self-harm increased. Jane, the reviewer, went through the draft findings verbally with Mary. Mary thought

overall they were reflective of the issues for Alice and could not think of anything to add.

1.5 REVIEWING EXPERTISE AND INDEPENDENCE

1.5.1 Sheila Fish is a research analyst at the Social Care Institute for Excellence. She brings expertise in incident review methodology. She has led national programmes to develop good practice standards for reviews across children's and adults' safeguarding. She provides training and supervision for incident reviews as well as conducting them herself. She had no involvement with the case under review.

1.5.2 Jane Wiffin is a social worker by professional background. She has worked in child and adult safeguarding for many years. She has been a pre- and post-qualifying practice educator and is now an experienced child safeguarding consultant. She has completed many serious case reviews and safeguarding adult reviews. She had no involvement with the agencies under review.

1.6 STRUCTURE OF THE REPORT

1.6.1 First, an overview is provided of what happened in this case. This clarifies the view of the review team about how timely and effective the help that was given to Alice was, including where practice was below or above expected standards and explaining why.

1.6.2 A transition section reiterates the ways in which features of this particular case are common to the work that professionals conduct with other families, and therefore provides useful organisational learning to underpin improvement.

1.6.3 The systems findings that have emerged from the SAR are then explored. Each finding also lays out the evidence identified by the Review Team that indicates that these are not one-off issues. Evidence is provided to show how each finding creates risks to other adults in future cases, because they undermine the reliability with which professionals can do their jobs.

2 APPRAISAL OF PROFESSIONAL PRACTICE IN THIS CASE

2.1 BRIEF TIMELINE OF THE PERIOD UNDER REVIEW: SUMMARY OF ALICE'S MOVES

2.1.1 A particular challenge in this review was putting together a chronology of professionals' work with Alice. Alice was subject to different types of plans guided by different legislation and approach, including Leaving Care regulations, a care plan as it related to her care and support needs under the Care Act 2014, regular learning disability health checks, care plans developed in each residential setting in which she lived, alcohol treatment care plans and more latterly, the care planning approach. This complex interplay of different services and sources of support was never integrated into one plan or approach for Alice. It is in itself revealing that such an overview did not exist to inform professionals' planning with and for Alice.

2.1.2 We have not included in this chronology the multiple overnight stays that Alice had in a range of hospitals, following drug overdoses or self-harm. Nonetheless, the hope is that the timeline works to give readers an impression of the type and quantity of moves Alice experienced. The timeline below places the period under review in the broader context of Alice's whole life.

Age	Amount of time	Placement	Borough
0 - 10		Alice born and living with her mother	Wandsworth
10		Alice comes into local authority care	Wandsworth
11		Short-break carers for next 7 months	Wandsworth
12	9 months	First children's home	Wandsworth
13 to 18	5 years	Second children's home	Croydon
18	7 months	Returned to live with mother	Wandsworth
19	4.5 months	Placed in adult placement 1	Newham
	7 days	Newham psychiatric hospital	Newham
	10 days	Adult placement 1	Newham
	2 weeks	Into Newham hospital detox	Newham
	4 weeks	Adult placement 1	Newham
	5 weeks	Living with her mother	Wandsworth
	8 weeks	Adult placement 1	Newham
	3 weeks	Living with mother	Wandsworth
	8 months	Adult placement 1	Newham
21 **21**	3.5 months	In detox and alcohol rehabilitation	Gloucestershire
	10 days	Transferred to hospital - Newham Centre for Mental Health	Newham
	10 days	Returns to adult placement 1	Newham
	10 days	Returns to Newham Centre for Mental Health	Newham
	3.5	Returns to adult placement 1	Newham

	months		
	4 days	Royal London Hospital, psychiatric ward	Tower Hamlets
	3 weeks	Back to adult placement 1	Newham
	2.5 months	Move to adult placement 2	Newham
	10 days	Newham Centre for Mental Health	
		Intensive Care Unit	Newham
	12 weeks	Newham Centre for Mental Health.	Newham
22	3 months	Starts at adult placement 3.	Barking and Dagenham
	6 weeks	In Goodmayes Mental Health Hospital	Redbridge
	2 weeks	Psychiatric Intensive Care Unit CU	
	6 weeks	Back to adult placement 3.	Barking and Dagenham
	1 month	Goodmayes Psychiatric Hospital. Absconded and stayed with her mother for one week in the middle	Redbridge
	10 days	Back to adult placement 3.	Barking and Dagenham
	3 months	Readmitted to Goodmayes	
23	4 weeks	Adult placement 3a)	Redbridge
		Alice dies	

2.2 IN WHAT WAYS DOES THIS CASE PROVIDE A USEFUL WINDOW ON OUR SYSTEM?

2.2.1 The starting point for this SAR was an exploration of the circumstances which led to the sad and untimely death of Alice. Although her circumstances were unique to her, the review team thought that this review was an opportunity to explore what is getting in the way of delivering effective care for other care-experienced young people like Alice with complex and multiple behavioural, mental health and drug dependency needs, across multiple agencies and geographical boundaries. The review hoped to consider what could be learnt about what is helping and hindering practitioners to manage these kinds of situations, and to provide timely and effective help. It is clear from undertaking the analysis in this review that early trauma and abuse, unsatisfactory care experiences, chronic instability and insufficient support with the leaving care transition from childhood are the key factors that can have an influence on the quality of provision to young people.

2.2.2 Although research suggests that many young people leaving care have poorer outcomes than their peers, it is clear that this group of young people are not a homogeneous group. Research has suggested that some young people leaving care do well across a number of measures, some struggle through, but there is a final group whose circumstances have left them at the time of leaving care with complex problems which require serious care and support. This report is focused on this group, whose characteristics reflect Alice's circumstances and the circumstances of many young people. The factors are: significant abuse and neglect being the reason for coming into care and remaining unaddressed and

unresolved; difficult and conflictual family relationships; children and young people being blamed for their episodes in care; mental health needs not met; and lack of maintenance of relational links and networks.

2.2.3 Children's services and their partners understand the concepts, practice and legal requirements regarding the leaving care transition process. When a young person is 18 and they are legally an adult, they move into a different world of services. This is a world which is much less aware of the leaving care process; young people move quickly from being children/young people with needs caused by their journey through the care system to adults with personal responsibility for themselves, who are considered fully able to make choices and decisions for themselves. This is despite the experience of care being at times restrictive of their choices and not always able to prepare young people for the journey to adulthood. This must be extremely bewildering. As one young person in a research review highlighted: "*It is like being on a cliff edge*". There are many care leavers in these circumstances, as is evidenced by several governmental reviews, feedback from care-experienced young people and adults and many research reviews over the last 30 years.

2.3 APPRAISAL SYNOPSIS

2.3.1 This appraisal of practice explores the four-year period of tumultuous change in Alice's circumstances and well-being before she took her own life. She had contact with a large number of professionals and agencies across different parts of London. This appraisal does not cover all of these contacts or responses but focuses on key episodes and the quality of the systemic response to a vulnerable care-experienced individual who was just out of childhood and had not been adequately prepared to be an autonomous, independent adult when the events that follow took place. This was not sufficiently recognised by professionals who came into contact with her when she was aged 18.

BACKGROUND: CHILD NEGLECT AND ATTACHMENT INSTABILITY

2.3.2 Alice had a complex and traumatic childhood. She experienced neglect from her mother, who herself had long-term mental health difficulties. Little is known about Alice's father, except that he was not living with the family from when Alice was aged three. Alice has two half-siblings but there is little information about them, except that they were older and estranged from Alice.

2.3.3 When Alice was aged 10, her mother said she could not manage Alice's difficult behaviour and asked that she be brought into local authority care permanently. This request, which must have felt like abandonment to a young child, does not appear to have been challenged and her mother's assertion that Alice was responsible for what happened was not questioned and support to her mother not provided. Subsequent children's services assessments and records would continue to highlight the reason that Alice came into care was because her behaviour was unmanageable, as opposed to the early neglect she had experienced. It was agreed that Alice would be placed in foster care, but over the next three years she moved between foster care, residential short-break placements and her mother's care, experiencing considerable instability in attachment relationships in her crucial middle years. The information about Alice's instability in attachments, alongside feelings of rejection, were well recorded and travelled with her on her journey into adulthood. What was missing

was an analysis of what this meant for her and her emotional well-being; this history became a description of her background.

2.3.4 At the beginning of adolescence, another critical developmental stage, Alice moved to one children's home and then quickly moved to a small residential home for young people with learning disabilities (in a different borough), where she lived for the next five years. At the start of this placement, she had been diagnosed with a mild learning disability, autism, and ADHD. Over these teenage years, Alice alleged rape and sexual assault and there was concern she was being sexually exploited. Alice asked for the incidents not to be reported to the police and although specialist psychological and psychiatric support was provided, it was in the context of Alice not coping, rather than an acknowledgement that she had experienced traumatic events which anyone would struggle to cope with. The records at this time indicate that professionals believed that Alice put herself at risk of harm through her impulsive and risky behaviour and she was provided with the support of a sexual exploitation worker; there was a lack of recognition that this victim-blaming approach would impact on her sense of self and well-being.

2.3.5 She started to self-harm, express suicidal ideation and misuse alcohol and drugs. She regularly ran away from the residential home, often to return to stay with her mother. This increased already existing conflict between them because Alice would often refuse to leave to return to residential care and her mother would become angry. Alice had few friends and attended school on a reduced timetable. The residential home noted that Alice found it hard to form relationships with staff, focusing on one member of staff at a time. This was considered to overstep boundaries and was discouraged. There was no plan to help her build friend-type relationships or to fill the absence of any parental/ adult attachment figures or extended family relationships.

2.3.6 Concerns grew about Alice. She attended regular sessions with a psychologist at Child and Adolescent Mental Health Services (CAMHS), who diagnosed early signs of unstable personality disorder. This was an early opportunity to consider underlying causal factors and develop a formulation based on Alice's early experiences of neglect, instability of attachment figures, the trauma of rape and sexual assault, her complete isolation, her potential individual vulnerabilities given a diagnosis of autism, ADHD and mild learning disabilities – and to take an early intervention approach.

2.3.7 Alice received individual psychology support for three years from CAMHS and other help and medication from child psychiatry. Her mental well-being did not improve and this support did not help with her poor emotional regulation, characterised by self-harm, overdoses, drinking alcohol and using drugs. Consequently, the residential home increased their supervision and surveillance of her, including a taxi to school (where she attended three half days a week). This was far from developing a level of independence that would be expected for someone of Alice's age and paradoxically this increased supervision reduced Alice's ability to regulate her emotions.

THE IMPORTANCE OF CAREFUL AND INFORMED TRANSITION PLANNING

2.3.8 Professionals discussed with Alice about where she would live and what support she would need in the lead-up to leaving residential care. Sadly, just before this, Alice's long-time social worker left, bringing further change and instability. She

was allocated a new social worker from the Wandsworth 0-25 disability team and a Leaving Care Personal Assistant (PA). Professionals had a lot of information about Alice's complex needs to draw on in making decisions about transition planning – a critical stage for young people leaving care. Alice had few independent living skills, had little autonomy in her day-to-day world and was also extremely isolated; she had no friends or family support beyond her mother, who was struggling with her own needs. Alice was self-harming, actively talking about suicide, saying she would take her own life when she was 18 to avoid leaving the residential home and there were concerns about her mental health. It was known that she had a diagnosis of autism, learning disability, ADHD and possible personality disorder.

2.3.9 Alice had a complex relationship with her mother and she had spoken about how she had not been able to get a clear understanding from her mother about why she needed to be in care. Alice reported a deep-seated sense of rejection because of this; this was compounded in this transition period by Alice's belief that the residential home was actively rejecting her by planning for her to leave. Sadly, this triggered a withdrawal from the residential home and Alice returned for longer and longer periods to her mother's home in an unplanned way. This led to further conflict because her mother did not want her at home and would ask for help to force Alice to leave. This created a circular pattern of feelings of rejection for Alice that no professional was able to resolve – a pattern that would remain in place over the next few years. There was some recognition by professionals at this time that Alice's continued self-harm and suicide threats were an expression of her emotional pain, caused by fragmented attachments, emotional distress, poor mental health and fear of any change; but there appears to have been no plan to address this. Plans to promote her independent living skills, problem solving and emotional regulation were therefore impossible to achieve because of her withdrawal from services and support at this time.

