Risk factors in cases of known deaths of young people with experience of care: an explanatory study

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Abstract

This paper discusses the issue of suicidal behaviour among young people with experience of care, through an identification of suicidal behaviour risk indicators.

Keywords

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Introduction

Suicidal behaviour, including attempted and completed suicide and deliberate and non-deliberate self-harm, is a growing concern in Scotland today. On average two people die in Scotland every day from suicide and over 7000 people are treated in hospital each year following episodes of non-fatal deliberate self-harm (Scottish Executive, 2002). This paper discusses the issue of suicidal behaviour among young people with experience of care, through an identification of suicidal behaviour risk indicators. Although there have been rigorous studies of adolescents in general, looked after children and young people as a group have previously been neglected by research and academic discourse. The paper also highlights the need to raise awareness of the need to improve recording of information relating to suicidal behaviour in case files.

Background to the research

The Looked After and Accommodated Children Joint Planning Group (Care and Support Sub-Group) of Glasgow City Council wished to examine suicidal behaviour as a risk factor for young people with experience of care. This followed a relatively high number of fatalities among this group in Glasgow (12 young people had died between 2001 and 2004) where social workers suspected suicidal behaviour. The planning group sought to identify evidence of common indicators within the case files that may have suggested that the

young people were at risk, with a view to developing effective preventative measures for future practice, thus avoiding such a tragic loss of life.

Despite wide-ranging research on the problem of suicide and self-harm, and in the more general area of mental health in Scotland, the vast majority of research has concentrated on adults. Only recently has attention been diverted to the issue in the context of how suicide affects young people generally and why young people, and young men in particular, are at risk of suicidal behaviour.

This ever-expanding body of work explores factors indicating the risk of suicidal behaviour among young people and how to identify risk factors (Sidley, 1999; Penumbra, 2000; McConville, 2001; McNeill, Gillies and Wood, 2002; FMR Research, 2003; Fergusson et al., 2005).

Other studies address connected issues such as the effects of suicide and suicidal ideation amongst gay and bisexual young men (Hutchison et al., 2003), mental health in young people who are looked after by local authorities (Meltzer et al, 2003; Meltzer & Lader, 2004), the relationship between childhood abuse and adult self-harm and suicidal behaviour (Mina and Gallop, 1998) and the sexual exploitation of (looked after) young people (Dillane, Hill and Munro, 2005). Despite contributing to a greater understanding of the reasons for, and risks of young people engaging in self-harming behaviours, previous research has failed to address the issue of suicide and self-harm amongst young people with experience of local authority care. An analysis of the circumstances of 50 looked after children who had died in Scotland between 1997 and 2001 found 11 cases of completed suicides (Scottish Executive, 2002). Other than that there is little evidence anywhere in the literature that suggests a significant effort has been made to investigate this area.

Methodology

Leaving Care Services case files in Glasgow were analysed for twelve young people who died by suicide or undetermined intent. All of the young people in the study were aged between 16 and 22 at the time of their death, with an average age of 19. Seven of the young people were male and five were female, and all were from a White Scottish background. None of the young people were in residential child care at the time of their death, although all of them had significant experience of care. While the small, highly selective sample renders impractical any attempts at generalising about young people with experience of care, the study was still felt to be valuable by providing some indicators for areas of further research and practice. Prior to the case file analysis a literature review was conducted, from which a set of 44 Individual Risk Factors (IRFs) were identified as indicating risk of suicidal behaviour. These IRFs were aggregated into a set of eight Key Indicators (KIs), which informed the case file search.

These KIs are as follows:

- Social Factors
- Mental Health

- Social Work History
- Health
- Familial Factors
- Acute Life Crises
- Personality/Behavioural
- History (suicidal behaviour/ideation)

Information from the 12 files was gathered manually on site over a number of weeks and entered into an electronic database (*Statistical Package for the Social Sciences*) for analysis of the prevalence of risk factors. The aim of the case file analysis was to identify common risk factors that retrospectively suggested that the young people were at increased risk of engaging in suicidal behaviour. It was felt that if these could be identified, they could represent potential intervention points. It was hoped that by highlighting the potential significance of certain indicators, the awareness of social workers and other staff about the possibility of suicidal behaviour in young people would be heightened.

Findings

As previously mentioned, the findings are based on a small sample (N=12) and should not therefore be regarded as representative of all young people with experience of care. What follows is a summary of the main findings for each Key Indicator used in the case file analysis.

Social factors

None of the young people in the study was employed at the time of their deaths. Although there was evidence of previous employment in various unskilled and semi-skilled posts whilst looked after, employment occurred predominantly during periods of relative stability in the lives of the young people. Half of the young people had not completed high school, with reports of expulsions and suspensions for misdemeanors such as swearing at teachers, verbal and physical abuse of staff and teachers, and one case of extorting money from other pupils.

Two-thirds of the case files provided evidence of social relationships with networks of other young people in their files. Taken at face value one would assume this to be a positive element in the lives of the people concerned. During data collection, however, it became clear that these networks (either within or outside of placements) did not always represent positive influences and in many cases may actually have been detrimental to the improved circumstances of the young people.

Social work history

The ages at which the young people first came into care ranged from two to 16, with half of the group having their first experience of being first looked after before the age of 14.

In over half of cases, the major placement type throughout the period of care was residential school, followed by children's unit and foster care. Time spent being looked

after ranged from 17 months to 180 months. Seven of the young people were looked after for three years or under, with three young people being looked after for over 10 years in total.