2.3.10 The pathway plan and process were discussed and it was concluded that Alice needed a specialist placement to address her complex needs and ongoing support from adult mental health services. However, there was no detailed discussion about either the type of placement or whether it existed/was available. Alice was assessed by adult mental health services who said she did not need mental health support. The reasons for this are not clear and there appears to have been no challenge of this inappropriate decision or advocacy provided for Alice through the corporate parenting responsibilities.

2.3.11 Alice decided she would like to return home permanently to live with her mother; her mother did not want this to happen, saying she could not cope, but was told by professionals that there were no appropriate placements because of Alice's complex needs. Alice returned to live with her mother when she was aged 18 with no plan to address their conflictual relationship, no specialist mental health support, no services for her autism and no connection to the residential centre and staff who had been supporting her for many years. She was to be supported by a social worker who would oversee her care and support plan; this consisted of an ongoing annual GP review for her learning disability, medication for her ADHD and a part-time adult education class. She was also to be supported through a leaving care worker/PA, but there is no record of what this support would look like nor how it would link with the care and support plan. In essence, there was no pathway plan in place. This was wholly inappropriate and there was an unspoken contradiction between the lack of an available placement because

of the complexity of Alice's needs and leaving her to drift home without any plan in place at all. The rehabilitation of children and young people from care back to their family requires appropriate assessment, including an understanding of the nature of relationships, what dynamics need to be addressed and confidence that the concerns that brought the child into care have been addressed. There was no evidence that this was the case here.

2.3.12 Alice moved to live with her mother in November 2013 and remained there for a period of nine months. There were early indications of the unsuitability of this arrangement. In March 2014, her mother called the police to report that Alice had broken a window and assaulted her whilst intoxicated. When the police arrived, Alice assaulted a police officer. She was charged and received a six-months conditional discharge. Alice's distress was clearly being articulated through aggression, anger and frustration. Although this incident was discussed by her social worker and PA, there were no plans about how the obvious signs of the unsuitability of this arrangement would be addressed, how Alice would be helped to regulate her emotions in ways that did not involve aggression, drinking or self-harm and what the impact of the lack of any specialist support would be. It is of concern that this quickly deteriorating situation was not addressed, leaving Alice extremely vulnerable and establishing a pattern whereby Alice signaled her distress and need for help through aggression, alcohol misuse and self-harm.

2.3.13 In August 2014, Alice was found in an intoxicated state in the street. Assistance was sought and Alice assaulted a police officer and ambulance worker; she was made subject to Section 2 of the Mental Health Act and taken to hospital (Wandsworth) where she stayed for three days. On discharge, there was a clear and appropriate plan: the mental health transition team would provide support; she would be offered a place on a Prince's Trust course; she would see her GP regularly; she would be offered art therapy and family therapy; and continue with the medication plan. This plan was never implemented because Alice was moved away from Wandsworth. When Alice was being discharged from hospital, her mother refused to have her home, but no placement was found and she returned home. On arrival, there was an argument which her mother reported to the police as an assault. Alice was taken to the police station until the early hours of the morning. The social worker was tasked with finding an emergency placement somewhere away from Wandsworth, because Alice was now viewed as a risk to her mother. An emergency supported placement was found in Newham, the other side of London, and unknown workers came and collected Alice and took her to Placement 1. This must have been a scary and unsettling time for Alice. She was moved again to a new place where she had no links or connections and with someone else making decisions for her. This pattern of instability continued with four further placements over the next four years.

MOVE TO ADULT PLACEMENT 1 AND DEVELOPMENT OF LOCAL MULTI-AGENCY SUPPORT PACKAGE

As a consequence of the crisis-driven nature of this first adult placement, no referral was received from Wandsworth 0-25 disability social work services and no pre-assessment was undertaken. The Wandsworth social worker provided the most recent assessment regarding Alice, completed a year earlier, and a verbal update. The in-depth knowledge that had built up about Alice's fear of change, rejection, poor attachments and a history of fractured relationships which triggered alcohol misuse, self-harm and suicidal threat, alongside lashing out

aggressively when intoxicated, was not. Importantly, this crisis move to an adult placement meant that Alice was no longer seen as a young person leaving care who was on a journey to adulthood and who had considerable attachment and support needs alongside co-existing mental health difficulties. Instead, she was catapulted abruptly from childhood to adulthood with no transition process and no meaningful overarching care plan in place. This move from children's services to adult services for young people means that they go from a system which is focused on support, risk assessment and protection, often through containment, to the adult services world focused on person-led choice, risk enablement, individual control and capacity risk management. There is a mismatch for young people like Alice, whose care journey has not enabled them to be emotionally mature enough to embrace choice, feel a sense of personal agency and grow into independence.

2.3.14 Placement 1 developed their own care plan focused on independent living skills, building Alice's confidence and college attendance. This support plan did not match Alice's needs or circumstances. Alice was provided with a bedsit in a building with some shared facilities, with 24-hour staff oversight for all residents and 13 hours of individual support a day. She was often away from the placement, either with boyfriends about whom little was known, with friends who appear to have been drinking allies, or at her mother's home. Wandsworth 0-25 disability team and leaving care services remained responsible for supporting Alice, and over the next two years there was instability in social work arrangements, with times when Alice had no social worker and therefore no oversight of her care needs or plan. The leaving care worker was a consistent presence who visited regularly, but their role was not incorporated into any wider plan and these visits took place in total isolation from other professionals and their concerns.

2.3.15 Within Placement 1 there were immediate concerns about Alice's alcohol misuse, sexual exploitation, her self-harm and suicidal ideation, and her physical and racial abuse to staff. Despite the plan being for independence, Placement 1 felt they needed to put some boundaries in place to manage this behaviour and Alice was subject to increasing levels of supervision and surveillance, thus undermining any sense of developing a better sense of self and the promotion of a move into late adolescence with preparation for adulthood. This should have prompted a review about whether this was the right placement for Alice given the mismatch between the stated purpose of the placement and Alice's current needs. The constant crises meant that there was no focus on the "ordinary everyday" of friendship, links with family and maintaining connections with the past.

2.3.16 In the period between August 2014 and May 2015, Alice was admitted to different hospitals across London on at least 13 occasions for self-harm, suicidal ideation and alcohol misuse. In December 2014, she took an overdose of tablets whilst intoxicated. She was diagnosed whilst in hospital with an alcohol dependency and an unstable personality disorder. The plan was for a referral to alcohol recovery services and the personality disorder team. Placement 1 ensured that a referral was made to a local drug and alcohol service and Alice was provided quickly with services. Alice said she did not want to attend the personality disorder service. Alice did initially engage well with the alcohol recovery service, but her alcohol misuse continued. There were concerns at this time that when under the influence of alcohol she was being sexually assaulted

by others and her PA suggested she was putting herself at risk because of her drinking.

2.3.17 At this time, Probation also became involved because Alice punched a member of staff at Placement 1. In the absence of any consistent oversight of Alice's needs from Wandsworth, Placement 1 brought together the local alcohol service and Probation to form a multi-agency team providing Alice with support. This group of professionals considered that Alice also needed specialist mental health input and over time they advocated for her to receive this input, without success. The 0-25 disability team in Wandsworth and the GP agreed and made referrals to mental health services. They were told that Alice did not have an underlying mental health disorder. Her mental health needs remained unaddressed. She continued to go in and out of hospital with self-harm, she would often run away before assessment, or be aggressive to staff. The placement would come and collect her or find her and return her to hospital; she would then run away again. This time was characterised by increasing chaos and the pattern of Alice demonstrating her distress and signaling her need for help in ways that brought rejection and increased surveillance and management of her day-to-day life continued. It is not that those working with her had not understood that she had experienced trauma, but there developed a belief that she could individually overcome her circumstances and learn to manage her emotions better.

2.3.18 In May 2016, Alice had seizures caused by alcohol misuse and underwent detox at Newham Hospital for two weeks. From there she attended a residential alcohol treatment programme in Gloucester planned for six months; this was organised by the local drug and alcohol service. Although this was intended to be helpful, there is a lack of evidence of discussion across the multi-agency network of how Alice would cope with this move, with the echoes of further rejection and a need to build new relationships, and how she would cope with the clear boundaries and sense of surveillance in this new setting.

2.3.19 When in Gloucester, Alice immediately started to challenge the boundaries and rules; she ran away, brought alcohol and nicotine substitutes and ultimately, she was told that she needed to leave. Alice was extremely distressed at what she saw as another rejection and at the meeting to discuss this she cut herself very seriously with a razor. She ended up in hospital. She was transferred back to Newham Centre for Mental Health by professionals she did not know in September 2016; professionals from Placement 1 and Wandsworth said there was no one who could collect her.

2.3.20 Alice remained in Newham Centre for Mental Health for 10 days. The conclusion of her hospital admission was that she had no "*major mental illness*", did have a personality disorder but was not suitable for psychological therapy. This was a confused picture for those trying to support Alice. She returned to Placement 1 and the care plan was for her to continue to take anti-depressant and anti-psychotic medication. There was also a recommendation of a referral to the community mental health team, ongoing alcohol support services and the offer of ongoing support to Placement 1 for her emerging symptoms of unstable personality disorder.

2.3.21 Over the next 10 weeks Alice continued to go in and out of hospital for acts of self-harm, suicidal ideation and significant alcohol misuse. This meant the community mental health services were unable to establish a relationship with Alice or a pattern of work; she continued only to receive alcohol misuse services.

Once again, there was inconsistency in opinion about whether Alice had an underlying mental health condition There was a focus on Alice's ASC needs, the first time this featured in a care plan. The view remained that she was not suitable for a referral to a therapeutic service and she was encouraged to engage with the community mental health team.

2.3.22 In November 2016 Placement 1 decided that they could not cope with Alice's complex needs; they were saddened by this as they recognised that a move would be painful for her, but they felt Alice needed more specialist care. The Wandsworth 0-25 team sought a new placement, but there remained a lack of clarity of what this specialist care should be, exacerbated by a lack of choice regarding available placements. This move was the start of a pattern whereby Alice's complex needs remained unresolved and unaddressed, her distressed behaviour increased, causing more and more crises, which led to changes in placements, the loss of established professional relationships and heightened feelings of rejection. Professionals needed to recognise this pattern and although it was difficult to address, at least form a plan and acknowledge the nature of the problem. There were in essence many different plans (leaving care, care and support plan, residential setting plan, discharge plan from hospital) running concurrently and without coordination.

MOVE TO ADULT PLACEMENT 2

2.3.23 In December 2016 Alice moved to Placement 2 where she remained for the next 12 weeks. This was a placement which specialised in supporting adults with ASC needs. The transition from the previous placement was unnecessarily disorganised because of disputes between the two settings and meant that once again this change/transition was not managed well for Alice. The connection with the positive relationships formed in her previous placement were lost alongside a detailed understanding of her needs. The placement care plan in Placement 2 was focused on emotional regulation and general support. Despite the increased level of concern about Alice, this placement was tasked with providing less 1:1 input, but the cost of the placement remained high.

2.3.24 The community mental health team in conjunction with Newham Centre for Mental Health remained responsible for addressing Alice's mental health needs, but they continued to struggle to engage with Alice. In addition, the impact of change and constant crises meant that no pattern of support was ever established. Alice continued to access alcohol services, but again, the changes and crises impacted on her ability to use these services productively. The care and support plan from Wandsworth noted all these services but did not reflect on how their efficacy was impacted by the continued crisis-led nature of Alice's circumstances. There was no integrated plan of care for Alice that accurately reflected her circumstances or needs. During the 12 weeks Alice was at Placement 2, she continued to misuse alcohol and was admitted overnight to hospital on six occasions due to significant self-harm and suicidal attempts using heroin. There remained a pattern of Alice running away to be with her mother, who asked Alice to engage in a suicide pact. This was shared with all involved professionals but was not addressed with either her mother or Alice.

2.3.25 At the end of February 2017 Alice was found by Placement 2 staff in a critical condition due to an overdose of methadone and alcohol. She was taken to hospital. She was transferred to Newham mental health in-patient ward. The assessment concluded that the existing diagnosis of unstable personality

disorder and ASC remained and she was discharged to Placement 2 with a hospital admission avoidance plan and community mental health support. A difficult situation for all, but ultimately Alice returned to the placement with a plan that had not previously worked. This discharge plan also recommended that Alice be moved to better address her complex needs. Alice was not consulted about this, taking away any sense of control she might have felt and immediately feeding into her ongoing (and justified) feelings of rejection and loss. There was insufficient discussion about the implications of this move, the likely crisis that might occur or how to manage the transition in a way that could keep Alice safe and contained. Alice was extremely upset about this plan and went back to Placement 2 and angrily challenged staff about their rejection of her. She went to a hotel and took an intentional overdose of heroin and wrote a suicide note. The police were alerted to this incident by Alice's mother. She was found and admitted to intensive care for the next eight weeks. Alice had quickly formed relationships with staff at Placement 2 and they were saddened to see her go. Alice would spend the next eight weeks in intensive care and then went into Newham Centre for Mental Health. Alice returned to Placement 2 for some overnight stays but would not return permanently. Thus, further relationships were disrupted.

IN-PATIENT ADMISSION

2.3.26 In May 2017 Alice was admitted to Newham Centre for Mental Health for an in-patient stay of 14 weeks from ICU. This was the longest period of time that she had been an in-patient in a mental health unit. It was an important opportunity to build on the earlier diagnoses of personality disorder and refine the formulation and treatment plan for Alice, taking into account her past and present trauma. Alice received intensive input whilst an in-patient. Alice engaged well with individual therapy support from a psychologist; this provided her with a consistent therapeutic relationship, and a formulation of her needs was developed. She also received group therapy and occupational therapy input weekly. However, Alice remained angry and aggressive to staff and patients; it was effective practice that the psychologist provided support to the in-patient team to help staff manage Alice's behaviour and to recognize it as a manifestation of Alice's emotional distress. A new placement was found and there were appropriate discussions about a gradual discharge process to take account of Alice's likely response to another change. Once again, there was no connection made with the previous placement nor any building on old relationships or their knowledge of Alice's needs.

MOVE TO ADULT PLACEMENT 3

2.3.27 In August 2017 Alice moved to Placement 3 from hospital. The discharge plan was that her mental health care would be overseen by a care coordinator; she would continue to receive psychological support for the next three months; she would have occupational therapy support for a period of time to address her autism needs; and she would be reviewed by the specialist autism team. It was proposed that Alice would continue to receive alcohol support, but the move to Placement 3 meant that she was out of the catchment area of the alcohol team she had previously engaged with. Her care was transferred to this new area and she never engaged again. The placement developed a new care plan focused on living skills and Alice was offered art therapy which she ultimately refused to

engage with.

2.3.28 The psychologist from Newham Centre for Mental Health spent a lot of time with the staff and key worker at Placement 3 to put in place a plan to help them manage Alice's complex needs and to help her regulate her emotions. The same pattern emerged with Alice misusing alcohol, self-harming in ways that were shocking and traumatic to witness. She was also running away to be with her mother. In August 2017 after four such incidents in the first month of placement, Placement 3 asked Wandsworth to find Alice an alternative community placement because they believed she needed to be somewhere with greater surveillance and supervision, and for her to receive dialectical behaviour therapy (DBT); but after discussion, agreed they would allow her to stay. This was because no other placement was found for her. This could have been a moment when there was a full review of Alice's needs; this did not happen.

2.3.29 Placement 3 carried on building relationships with Alice and she agreed to attend a gym and to think about volunteer work. The community mental health team tried to meet with Alice and the alcohol services also sought to engage her, but the ongoing chaotic nature of her distress-related short-term admissions to hospital meant that relationships were not formed and work not completed. Over a 12-week period she was brought to different London hospitals on 13 occasions as a result of either cutting herself, causing deep lacerations, or injecting heroin with the intention of suicide. Her medical needs were addressed and she would return to Placement 3.

FURTHER IN-PATIENT ADMISSION

2.3.30 In November 2017 Alice was admitted to an in-patient unit in Redbridge for four weeks; Alice was seen by a new psychiatric team because of the move to Placement 3. The comprehensive package of care and analysis of her needs formed in her last in-patient admission got lost and due to sickness, there had been no transfer of care meeting. At this admission, Alice was described as irritable, angry and aggressive. She continued to self-harm using razors whilst on leave or out for walks and at the beginning of December 2017, she was admitted to a Psychiatric Intensive Care Unit for two weeks because of her aggression. She returned to the in-patient unit and there were concerns that she would attack another patient. She was discharged back to Placement 3 in December 2017 and the discharge plan suggested that the current support plan should remain in place, without reflection that the evidence was that it was neither sufficient nor working to keep Alice safe and address her needs. All the specialist input that had been put in place in her last hospital admission had now ceased and her care was to be overseen by a new care coordinator. Once again, the crisis nature of Alice's circumstances meant that there was no consistency of support.

2.3.31 In December 2017 Alice returned to Placement 3. She stopped misusing alcohol and there was a noticeable growth in her concern about access to medication, which caused her to damage property and assault staff. Alice continued to self-harm, run away and be aggressive to staff. She also continued to go to see her mother. She was not in receipt of any specialist mental health support or services for her autism beyond the management plan developed by the psychologist from Newham Centre for Mental Health which was to be implemented by Placement 3. This was not possible because of the ongoing crises.

FURTHER IN-PATIENT ADMISSION

2.3.32 At the beginning of February 2018 Placement 3 called the police because Alice was attacking staff. She threatened to kill herself with an overdose of heroin. She was readmitted to Goodmayes hospital under Section 2 of the Mental Health Act for a month. Whilst on leave from hospital, Alice returned to Placement 3, forced herself into the office and took a large amount of medication. She then went to her mother's and was returned to hospital by the police. Local services got involved and she returned to in-patient treatment. She was discharged in the first week of March 2018 with the current support plan to remain. Again, there was no reflection that it was not based on a current formulation, did not contain any therapeutic support and, given the crisis-driven nature of Alice's distressed circumstances, could not be implemented.

MOVE TO ADULT PLACEMENT 3(A)

2.3.33 In December Alice was moved to a new building which was part of adult Placement 3; adult placement 3a. This was because she had previously had a ground floor room and could escape undetected. This new placement was in Wanstead, but included the same care team – it was still a further change.

2.3.34 A week later Placement 3 (a) reported to police that Alice had told them she was going to overdose on heroin and she was re-admitted to hospital. She would remain there for the next 12 weeks and was provided with group support, psychology input and 1:1 support. During this time, Alice took part in an unsuccessful suicide pact with another patient using an overdose of heroin and whilst away from the hospital she took another heroin overdose in a hotel room. There were considerable concerns about her wellbeing and a forensic assessment was completed to support a referral to a low secure unit. Alice was against this, but the assessment recommended this was the right course of action to keep her safe. She was placed on a waiting list.

2.3.35 Alice was discharged back to Placement 3(a) in mid-June 2018. The discharge plan was that she would continue to be supported by the local community mental health team (recovery team), and there was a referral to IMPART – the personality disorder service. Alice's care coordinator visited her at the placement and Alice reported that she was "a ticking bomb"; she would not elaborate about this. Staff at Placement 3(a) said she had settled well.

2.3.36 At the beginning of July staff at Placement 3(a) found Alice unconscious as a result of alcohol misuse and self-harm. She was taken to hospital where she ran away and returned to Placement 3(a). There, she continued to drink vodka, barricaded herself in her room and lacerated her arms. Police broke into her room and took her to hospital. Alice ran away again and when found by the police she said that she wanted to kill herself. She was treated medically in hospital and assessed by a mental health practitioner. Alice wanted to return to her placement and it was agreed that there was no need to detain her. This admission was followed up by her care coordinator and Alice asked if she could visit her mother. This was not agreed because of the concerns about a possible suicide pact with her. After 10 days, Alice received a letter from IMPART, the borderline personality disorder service, saying she was on their waiting list. Two weeks later, Alice was found having taken a drug overdose from which she sadly died.

3 SYSTEMS FINDINGS

The Review Team has prioritised five findings for the SAB to consider. These are:

	Finding
1	FINDING 1: **'PULL' OF BIRTH FAMILY** Work with children living in or leaving children's homes 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. Without this, the corporate parent risks leaving the child burdened with the responsibility for understanding the reasons they originally came into care. In addition, the corporate parent effectively abandons some care-experienced young people to further crises and rejection when they do return home, compounding their trauma and escalating their distressed behaviours, including self-harm.
2	FINDING 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. This increases the chances that the most vulnerable young people end up catapulted into adulthood, with a range of disparate and ineffective care plans across agencies that do not address the seriousness of their circumstances, with no social worker from adult social care involved and no routes for escalation to the corporate parent despite the desperate circumstances of their young charge.
3	FINDING 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; it leaves unqualified supported living staff trying but failing to provide the necessary support for young people who have a history of parental neglect, sexual abuse, sexual exploitation and re-abuse created by crises-driven responses by services.
4	FINDING 4: **VICTIM BLAMING** The absence of functioning local authority leaving care processes for complex cases (Finding 2) and/or effective mental health interventions (Finding 3) creates fertile ground for routine victim blaming that sees young women 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 women concerned, when a trauma-informed approach that acknowledges the history of parental neglect, sexual abuse, sexual exploitation and re-abuse created by crises-driven responses by services is more appropriate. It creates the conditions where awful self-harm and increasingly determined efforts by young women to take their own lives become normalised.
5	FINDING 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 a continuity over time. This risks deepening 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 and includes the legacy of people who liked and cared about them (akin to life story work), 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 (e.g. – Lifelong Links type work; mentor).

3.1 FINDING 1 - 'PULL' OF BIRTH FAMILY

Work with children living in or leaving children's homes 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. Without this, the Corporate parent risks leaving the child burdened with the responsibility for understanding the reasons they originally came into care. In addition, the Corporate parent effectively abandons some care-experienced young people to further crises and rejection when they do return home, compounding their trauma and escalating their distressed behaviours, including self-harm.

CONTEXT

The most common reason for children and young people to come into local authority care is that they have been abused and/or neglected, often by their parents/family members[1]. There is good research[2] which suggests that this betrayal of the parental/care role to love, care and meet the needs of children (for whatever reason) creates attachment and relationship difficulties as well as causes changes in the brain architecture which can lead to mental health difficulties in adulthood and struggles with everyday life[3]. It is critical that children understand their own story; why they came into the care system and what their history is. This personal history is like the family pictures we look at, the stories we tell, and the family stories we impart. It is important because it creates identity and a sense of belonging. Its absence causes instability, feelings of rejection and a sense that no one is there for you.

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, overseen by a positive corporate parenting process, work is undertaken to ensure that family and parental relationships are healed where possible and wider family and friendship links are maintained[4]. It is absolutely essential for this that the problems that brought a young person into care have been largely addressed. This is the cornerstone for ensuring that children and young people can have positive links with siblings, parents and wider family.

When young people who are in care are aged 16[5], the process of planning should start with consideration of where is the best place for them to move to as the first steps of independence and the journey into adulthood[6]. This is an important process which needs to take account of the needs of young people. Factors which influence the effectiveness of this moving on process are the quality of the care provided, the impact of instability in care placements and caregivers as well as support provided. Other

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[1] **https://www.becomecharity.org.uk/media/2357/children-in-care-and-care-leavers-recovery-plan-briefing.pdf**

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/200471/Decision-making_within_a_child_s_timeframe.pdf

[3] https://youngminds.org.uk/media/3091/adversity-and-trauma-informed-practice-guide-for-professionals.pdf

[4] Rahilly, T. and Hendry, E. (eds) (2014) **Promoting the wellbeing of children in care: messages from research**. London: NSPCC.

[5] Department for Education (DfE) (2015) **The Children Act 1989 guidance and regulations volume 2: care planning, placement and case review (PDF)**. London: DfE.

[6] Cabinet Office et al (2016) **Keep on caring: supporting young people from care to independence (PDF).** London: Cabinet Office.

factors are the extent to which services have addressed young people's early trauma, their level of mental health needs and any issues of disability. As has already been said, the quality and extent of family links is also an important factor[7]. Young people whose final placement is in a children's home, before leaving care, are often the most vulnerable in the care system, having greater needs than those in foster care[8].

Evidence suggests that despite the considered approach needed to match leaving care placements to the needs of the young person, many return to their birth families without this being planned or appropriate. As Martin Narey (2016) put it in his review of the support needs of those leaving residential care: "*We cannot allow young people, often just weeks from childhood, to be left to navigate life on their own. And nor should we sit by and allow them to drift home when that is patently not in their interests*[9]*".* It is essential that appropriate assessments are undertaken using existing tools and frameworks[10] to evaluate whether reunification is possible and appropriate for the young person, what plans need to be put in place and what support is needed. When this drift home – or pull of the birth family – happens in an unassessed and unplanned way without appropriate support plans in place, including emotional and mental health support, there is likely to be a quick breakdown, with young people requiring emergency accommodation or becoming homelessness[11]. This causes further family rifts and problems, causes the young person to feel alone, rejected and unloved, and means protective wider family and community links are lost.

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[12].

HOW DID THE FINDING MANIFEST IN THIS CASE?

Alice's is a textbook case of the 'pull' of the family being inadequately addressed. Alice could articulate clearly that she had not been able to get a clear understanding from mother about why she needed to be in care. Alice reported a deep-seated sense of rejection because of this that remained unresolved.

From early on, she regularly ran away from the residential home, often to return to stay with her mother. This increased already existing conflict between them, because Alice would often refuse to leave to return to residential care and her mother would become angry. There does not seem to have been any concerted work with Alice to protect her from this damaging dynamic. In fact, the opposite occurred as, during the transition period, Alice believed that the residential home itself was rejecting her by planning for her to leave. This seemed to drive her ever more to her mother's home, creating yet more conflict and rejection because her mother did not want her at home and would ask

[7] https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/185935369x.pdf

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/534560/Residential-Care-in-England-Sir-Martin-Narey-July-2016.pdf

[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/534560/Residential-Care-in-England-Sir-Martin-Narey-July-2016.pdf

[10] https://learning.nspcc.org.uk/media/1095/reunification-practice-framework-guidance.pdf

[11] Bullock, R., Gooch, D. and Little, M. (1998) Children Going Home: The Re-unification of Families, Aldershot, Ashgate.

[12] Farmer E. (2015) Reunification: A Research Overview, Bristol, University of Bristol.

for help to force Alice to leave.

For Alice there were no assessments undertaken that included Alice and her mother to evaluate whether reunification was possible and appropriate for the young person, what plans needed to be put in place and what support was needed. Alice said she would like to return home to live with her mother and the residential home supported this in the face of her mother's protest, leaving the predictable cycles of conflict and rejection to play out.

HOW DO WE KNOW IT'S UNDERLYING, NOT A ONE-OFF?

Research since the mid-1990s has noted the strong tendency of care leavers wanting to reconnect with their birth families, with many wanting to live with their families when they leave care[13] [14]. Similarly, it has been standard to underline the importance of social workers and leaving care workers being proactive in exploring family relationships when pathway planning, in order to manage young people's expectations and prepare them for renewed or increased contact e.g. Right2BCared4 Pilots[15].

Yet 'life story' and other approaches and tools to support social workers and foster carers to help children create their family histories and a sense of belonging are arguably not designed for the kind of complex relationship and compound feelings of rejection that Alice had with her mother[16]. Similarly, there do not seem to be any practice tools dedicated to working with young people as part of leaving care or about their likely reconnection with their birthparents, siblings and families, and none specifically designed for the most vulnerable young people, who are often those leaving children's homes.

Recent innovation has instead focused on extending options for children leaving children's homes, for 'staying close'[17], in recognition that some want to live in accommodation close to their existing residential care, live longer within their children's home or live with a responsible adult.

A thematic review into deaths of vulnerable care-experienced young adults in Somerset identified a similar finding. When children became looked after, the focus was on supporting them with the separation from family and in some instances with termination of contact. During their adolescence, the focus of support was around future planning as opposed to revisiting the traumas in a young person's history. This left the role that the family could go on to play in the young person's adult life insufficiently recognised and the young people inadequately prepared for the renewed relationships, which were often complex and for some led to greater stress.

HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLY AFFECTED BY IT?

The research conducted as part of this SAR did not identify discussion or tools focused

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[13] Biehal, N. (2006) Reuniting looked after children with their families: A review of the research, London, National Children's Bureau.

[14] Farmer, E., Sturgess, W., O'Neill, T. and Wijedasa, D. (2011) Achieving Successful Returns from Care: What makes reunification work? London, BAAF (British Association for Adoption and Fostering, now CoramBAAF)

[15] https://repository.lboro.ac.uk/articles/Evaluation_of_the_Right2BCared4_pilots_final_report/9580175

[16] https://corambaaf.org.uk/books/life-story-work

[17] https://innovationcsc.co.uk/wp-content/uploads/2018/01/StayingClose-policy-brief.pdf

on working with children living in or leaving children's homes to address the complex relationships between them and their birthparents, in anticipation of their transition to adulthood. As stated earlier, the focus of innovations currently is on options for young people living in children's homes to 'stay close' as they transition to adulthood. This suggests that the lack of priority or tools is an England-wide issue.

SO WHAT? WHY SHOULD THE SAB AND PARTNERS CARE?

Young people whose final placement is in a children's home before leaving care are often the most vulnerable in the care system, having greater needs than those in foster care. Without adequate attention to the 'pull' of the family for these young people, they are left without any support in navigating these simultaneously highly complex and primal relationships. This risks recreating behaviours from their childhood, which may be associated with why they became looked after in the first place, at an extremely high cost to the young person involved.

FINDING 1: 'PULL' OF BIRTH FAMILY

Work with children living in or leaving children's homes 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. Without this, the Corporate parent risks leaving the child burdened with the responsibility for understanding the reasons they originally came into care. In addition, the Corporate parent effectively abandons some care-experienced young people to further crises and rejection when they do return home, compounding their trauma and escalating their distressed behaviours, including self-harm.

SUMMARY

The Children and Social Work Act 2017[18] defined for the first time in law the responsibility of corporate parents to ensure, as far as possible, secure, nurturing and positive experiences for looked-after children, young people and care leavers. It also expanded and extended support for care leavers up to the age of 25.

In order to thrive, children and young people have certain key needs that good parents generally meet. The "Corporate Parenting Principles" (DfE 2017)[19] set out seven principles that local authorities must have regard to when exercising their functions in relation to looked-after children and young people. However, these principles do not explicitly speak to addressing the place and role of their birthparents. Without sufficient priority to this vital area, even the most vulnerable care-experienced young people are left to navigate the pull of the birth family on their own. Any benefits to a young person of previous corporate care risk being undermined, with tragic personal impact on the young person themselves.

[18] https://www.legislation.gov.uk/ukpga/2017/16/contents/enacted

[19] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/683698/Applying_corporate_parenting_principles_to_looked-after_children_and_care_leavers.pdf

QUESTIONS FOR THE SAB TO CONSIDER

- [For Children's Partnerships]. What data is gathered about the support provided to children living in and leaving children's homes linked to their reestablishing relationships with their birth-mother and/or father, siblings and wider family? Is this regularly scrutinised by the Partnership?
- [For SABs] What opportunities does the SAB have to share learning and to influence the local authority's children's social care service in terms of the priority and support for reconnecting with their birth-families for vulnerable young people transitioning to adulthood?
- [For SABs] What role do adult services, including adult social care and mental health services, play in supporting young people leaving care and adult birth-parents in their relationships, as young people leave care and relationships are likely to be re-established?
- [For SABs] Does the SAB know how many adults are parents of children who are care leavers in your area?

3.2 FINDING 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. This increases the chances that the most vulnerable young people end up catapulted into adulthood, with a range of disparate and ineffective care plans across agencies that do not address the seriousness of their circumstances, with no social worker from adult social care involved and no routes for escalation to the Corporate parent, despite the desperate circumstances of their young charge.

CONTEXT

For most young people, their journey to adulthood often extends into their mid-20s[20]. It is a journey from a childhood status which is characterised by dependency to an adult status derived in part from choices, such as becoming a student, employee, householder, partner or parent[21]. In contrast to the extended transitions made by most young people, the journey to adulthood for many young care leavers is shorter, steeper and often more hazardous. It is less of a journey for many and instead has been described as "falling off a cliff" by many care-experienced young people[22]. Leaving care is not the same as leaving home. Young people who have been in care rarely have the

[20] https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(18)30022-1/fulltext

[21] https://www.who.int/maternal_child_adolescent/topics/adolescence/development/en/

[22] file:///C:/Users/janew/Downloads/Independence%20or%20cliff%20edge%20briefing.pdf

stability or support networks that most teenagers take for granted[23] [24].

There is considerable evidence that those leaving the care of the state are more likely to have poor educational outcomes, be unemployed, in contact with criminal justice processes, have poor housing, inappropriate care placements and to be homeless, as well as having impaired mental health without access to support or care[25]. The likelihood of these negative outcomes is not inevitable and is connected to the level and extent of the harm they experienced pre-care, including intra-familial abuse and neglect and extra-familial contextual threats and harm such as sexual exploitation, modern slavery, county lines and gang-related activity. The context in which they grew up is also influential, including poverty, discrimination, experience of parents with mental health concerns, parent with substance misuse difficulties and domestic abuse and/or sexual assault. Other factors include the quality and stability of the care experience, the opportunity (or not) to establish a positive and supportive alternative attachment relationship and support to understand the reasons for being in care. Alongside all these other factors, children with complex needs including disability, ASC and existing poor mental health will need more support to make the transition successfully.

The evidence base has established a clear framework for identifying those needing the most support and being most at risk of negative and costly outcomes[26]. Despite this knowledge, there is insufficient support nationally, which has led to these care-experienced young people, who are at most risk because of their circumstances, feeling marginalised, stigmatised and questioning their own self-worth. This has the potential to be a form of victim blaming causing internal self-blame (see Finding 4) whereby care-experienced young people are held responsible for their failure to negotiate this tricky process of change, rather than not having the right support, leading to an internal sense of low self-esteem and self-worth. When these same young people 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 their responsibility for themselves, Adult services see adults as adults, whereas these care-experienced young people are barely out of childhood and need to be viewed as such. Young people with supportive families and networks will have those to advocate and navigate with them and for them. Care-experienced people do not always have this.

There has been increasing recognition of the circumstances and vulnerability of care leavers, and associated increased funding arrangements, remaining with foster carers beyond 18, legislation and guidance. This means there is a framework in place for leaving care[27]. This framework[28] is clear to those in the world of provision of services to children and young people; it is less clear whether this framework is known or influential

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[23] https://www.bigissue.com/latest/study-finds-shocking-lack-support-young-people-leaving-care/

[24] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf

[2525] https://www.nao.org.uk/wp-content/uploads/2015/07/Care-leavers-transition-to-adulthood-summary.pdf

[26] https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/185935369x.pdf

[27] The statutory responsibilities of councils are set out in the Children Act 1989, including through amendments made by the Children (Leaving Care) Act 2000 and the Children and Families Act 2014.

[28] https://www.local.gov.uk/sites/default/files/documents/15.12%20Support%20for%20care%20leavers%20resource%20pack_02_1WEB.pdf

within services for adults. This creates a transitional gap. There is now growing recognition nationally that this gap exists and work is ongoing to address it[29]. This was not in place for Alice.

The planning process for leaving care starts when children are 16 and the process by which this happens is the pathway plan and assessment. This plan should be co-constructed with the care-experienced young person and their families, and any connected adults. The assessment and the plan should take account of the current and past circumstances of the care-experienced young person, weighing up: risk and resilience factors and deciding on where a young person can best be supported to live; what independent living skills need enhancing or developing; how financial support will be provided and financial literacy taught; what educational or vocational provision is necessary; how mental health needs and other co-existing individual needs will be addressed and supported; and how links with family and friends will be maintained, healed or formed. For most young people, this pathway planning is overseen by a qualified children's social worker up until they are 18. They may then be allocated to a social worker in adult services, or in some areas, such as Wandsworth, they may have a social worker responsible until they are 25. All care-experienced young people leaving care will have a PA who works with them until they are aged 25, will review the pathway plan every six months and continue the process of review of support and needs in a co-constructed way. The PA may be the children's social worker, or more likely will be another individual who is often experienced in working with young people but does not have a social work qualification.

Those care-experienced young people who leave care with the most complex needs and traumatic backgrounds are those that should have the most comprehensive and multi-faceted and coordinated care plans, with one key professional consistently overseeing them. Those with complicated and damaging attachment histories should not be required to engage with a never-ending array of different and new professionals. This can be hard to ensure, but must be part of the ongoing review of the pathway plan reviewing process, and a problem-solving approach should be adopted. The pathway plans[30] for the care-experienced with the most complex needs are likely to include many agencies and professionals and there is a danger that there are too many people in a young person's life and a myriad of care plans which are not connected nor coordinated. This can cause confusion and inconsistency. It is important that the pathway plan links all other plans together to provide one care plan for a young person, which they feel connected to and which they have some control over. Adult services placements and specialist services need to understand the part they play in the overall pathway plan. The current evidence is that this is not always so[31].

HOW DID THE FINDING MANIFEST IN THIS CASE?

At the point when the pathway planning process started for Alice, it was clear that because of the abuse and neglect she had experienced as a child and adolescent, the

[29] https://www.researchinpractice.org.uk/all/publications/2018/august/transitional-safeguarding-adolescence-to-adulthood-strategic-briefing-2018/

[30] https://www.york.ac.uk/inst/spru/pubs/pdf/supporting.pdf

[31] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/266484/Care_Leaver_Strategy.pdf

instability of her early alternative care, the instability of later attachment relationships (she spent five years in residential care with changing staff), the conflictual and rejecting relationships with her family, her deteriorating mental health and self-harm, alongside autism spectrum condition, ADHD and mild learning disability, that she needed a complex multi-agency care plan. This did not happen. There was discussion of the need for a specialist adult placement, but once Alice said she wished to return home, this was shelved. The contradiction between a recognition of her complex needs and a return home to the care of someone who had her own mental health difficulties, who had asked for Alice to come into care eight years earlier because she could not cope, was not noted.

Alice returned home with a piece of paper called a pathway plan, but with no plan for support in place. Adult mental health services had said that she did not meet the threshold for services and there was no one who advocated for this decision to be changed. Alice living with her mother ended in crisis and she moved to Newham in a crisis with no assessment of her needs and without sufficient information being shared for this placement to put in place the support she needed. The pathway plan remained in place, but did not take into account Alice's escalating needs and the many different services she was involved with.

There was a care plan for each placement – three different ones, each individual from the other. There was a treatment plan developed by the specialist alcohol services she attended and a probation plan. There were many discharge plans and approaches that emerged from Alice's many brief in-patient visits, though no real care plan of substance. These were all developed and overseen independently from each other. Alice had an ever-changing group of social workers, as well as different care staff, alcohol treatment workers, community mental health practitioners, psychologists, psychiatric staff and psychiatrists, probation staff, ambulance workers and police officers. It is impossible to work out how many professionals she came into contact with over a four-year period, but it is likely to be well into the hundreds. She did have a consistent Leaving Care Personal Assistant, but this person was on the margins. She visited Alice, but was not included, and did not include herself, in any of the many meetings that took place; this is likely because she thought this was the role of the social worker. This confusion of roles and responsibilities was not acknowledged or addressed.

The pathway planning process was unsuccessful in integrating the specialist services and support Alice was engaged in, did not prioritise the building of relationships with trusted adults who would provide consistency and address her ongoing feelings of rejection, despair and loss.

HOW DO WE KNOW IT'S UNDERLYING, NOT A ONE-OFF?

As part of the review process, we have not identified research specifically on the effectiveness of transition planning and the care advisor role for young people leaving children's homes needing a range of adult services provision and a coherent, integrated plan.

A thematic review of deaths of young vulnerable care experienced young adults in Somerset[32] indicates a similar pattern, meaning that once the young people enter Leaving Care Services, any support that was offered tended to operate individually,

[32] https://sscb.safeguardingsomerset.org.uk/wp-content/uploads/2016/08/Improving-Services-for-Care-Leavers.pdf

without evidence of joint planning and coordination. It was not yet clear at the time of writing that report to what extent attempts to provide multi-agency coordinated planning via the Pathways2Planning strategies for care leavers were beginning to be able to deliver the co-ordinated planning, intervention and support that such vulnerable young people need.

HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLY AFFECTED BY IT?

The research conducted as part of this SAR was not able to identify whether this is an England-wide issues.

The finding will potentially affect the population of children and young people living in children's homes.

SO WHAT? WHY SHOULD THE SAB AND PARTNERS CARE?

Corporate parents strive to mirror key elements of familial parenting in order that looked after children are not further disadvantaged, feel validated, loved and can reach their full potential. Like familial parents, corporate parents should not have favourites, nor love their less troubled children more nor strive for those with the most deep-rooted and compounded trauma any less. This means a realistic view is needed of the seriousness of each looked-after young person's circumstances as they transition into adulthood in order that the nature of support can be tailored appropriately. Minimising the premature deaths of care leavers depends on it.

FINDING 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. This increases the chances that the most vulnerable young people end up catapulted into adulthood, with a range of disparate and ineffective care plans across agencies that do not address the seriousness of their circumstances, with no social worker from adult social care involved and no routes for escalation to the Corporate parent, despite the desperate circumstances of their young charge.

SUMMARY

Corporate parenting responsibilities extend to all children who have been looked after by the local authority and extend to support those children into adulthood and into adult services. Yet this finding draws attention to the ineffectiveness of mechanisms designed to achieve those goals for the very young people who need them most. Without a more tailored strategy and concerted effort for providing support for this small but very high-risk cohort, the chances increase that they are effectively abandoned.

QUESTIONS FOR THE SAB TO CONSIDER

- [For Children's Partnerships] How much is known about the effectiveness of transition planning and support for young people leaving care with complex needs, requiring a range of adult services, often placed out of area?
- Is there further scope to join up leaving care roles and mechanisms in adult services to support practitioners working with complex cases where the risks to the person are high and not easily managed, such as High-Risk Panels or Vulnerable Adult Risk Management Panels (VARMs)?
- What are the escalation routes from leaving care workers or adult services professionals, back to the corporate parents for cases where a young care leaver is repeatedly self-harming and telling practitioners they want to kill themselves? Are these routes adequately publicised?
- Is the SAB aware of the extent to which different adult services agencies think about young care-experienced people being in a process of transition toward adulthood, or adjust their engagement accordingly? What are the known barriers?
- Does the SAB collect data about young adults in transition that would provide indicators when the system is failing them?
- Is there a role for the London Safeguarding Children's Partnership, given the likelihood of the most vulnerable care leavers crossing local authority boundaries?

3.3 FINDING 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 parental neglect, sexual abuse, sexual exploitation and re-abuse created by crises-driven responses by services.

CONTEXT

Autism and co-occurring psychiatric disorder

The Royal College of Psychiatry has recently published a report on the psychiatric management of autism (January 2020[33]) from which the information below is drawn.

[33] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_20.pdf?sfvrsn=85af7fbc_2

Autism is one of a range of neurodevelopmental conditions ranging from specific learning disabilities (e.g. in language, dyslexia or dyscalculia) to more complex syndromes that include ADHD and developmental coordination disorder (DCD). Autism is associated with these other conditions, ADHD being present in 30% of autistic children (as against 4% in the general population). The elements that combine to give a condition are common to several conditions rather than being specific to one. A categorical diagnosis provides a caricature of someone whose complex mix of skills and difficulties requires a broader, more descriptive diagnostic assessment.

Autistic people are at greater risk of co-occurring psychiatric disorder (especially anxiety and depression). Therefore, although autism is present in about 1% of the general population, it is encountered in 3-5% of mental health service users, its presentation and management being affected by their co-occurring disorders. 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. Autism is over-represented among individuals presenting with eating disorder and also with substance abuse.

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 the usual ones such as depression, isolation and unemployment.

The presence of autism requires a multidisciplinary approach including, for example, psychology, speech therapy and occupational therapy. In addition, and subject to the agreement of the autistic person, families and carers need to be included. The management of autism itself is chiefly about the provision of the education, training and social support/care required to improve the person's ability to function in the everyday world. The psychiatrist and their team need to work collaboratively with these services, potentially wide ranging but very uneven in their provision.

Health's remit is limited in the main to the diagnosis of autism and the management of co-occurring psychiatric disorder. The latter is often long-term and the population is one in which many find it difficult to access services: ill-served by unfamiliar staff and time-limited case management, they require the infrastructure appropriate to chronic conditions. It is essential that the mental health team knits into the wider, multiagency network in which the substantial part is taken by other services, such as education, social services and the voluntary and independent sectors.

Whatever form the service takes, it is essential that there is adequate psychiatric input. Not all individuals will be seen by a psychiatrist but, if they are, they should have access to the psychiatrist's core skills:

- Diagnosis – particularly where the presentation is complex or involves a co-occurring disorder
- The assessment of certain forms of risk
- The recognition and management of co-occurring conditions
- The provision of legal opinion to the courts, both civil and criminal
- The assessment and management of patients under the various legislations

Personality disorder

There has long been concern that personality disorder was under-recognised as a

serious psychiatric problem[34] [35]. These disorders were seen as a difficult area of practice with limited hope of therapeutic success[36]. Service users were often excluded from treatment and their emotional and mental distress minimised. This is a serious issue because it is known that 1 in 10 people have a diagnosable personality disorder[37], which often emerges in adolescence and without treatment is likely to become severe and enduring across the life course. There is also an increased risk of suicide and in the recent National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), personality disorder was found to be the diagnostic category with the highest risk in women.

There has been considerable change over the last 20 years with pockets of excellent practice across the UK, clear guidance from NICE[38], which outlines the quality standards for the improvement of care and recommends that psychological interventions are made widely available, with appropriate patient involvement in choosing the type, intensity and duration of therapies. There is now also an evidence base regarding effective psychological treatments. Despite these improvements, the evidence from research, professionals and experts by experience (those living with the diagnosis of personality disorder) suggests there is progress to be made. As Norman Lamb put it in the 2018 Consensus statement, People with complex mental health difficulties who are diagnosed with a Personality Disorder[39]: "*There has been some encouraging progress over the last few years, with mental health gradually brought out of the shadows and more people accessing treatment. But I am still horrified at the scandalous neglect and exclusion of those given a diagnosis of 'personality disorder' . "The disadvantages they face – not just in the NHS, but in wider society – are clear. Lower life expectancy, inadequate access to treatment, barriers to employment, and a lack of awareness in society. This is especially unjust when we know what approaches are effective in supporting people to live more fulfilling lives".*

Evidence suggests 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 despite being frequent users of mental health services, there is often no clear pathway for patients to access effective treatments.

Research suggests this high usage of mental health services by people who have characteristics or a diagnosis of borderline personality disorder can lead to difficulties in relationships between staff and patient, particularly if patients exhibit behaviour that challenges and there is a co-morbidity with alcohol and/or drug use. Currently, co-morbid mental health diagnoses such as anxiety, depression and substance misuse complicate treatment pathways. Although these diagnoses can open the doors to

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[34] https://www.cambridge.org/core/journals/psychiatric-bulletin/article/personality-disorder-no-longer-a-diagnosis-of-exclusion/F09D0A905B444F52430D577C37A17856/core-reader

[35] https://www.bmj.com/bmj/section-pdf/743078?path=/bmj/347/7924/Clinical_Review.full.pdf

[36] https://www.bmj.com/bmj/section-pdf/743078?path=/bmj/347/7924/Clinical_Review.full.pdf

[37] https://www.time-to-change.org.uk/category/blog/personality-disorders

[38] https://www.nice.org.uk/guidance/cg78

[39] Lamb N, Sibbald S & Stirzacker A (2018) "Shining lights in dark corners of people's lives" The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder. Available at: https://www.mind.org.uk/media/21163353/consensus-statement-final.pdf

services, patients can feel ‘batted’ around in a cycle of referrals and unable to access therapies that could address the underlying trauma and distress. There is also emerging evidence that a combined diagnosis of emotionally unstable personality disorder and autistic spectrum condition brings additional risks, complexity and severity of symptoms.

The nature of personality disorder is that those who experience it have enduring emotional and cognitive difficulties which affect the way an individual relates to others or understands her/himself[40]. This pattern of behaviour is pervasive and occurs across a broad range of social and personal situations. This means that continuity and stability of care is critical. Preventing, rather than responding to, crises can be achieved by having a consistent approach and building a trusting relationship between staff and patients, ensuring the development of clear crisis planning and facilities, and avoiding in-patient admission and the use of the Mental Health Act where possible.

There has been controversy about a diagnosis of borderline personality disorder, with many experts by experience and professionals seeing it as stigmatising and not reflective of the trauma and abuse that frequently underlines the development of the difficulties that form the diagnosis. Other groups see a diagnosis as a gateway to appropriate services and an acknowledgement of their pain and distress. A diagnosis is, however, insufficient in itself. The effective response to personality disorder requires a comprehensive assessment and a conclusion about the level of concerns, from mild, to moderate, to severe. This assessment must lead to a psychological formulation which takes account of an individual’s social circumstances, life events and the sense they make of them. It is also critical for those with borderline personality concerns that there is a focus on co-existing issues of ADHD, ASC and attachment difficulties[41]. This should lead to a therapeutic response and care plan. This is highlighted in the Royal College of Psychiatry position statement on services for people diagnosable with personality disorder: “Good care should be guided by a co-constructed psycho-social formulation which gives patients an experience of being understood”.

Additionally, this position statement makes clear that the management and treatment approach for those with severe disorders should be carried out by a team with close and frequent contact, able to implement a consistent and coherent approach with an emphasis on stability of relationships. This team will need to be supported to manage their own response to the emotional distress exhibited, which is often characterised by self-harm, suicidal ideation, aggression, anger and hopelessness.

HOW DID THE FINDING MANIFEST IN THIS CASE?

Alice was diagnosed with autism at an early age, and it was known that this concern co-occurred with ADHD and a mild learning disability. In her early teens, she was assessed as having a likely emerging personality disorder and was provided with support through individual psychological support. During this time a formulation emerged which linked her difficulties to her experience of abuse and neglect, her rejection by her family and her care experiences. The treatment response helped her to connect her self-harming

[40] https://www.rethink.org/advice-and-information/about-mental-illness/learn-more-about-conditions/borderline-personality-disorder/?gclid=EAIaIQobChMI74Tor8HS7AIVQuDtCh1IywXTEAAYASAAEgLPCvD_BwE

[41] https://www.researchgate.net/profile/Goeran_Ryden/publication/228478050_Borderline_personality_disorder_and_Autism_Spectrum_Disorder_in_females_-_A_cross-sectional_study/links/0c960519dc1328610a000000/Borderline-personality-disorder-and-Autism-Spectrum-Disorder-in-females-A-cross-sectional-study.pdf

behaviour and alcohol misuse to her ongoing and unmanaged distress. Somehow, this clear understanding of her needs did not translate into any specialist psychiatric input when she turned 18 and was assessed as not meeting the threshold for adult mental health services.

Alice moved to Placement 1 without any specialist support for her co-occurring conditions of personality disorder and autism. She yoyo-ed in and out of a number of psychiatric hospitals over a two-and-a half year period, with debate about whether she did or did not have an underlying mental health disorder which was treatable with specialist therapeutic input. This left her with no specialist input in the face of an increasingly deteriorating situation, being cared for by staff whose role was to promote independence, not to help with mental health issues. It is unsurprising that these placements were unsuccessful.

In March 2017 Alice attempted suicide and was found close to death; she spent eight weeks in intensive care and then transferred to Newham Centre for Mental Health. She was to remain as an in-patient for 14 weeks. During this time, she received intensive therapeutic input including from a clinical psychologist with whom she built a significant therapeutic relationship. The team recognised the complexity of Alice's needs and how hard it was to support her because of the level of her distress.

Alice returned to Placement 3 with time-limited psychology and Occupational Therapy input. She had refused to meet with the autism consultant or engage with the learning disability team. There was a plan for Placement 3 staff to help Alice manage her emotional regulation, but without any specialist psychological input. Alice had moved areas and now fell under a new psychiatric service. There was no case transfer meeting and quickly the familiar pattern of crisis incidents with Alice misusing alcohol, self-harming and moving between placement and hospital emerged.

Despite this, she stopped receiving any specialist input in the community and the placement staff were left trying to support her complex needs. The focus became about healthy eating, attending the gym and volunteering at a local animal centre. There appears to have been a complete mismatch between this ambition for her and the reality of her circumstances. She would have two further in-patient stays and after a short period of time would return to placement, with no specialist input. Although on her last in-patient stay there were a number of assessments because of the seriousness of her needs and circumstances, she was discharged back to Placement 3(a) on waiting lists for specialist treatment. Once again, she had no specialist input and despite signaling over a two-week period that she was struggling, this did not change.

HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLY AFFECTED BY IT?

Within this review it has not been possible to establish a local evidence base, but there is a wealth of evidence regarding the current inadequacies of the national response to young people with a diagnosable personality disorder, which is severe and enduring, and co-exists with other vulnerabilities such as ASC, ADHD and early trauma caused by poor attachments, abuse and neglect. Norman Lamb described the situation in 2018 as 'scandalous neglect'.

SO WHAT? WHY SHOULD THE SAB AND PARTNERS CARE?

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 horrendous Catch-22 whereby their complex needs go unresolved and unaddressed, leading to changes in placement and relationships (with no plan for scaffolding or linking them together), causing more crises and more complexity. This is not cost-effective for commissioners and the human cost for the person could not be higher. There is also an increased risk of suicide and in the recent NCISH personality disorder was found to be the diagnostic category with the highest risk in women.

FINDING 3: CLINICAL OWNERSHIP, PSYCHOLOGICAL FORMULATIONS AND THEREPEUTIC 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 parental neglect, sexual abuse, sexual exploitation and re-abuse created by crises-driven responses by services.

SUMMARY

The concept of 'requisite variety' highlights that a system must have available a variety of responses that is as great as the variety of circumstances it confronts[42]. The job of a shoe shop assistant may be made easier by having available only two styles of shoe, but it is unlikely to meet the needs of its customers. This finding highlights notable gaps in mental health services needed for young people/adults with diagnoses of autism and co-occurring conditions, including emerging personality disorder, for whom the risk of suicide is substantially greater than for the general population, particularly for women and in the presence of ADHD. This case has drawn attention to significant delays in getting a substantive response, despite cycles of crisis contact over years; and the poignant tragedy of the input, when it did occur, being time-limited, when consistency of relationship, continuity of care and regularity of support is needed. Without the required services commissioned, supported living providers end up valiantly attempting but ultimately failing to provide support for these most vulnerable young people/adults.

QUESTIONS FOR THE SAB TO CONSIDER

- [For both Children's Partnerships and SABs] How much is known about the nature and effectiveness of mental health treatment options for young people and young adults with diagnoses of autism and co-occurring conditions, including possible emerging personality disorder?

[42] The Munro Review of Child Protection: Final Report A child-centred system DfE 2011 **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf**

- Do Partnerships/SABs receive data to scrutinise levels of 'revolving door' scenarios for young people/adults and/or rates of taking their own lives?
- To what extent is the introduction of NHS-led Provider Collaboratives, with its focus on a shift in the approach to commissioning specialised mental health, learning disability and autism services, going to address gaps in services for the cohort of young people with emerging personality disorder?
- What opportunities do SABs have for raising the profile of the commissioning gap in services for this cohort, to provide options between a secure mental health hospital and supported living?
- Is there adequate clarity about who is responsible when there is no service to meet identified needs and how escalation should work?

3.4 FINDING 4: VICTIM BLAMING

The absence of functioning local authority leaving care processes for complex cases (Finding 2) and/or effective mental health interventions (Finding 3) creates fertile ground for routine victim blaming that sees young women 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 women concerned, when a trauma-informed approach that acknowledges the history of parental neglect, sexual abuse, sexual exploitation and re-abuse created by crises-driven responses by services is more appropriate. It creates the conditions where awful self-harm and increasingly determined efforts by young women to take their own lives become normalised.

CONTEXT

Victim blaming is a concept that describes the process whereby blame for a crime is transferred from the perpetrator of that crime onto the victim (Ryan 1971[43]). Research around sexual violence, rape and sexual exploitation[44] has found that victims are particularly vulnerable to being blamed for the harm they experienced with a focus on what they did, what they wore and where they went, as well as a focus on attitudinal issues and their internal characteristics. Research suggests that this leads to behavioural self-blame, where the victim thinks over, sometimes obsessively, their own behaviour or actions as the cause of the abuse. Characterological self-blame leads victims to think there is something wrong inside them that caused the abuse to happen. These responses caused by victim blaming are harmful, linked to poor self-esteem and depression. They also mean that the perpetrators of abuse are not held responsible for their actions. These are serious concerns. Domestic abuse also follows the same pattern with evidence that those who are victims are held responsible for what happens to them and for not keeping themselves or others safe.

[43] Ryan, W. (1971) Blaming the Victim, Penguin Random house

[44] Taylor, Dr Jessica. Why Women Are Blamed for Everything: Exploring Victim-Blaming of Women Subjected to Violence and Trauma (p. 396). Little, Brown Book Group. Kindle Edition.

There is also growing evidence that victim blaming in the context of childhood abuse and neglect is a critical issue. Research and serious case reviews have highlighted the extent to which adults who harm children, who are often parents or parent figures, hold the child responsible for the harm they experience. This is characterised by adults describing children as difficult, damaged, hard to manage, violent themselves or too hard to look after. In adolescence, this victim blaming can be seen in the context of child sexual exploitation (CSE)[45] where victims have been described as "*putting themselves at risk*" through "*their risky behaviour*"[46] such as drug and alcohol misuse and running away. These young people have been made to feel a sense of behavioural self-blame and characterological self-blame[47]. The harm happened because of who they are and what they did. This is harmful, ineffective and prevents young people from seeking help or being protected.

The concept of victim blaming in the context of mental health services has focused on issues of stigma and discrimination[48]. There is considerable evidence that there is strong social stigma associated with mental ill health and people with mental health problems experience discrimination in all aspects of their life including educational opportunities, employment, relationships, friendships and access to social activities. All these are aspects of life we all take for granted and which are essential for a sense of self and of well-being. This stigma or discrimination also takes the form of dismissive attitudes by professionals, family members and the public by having their mental health concerns dismissed – "it is just attention seeking behaviour", or minimised – "everyone experiences depression", or as a choice which an adult can choose to "snap out of" or as a failing as a person – "you could get better if you tried harder". These stigmatising, and victim-blaming responses exacerbate mental health issues and prevent people from seeking help[49].

These different aspects of victim blaming are connected across the developmental life course and are cumulative in the harm they create. For some individuals their experiences start in childhood, move into adolescence and get confirmed in the context of services for mental health, substances misuse, criminal justice and sexual assault.

HOW DID THE FINDING MANIFEST IN THIS CASE?

Alice experienced victim blaming across her whole life. Alice came into care at age 10 because of neglect and poor care by her mother, caused by her mother's mental health difficulties and complex family circumstances. The records at the time reported that she was in care because her mother could not manage her difficult behaviour. This put blame and responsibility onto a child. Alice was well aware of this description and would repeat it to the many professionals she came into contact with. This description was then written in assessment and records across Alice's life and became a truth which was not discussed or challenged.

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[45] https://www.csepoliceandprevention.org.uk/sites/default/files/Guidance%20App%20Language%20Toolkit.pdf

[46] https://safeguardinghub.co.uk/victim-blaming-language/

[47] Taylor, Dr Jessica. Why Women Are Blamed for Everything: Exploring Victim-Blaming of Women Subjected to Violence and Trauma (p. 396). Little, Brown Book Group. Kindle Edition

[48] https://www.mentalhealth.org.uk/a-to-z/s/stigma-and-discrimination

[49] https://www.mind.org.uk/information-support/types-of-mental-health-problems/mental-health-problems-introduction/stigma-misconceptions/

Alice moved to a children's home when she was 13 and during this time she made allegations of sexual exploitation. Professionals took this concern seriously but held Alice responsible for the abuse. She was told she was making poor choices in her relationships and was offered an educational programme to choose better relationships and to learn to keep herself safe. The children's home increased their surveillance of her because they said she was "putting herself at risk" by running away and misusing drugs and alcohol. The implications being that the harm was her fault.

When Alice moved to Placement 1 aged just 19, her self-harming behaviours and alcohol misuse escalated – a demonstration of her distress. She talked about being sexually assaulted whilst under the influence of alcohol to her Leaving Care worker, who encouraged her to work hard to reduce her alcohol intake. She was not encouraged to go to the police. Other professionals had concerns that Alice was "sex working" rather than being sexually exploited at this time. The focus was on Alice's alcohol misuse, not the actions of those who took advantage of it.

It is of particular concern that Alice's self-harm and suicidal behaviour was at times seen as "attention seeking" and in her own control. She was told in a meeting in 2015 that she could control the self-harm and in 2017, a member of staff said that if she continued to self-harm she would lose her placement and she needed to stop it. Alice made it clear that she self-harmed and attempted suicide to try to manage feelings of hopelessness, depression and despair. Telling her she could stop was to invalidate those feelings; a perfect example of victim blaming which probably took her back to the helplessness of childhood and coming into care.

HOW DO WE KNOW IT'S UNDERLYING, NOT A ONE-OFF?

As part of this review process, we have not been able to fully explore the extent to which victim blaming is a known issue in professional practice locally. The review team certainly recognised that this was a dynamic they noticed in practice across the continuum from working with and for children, young people and adults. Research suggests that victim blaming is an issue in the mass media, law, education, religion and cultural norms[50]. Waltham Forest Youth Independent Advisory Group recognised that victim blaming was an important issue and have facilitated young people to make a video highlighting victim blaming attitudes amongst professionals and highlighting the negative impact on children's and young people's lives[51]. The Children's Society, in partnership with Victim Support and the National Police Chiefs' Council, have produced guidance regarding victim blaming language in the context of child sexual exploitation, recognition of its widespread use and its harm to children, young people and adults[52]. There is considerable evidence that a form of victim blaming, characterised by stigma, is having a widespread impact on children, young people and adults with mental health concerns[53] and that this is particularly acute for those with a diagnosable personality disorder[54]. There is also evidence that this is an issue for adults and children with

[50] Logically I know I am not to blame, but I still feel to blame': Exploring and measuring the victim blaming and self-blame of women who have been subjected to sexual violence: DOI: 10.13140/RG.2.2.12986.95682

[51] https://www.nwgnetwork.org/resource/victim-blaming-language/

[52] https://www.csepoliceandprevention.org.uk/sites/default/files/Guidance%20App%20Language%20Toolkit.pdf

[53] https://www.time-to-change.org.uk/node/103150

[54] https://govconnect.org.uk/images/events/t4-mental-health-2019/14-20-alex-stirzaker.pdf

ASC[55].

SO WHAT? WHY SHOULD THE SAB AND PARTNERS CARE?

Victim blaming by professionals runs contrary to the legislative[56] ethos of child-centred practice in services for children and young people. It also runs contrary to person-centred approaches to working with adults[57] and the making safeguarding personal approach[58]. This lack of a relational and empathetic approach to meeting needs undermines safety and makes it harder for children and young people to engage with professionals and services, thus wasting money and undermining human potential.

FINDING 4: VICTIM BLAMING

The absence of functioning local authority leaving care processes for complex cases (Finding 2) and/or effective mental health interventions (Finding 3) creates fertile ground for routine victim blaming that sees young women 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 women concerned, when a trauma-informed approach that acknowledges the history of parental neglect, sexual abuse, sexual exploitation and re-abuse created by crises-driven responses by services is more appropriate. It creates the conditions where awful self-harm and increasingly determined efforts by young women to take their own lives become normalised.

SUMMARY

Victim blaming is antithetical to the 'helping' professions. That victim-blaming discourse is sustained for certain cohorts of people is a vital systemic weakness to be addressed. This SAR has identified some of the systemic issues that create fertile conditions for victim blaming to become normalised because viable, effective responses are not available. However, if a compassionate, relationship- and rights-based culture was thriving, we would also expect to see such victim blaming problematised and with healthy professional challenge exerted between practitioners. This review has identified that, for young women with unregulated emotional behaviour and behaviours that challenge linked to autism and personality disorder, victim blaming remains widely unconscious, albeit unintentional. This creates organisational risks that strategically, areas of unmet need are not recognised. It exacerbates risks for extremely vulnerable individuals, pushed further away from being seen and having a sense that they have been understood.

QUESTIONS FOR THE SAB TO CONSIDER

[55] https://www.cpft.nhs.uk/Latest-news/Basic-human-rights-of-those-with-autism-are-not-being-met.htm

[56] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

[57] https://www.scie.org.uk/prevention/choice/person-centred-care

[58] https://www.local.gov.uk/sites/default/files/documents/Making%20Safeguarding%20Personal%20-%20Guide%202014.pdf

- How can the SAB and partners support critical reflection across partners on discourses that are victim-blaming, albeit unintentionally, beyond scenarios of child sexual exploitation?
- How might highlighting normalised victim blaming of young people with emerging or diagnosed personality disorder help further progress in shifting victim-blaming discourses around child sexual exploitation?
- Is appropriate support in place for practitioners who engage with young people with unregulated emotional behavior, including violence to others and property, drug and alcohol misuse and concerted self-harm, in order that their compassion for people can be sustained?
- To what extent are partners using practitioner frustration as an indication of systemic issues of service failure for particular cohorts needing urgent attention?
- How would the SAB and partners know if practice had improved in this area?

3.5 FINDING 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 a continuity over time. This risks deepening 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 and includes the legacy of people who liked and cared about them (akin to life story work), 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 (e.g. – Lifelong Links type work; mentor).

CONTEXT

Elaine James, Rob Mitchell and Hannah Morgan describe "the highly rigid care management environment where your core function is to broker care packages and move the person on to the next setting as quickly as possible" [2], and the language we use shines a spotlight on this sorting office approach. We 'place', 'transfer', 'discharge', 'admit' and 'refer' people in to 'care'.[59]

Housing is about more than shelter. We must feel connected to feel secure"[60].

If we are genuinely going to shift from placing people 'in care' to caring about people living in the place they call home, we need to take time (and have time) to listen hard, observe and be genuinely curious to find out what home really means for the people

[59] Social work, cats and rocket science, Elaine James, Rob Mitchell and Hannah Morgan, Jessica Kingsley, 2019

[60] Many rough sleepers…, Darren McGarvey, Twitter, 2018

we're working with – then support people to find, remain in or return to a place that feels like home[61].

The weight of evidence, from all quarters, convinces us that the relationships with people who care for and about children are the golden thread in children's lives, and that the quality of a child's relationships is the lens through which we should view what we do and plan to do[62].

In common with most of the findings in this review, this finding is about how concerns and needs arising from childhood traumatic experiences influence a successful, secure and relationship-building transition to adulthood. This requires ensuring that young people have a place they can call home and feel at home; stability in relationships, places and attachments as the foundation for the adults we become.

Research has shown how the brain is impacted when in their early years, children seek connections with their caregivers and those are either rebuffed or treated with violence or hostility, and they give up through fear or rejection or to avoid further disappointment[63]. This is often described as living constantly either in shark-infested waters or on a desert island[64]. These children's brains and behaviours have to adapt to those circumstances, leaving them either constantly hypervigilant to threat from others, even when none exists, or closed down from the world[65]. This leaves children with poor early attachments and without the necessary foundation for a secure and positive sense of self. There is evidence that these children can therefore struggle to know how to build appropriate relationships; and sadly, other adults and children can recognise this and be reluctant to form connections with these children and young people. It is noticeable that children who have early relational and developmental trauma go through a process of social thinning[66], their connections and networks shrink as they move through early trauma, to out-of-home care and leaving care. This is in contrast to many other young people, whose social contacts expand and grow as they mature and develop. It is unsurprising that care-experienced young people/care leavers feel lonely, isolated, rejected and unloved[67]. It is the professional's task to knit all connections together for children, young people and young adults on their journey to adulthood. This requires a conscious effort, because professionals come and go, the number of professionals needed to engage with grows and changes and the lack of family means that this history or memory is not kept.

When children and young people come into the "care of the state", there is a danger that they lose contact and connection with their siblings, parents and wider family – and importantly their history and their connections of care. This is the first layer of instability that they are likely to experience. They also may not understand why they needed to

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[61] https://rewritingsocialcare.blog/2020/10/10/home/

[62] https://www.adoptionuk.org/Handlers/Download.ashx?IDMF=85fe35ed-2c73-4ba8-83e5-5396d34969a7

[63] https://uktraumacouncil.org/wp-content/uploads/2020/09/CHILDHOOD-TRAUMA-AND-THE-BRAIN-SinglePages.pdf

[64] Treisman, K (2016) **Working with Relational and Developmental Trauma in Children and Adolescents; Routledge**

[65] https://uktraumacouncil.org/wp-content/uploads/2020/09/CHILDHOOD-TRAUMA-AND-THE-BRAIN-SinglePages.pdf

[66] https://uktraumacouncil.org/wp-content/uploads/2020/09/CHILDHOOD-TRAUMA-AND-THE-BRAIN-SinglePages.pdf

[67] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf

leave their family, community, school and friendship networks and research suggests that without a sensitive exploration of this, children can see themselves both to blame for what happened to them and therefore unlovable. Children also feel a sense of rejection and abandonment which will stay with them unless actively addressed. This is why life story work is essential[68] and approaches such as Family Rights Group's Lifelong Links work on building connections. The second layer of instability is children moving from one home to another and the level of instability in place and relationships. The more moves children experience, the more feelings of rejection they can have. The third layer of instability is the number of professionals in children's lives, that change constantly, unexpectedly and often without an opportunity to say goodbye or understand where people have gone.

It should be the task of care planning and leaving care pathway plans to recognise these instabilities and to address them, with the priority being consistency in care, coordinated care plans, a single point of contact and work on helping care-experienced people build positive, long-lasting relationships outside of a professional network. Creating stability is critical, as is addressing feelings of rejection, abandonment and loneliness which appear to travel with children and young people into adulthood and often across the life course.

When care-experienced young people move into adult placements, creating stability, continuity and building a network of relationships is critical. This should be a central part of the care and support care plan which should be in place when someone reaches the age of 18. This should be reviewed annually and is an opportunity to address these issues along with a range of other needs. It is important that in the transition process from childhood to adulthood, the adult [i]care and support assessment draws on important information from childhood concerns and incorporates this early relational trauma into the care plan. This does not always happen.

HOW DID THE FINDING MANIFEST IN THIS CASE?

Alice came into care at a young age (10) and initially experienced instability in her placements, moving between foster care, short-break care and her mother's care. When she was 13, she moved to a residential unit for young people with learning disabilities. During this time, she experienced instability in attachments, with a rota of changing staff. Alice moved between the residential unit, her mother's home and when she would regularly run away, her destination was not always known. Alice left the residential unit where she had lived for five years without any connections being maintained and with no tangible evidence of her time there. There was no life story book, as far as we can tell, no memories, no pictures, no stories. There was no one to remind her of the fun times, the difficult times, how she had grown and developed. There would be no looking back at video footage, letters, visits. She had lost this history. Her only history was with her mother.

Alice moved to Placement 1 without any connection with her past. She would stay there for a period of over two years and there is evidence that she formed positive relationships with staff. They were part of her community and holders of her memories. When she was asked to leave, there was no handover, staff did not visit her at the new setting, they did not share their understanding of her, their positive stories, their understanding of who she was. This was another new start with new relationships and

[68] https://learning.nspcc.org.uk/services-children-families/life-story-work

no history or memory.

In Placement 2 Alice had to start again, forming new relationships without any connection to the past. She stayed for 12 weeks and staff liked her. She was told she would be moving again whilst in hospital. Despite staff having fond memories of her, those memories did not travel with her. She never saw any of these people again. There were no photos and no memories. No connecting biographical details, which might have made her feel part of something, with relationships and connections.

The move to Placement 3 happened from hospital five months after leaving Placement 2. There was considerable discussion about helping Alice transition from a hospital admission to a new placement, but the link with Placement 2, the people, the things she did there, was lost. She had to start again, starting new relationships, again without any shared collective memory of her last nine years or her family past. No professional had a picture of that past, nor noticed its absence.

Alice experienced deep feelings of rejection and abandonment throughout her young life. She talked of being lonely and alone. The many crises and moves added to these feelings, but it should have been possible to keep connections, build a story of her life, share memories, maintain relationships, build new relationships and see the routine collection of biographical detail as a critical part of helping Alice understand her connections.

HOW DO WE KNOW IT'S UNDERLYING, NOT A ONE-OFF?

There is considerable evidence that children and young people who come into the care of the state are at risk of losing contact with their parents, siblings, wider family and community. The longer they are in local authority care the more connections they lose[69] and the more likely they are to report feelings of loneliness and isolation[70] [71]. The care inquiry[72] into how to improve the wellbeing and outcomes for children who are either in care or have left it concluded that there is a need for a care system that places at its heart the quality and continuity of relationships and that promotes and enhances the ability of those who are important to children and young people, including care givers and others, to provide the care and support they need. Relationships for children in care are important for many reasons and they serve a number of purposes. Many children and young people, of different ages, need to build security through attachments, to develop 'felt security' and to build resilience. All need to understand their past and to build confidence in their ability to sustain relationships in the future. They need to be enabled to maintain links with the past and connect together their life story. Yet there is inconsistency in life story work, and a lack of a framework within adult services and

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[69] https://www.basw.co.uk/adoption-enquiry/docs/The%20Role%20of%20the%20Social%20Worker%20in%20Adoption%20Enquiry.pdf

[70] https://publications.parliament.uk/pa/cm201012/cmselect/cmeduc/744/744ii.pdf

[71] https://www.amazon.co.uk/Leavers-Experiences-Transitioning-being-Independent/dp/1717765351/ref=pd_lpo_14_t_1/261-8652483-1021334?_encoding=UTF8&pd_rd_i=1717765351&pd_rd_r=43e5e586-a8f3-4b42-aa76-7dd5d95bf9ad&pd_rd_w=PlzQH&pd_rd_wg=zfPBI&pf_rd_p=7b8e3b03-1439-4489-abd4-4a138cf4eca6&pf_rd_r=TRQJAZ023EFS51Q2H3RP&psc=1&refRID=TRQJAZ023EFS51Q2H3RP

[72] Making not Breaking: building relationships for our most vulnerable children: https://www.adoptionuk.org/Handlers/Download.ashx?IDMF=85fe35ed-2c73-4ba8-83e5-5396d34969a7

placements to continue making connections from childhood.

SO WHAT? WHY SHOULD THE SAB AND PARTNERS CARE?

Young people leaving care are amongst the most vulnerable in our society. They are at increased risk of poor mental health, loneliness, isolation, poverty, criminality and homelessness. The care inquiry talked about the “golden thread” of relationships, enabling young people to understand their past and build relationships over time. If professionals do not actively ensure that continuity is maintained for these young people, their vulnerability increases and their contact with services becomes crisis-led and unstable. This makes it harder for young people to engage with services and the never-ending number of adults they are meant to make brief relationships with. This is an unhelpful and damaging cycle. Keeping connections with positive relationships and supporting a narrative of a young person’s life and history can create continuity, stability and care in turbulent times.

FINDING 5: CREATING STABLITY & 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 a continuity over time. This risks deepening 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 and includes the legacy of people who liked and cared about them (akin to life story work), 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 (e.g. – Lifelong Links type work; mentor).

SUMMARY

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 a continuity over time. This risks deepening 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 and includes the legacy of people who liked and cared about them (akin to life story work), 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 (e.g. – Lifelong Links type work; mentor).

QUESTIONS FOR THE SAB TO CONSIDER

- Are there practices from fostering and adoption services that could be drawn on to sustain a personal life narrative for care leavers who experience a pattern of reactive, crisis-led responses that see them with frequent placement changes?
- Is there a role for SABs in bringing together relevant leaving care services/roles and relevant adult service providers, to help understand the significance of this continuing life story work for young people transitioning to adulthood against a significant history of abuse and neglect and relative roles in achieving it?
- How would the SAB know if practice in this area had improved?

4 Conclusion

4.1.1 This review has looked at the short and sad life of Alice. Her story should remind services of the long-term impact of child abuse and neglect and the long shadow this casts for children and young people on their journey to adulthood. The five findings that have been prioritised in this review are all connected by the past influencing the present and the future. Childhood trauma needs to be addressed, parents need supporting, children need to understand why they need to be in the care of the state and the corporate parent needs to take the task of looking after children seriously. Where being in care increases vulnerability through abuse and exploitation, this needs to be addressed appropriately. Those in care need stability and the opportunity to maintain important relationships and build new ones. Once those young people are in the process of leaving the care of the state, they need appropriate planning and a recognition of their needs. The corporate parent needs to own up when it has not done a good enough job either to address the circumstances that led to the child coming into care or to change family relationships. It is far too easy for this responsibility to be left with young people. They can end up feeling that they "are damaged" rather than have been left in damaging circumstances; that they are to blame for their difficulties. The tendency for these young people to return to the family they were asked to leave, without planning to consider whether this is a good thing or how it could be made better, needs careful thought and planning. It should never just happen and professionals and services should never see it as inevitable or appropriate without thought and planning.

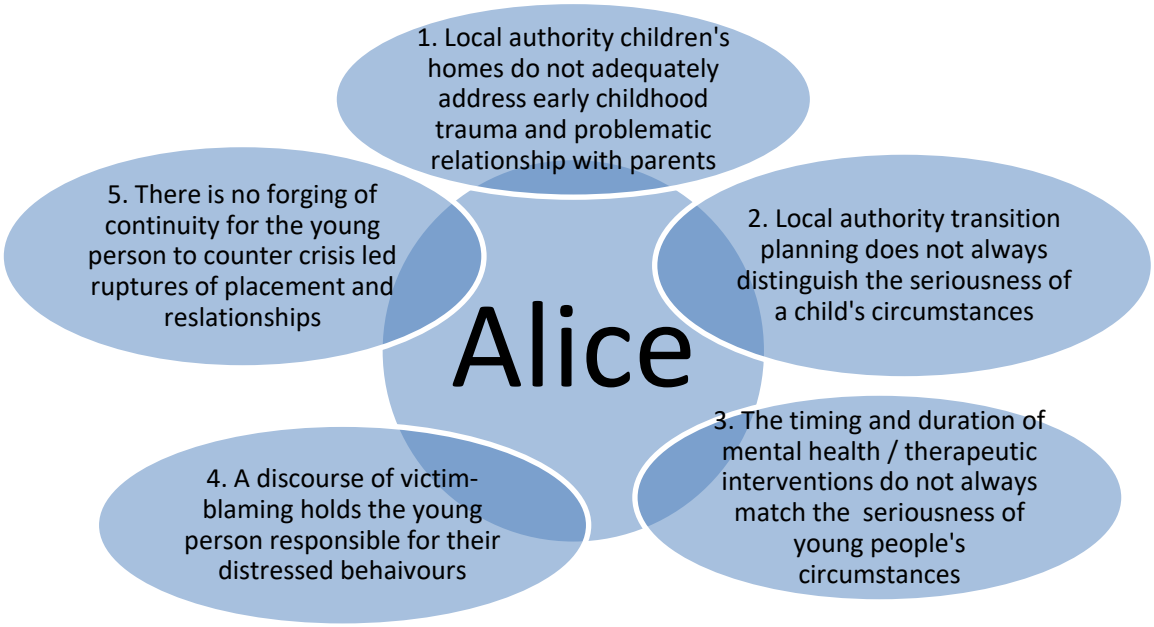
4.1.2 When young people leave care having not had their emotional and attachment needs met, and with co-occurring difficulties of alcohol and drug use and sexual and criminal exploitation, they are likely to feel a sense of anger, depression and rejection. This makes it difficult for them to feel trust in agencies and professionals. This is not surprising. Young people like Alice experience large numbers of professionals in their lives, constantly experiencing change, telling their story over and over again, increasingly meeting professionals in the context of what is going wrong for them and circumstances that seem to imply something is wrong with them – a message that can cast a long shadow. This is difficult for all the professionals who meet these young people with such long histories; these professionals start out intending to develop supportive relationships and to effect change. It is easy to forget that for these young people they have been here before and these past experiences make engagement complicated. For Alice, she felt rejection acutely and yet she ended up experiencing constant change, new people, new places, new ideas – and usually in the context of problems. She was angry, aggressive and rejecting, and this led to more rejection and change. This is a circular pattern that is difficult to address, but one that needs acknowledging and planning for.

4.1.3 If those young people who are most at risk at the point of leaving care due to their context and circumstances are not recognised and provided with appropriate services to meet their complex needs, then their overall wellbeing is likely to deteriorate. They then enter the world of adult services, which is predicated on notions of empowerment, choices and decision making; an assumption of ability to be responsible for oneself. Young people leaving care are not adults; they are on a journey to adulthood and adult services need to

recognize their role in this. It is important that adult services recognise their role in supporting those with the most complex needs who are leaving care and for whom all services have a particular responsibility. Co-occurring concerns and vulnerabilities need to be recognised and an early intervention approach to mental health difficulties for this population adopted.

4.1.4 Abuse and neglect from a child's earliest days impacts on attachments and relationships; care experiences can compound instability in relationships and social thinning. This can mean that history and biography – the golden thread through all people's lives of knowing who you are, what your history is, who you are connected to – is lost. The instability of care can exacerbate this. The crisis nature of life without appropriate support and care planning when leaving care can also exacerbate this. Being catapulted into adulthood before you have been prepared and unsurprisingly struggling can be seen as the young person's fault, that there is something wrong with them that needs fixing. This sense of wrongness can be drugs, alcohol, self-harm or homelessness. The route cause gets lost. Early damaging relationships and poor attachments are the start of the journey and cast a long shadow for young people when they are on the road to adulthood from leaving care; what they need is the ability to build and maintain everyday relationships as well as an opportunity for appropriate therapeutic relationships which can address their complex needs.

4.1.5 With this SAR we have highlighted five systemic patterns that make it less likely that young, extremely vulnerable care leavers like Alice will receive the help they need in a timescale they need. For the purposes of this SAR, we have separated them out. The aim is to make it easier for SABs and Local Children's Partnerships to consider how to address each in its own right. Ending this SAR report, we also want to underline how each systemic issue inter-relates and compounds the negative impact for the person at the centre, in this case Alice, but also other extremely vulnerable care leavers across London.



4.1.6 Redbridge SAB chose to conduct this SAR even though they had known her very briefly. In doing so, they have allowed these important systems issues to emerge for all the boroughs that had contact with her. The onus is now on all the SABs and Children's Partnership areas who had duties toward Alice to engage with these systems findings and drive forward improvements.