Four of the young people in the study had spent time on the child protection register for episodes of parental physical abuse, with one also being the victim of sexual abuse. Most of the young people had between two and four placements during their time in care, with an average of four placements prior to their death. In terms of subsequent accommodation on leaving care, two noteworthy issues that repeatedly arose were multiple accommodations in the latter stages of being looked after and experience of homelessness. Many young people spent time in homeless or 'bed and breakfast' accommodation and in most of these cases had exhausted all available options due to evictions for anti-social behaviour or rule-breaking. In several cases social workers noted that lack of permanent accommodation was a source of stress for the young people concerned.

Perhaps the most potentially beneficial area of information sought in the files was on social work interventions. Interventions were clearly occurring but recording was limited to a brief description rather than a full record of what the social worker or young person thought of the intervention, or how successful they had been.

The types of interventions give an indication of how chaotic the lives of the young people were. The most common type of intervention addressed drug and alcohol issues, usually through residential rehabilitation programmes or counselling services. Other common interventions addressed emotional/mental health issues, accommodation issues, personality/behavioural issues, and in three cases suicide/self-harm issues. In one in 10 cases the intervention was designed to address more than just one issue and in many cases young people had experience of different types of intervention.

Familial factors

Parents were separated in seven of the 12 cases and there were four two-parent families. Half of young people had experienced childhood physical abuse within their families. This figure is higher than the figure for child protection registration, indicating the problem with using previous registrations as a standalone indicator of past abuse. Of the six young people who had been abused as a child, four had a history of self-harm or attempted suicide and three had expressed suicidal ideation.

Personality and behavioural factors

Low self-esteem/social inadequacy is one of the key personality traits associated with suicidal behaviour in young people (Koprowska & Stein, 2000) and reference to low self-esteem was made in three-quarters of the files. All but one of the young people engaged in activities that would come under the wide umbrella of 'anti-social behaviour.' These behaviours included loss of temper, furniture throwing, damage to personal property, threatening behaviour towards others, serious assault, arson, theft, attempted armed robbery, breach of the peace, mugging, drug dealing and absconding. Some young people

engaged in particular behaviours that placed them at risk such as prostitution, street begging, sleeping rough, and associating with convicted criminals.

Mental health factors

The search for issues relating to this risk indicator involved very broadly searching for signs of mental ill health, including anything from diagnosed evidence of mental illness to displaying depression, anxiety or stress. Such signs were noted in all files, with five young people receiving input from interventions designed to address emotional or mental health issues. These involved visits to the adolescent psychiatry unit, clinical psychologist, child psychologist, counselling, or hospitalisation. Some of the symptoms mentioned in the files of these young people included depression, hallucinations, hearing voices, feelings of abandonment and isolation, mood swings, and suicidal ideation. Clearly, using such a wide definition of mental ill health facilitated the identification of issues for each of the young people concerned. Without a control group to measure against it is difficult to know whether a similar list of issues would be present in young people with no experience of care.

Health factors

Only one young person had no mention of drugs or alcohol in their file. Drug use ranged from solvents, cannabis and amphetamines, to cocaine and heroin. Generally there appeared to be evidence of an escalation in use from cannabis to more dangerous Class A drugs. It also appeared that usage increased in the period prior to the young persons' death. The most common scenario was for both drugs *and* alcohol to be mentioned. Two-thirds of young people were involved in some form of risky sexual health behaviour, ranging from unprotected sex to potentially more dangerous activities such as prostitution, as found in seven of the 12 young people. More males than females were involved in prostitution (four males as compared to three females).

Acute life crises

Every young person in the study experienced involvement in legal proceedings, with some having experience both as a victim and a perpetrator. Three young people had experienced extreme stress as a result of being a witness against a family member or acquaintance. In one particular case, involvement in the trial of a family member caused a young person to suffer a huge amount of personal trauma that arguably contributed to future problems. Reasons for appearances in court included a range of crimes such as shoplifting, car theft, serious assault, breach of the peace, armed robbery, mugging and vandalism. Three young people experienced bereavement due to the death of a family member during their lives and one suffered the death of a friend. In the case where the friend passed away the social worker noted that this was thought to be a contributory factor in the suicide of the young person who suffered the bereavement. Other crises that occurred which might have had serious effects on the young people included being held hostage, imprisonment, childbirth, physical assault, chaotic family life and rape.

History of suicidal behaviour

Ten of the young people had previously engaged in self-harm or had attempted suicide, and seven showed evidence of suicidal ideation. There were 11 instances in the files of self-harm by cutting (hands, arms, wrists, necks); six cases of overdoses (drugs, prescription medication, tablets) and at least five suicide attempts (by hanging, lying on roads and other means).

Discussion

This project was carried out to raise awareness of suicidal behaviour risk indicators among young people with experience of care. While it is important to remember that the sample in this study was small and that the analysis was done retrospectively, it may give some clues about the factors which are implicated in suicidal behaviour, and how to temper these in practice.

Among the social factors, it was interesting to note that withdrawal from work or education was a feature in the lives of these young people. This could represent an early indication that a young person is experiencing instability or problems that require attention. Future research could attempt to gain a better understanding of the link between suicidal behaviour and educational or work experiences. In terms of practice, residential staff and social workers should work proactively to help young people maintain their work or educational placements.

The quality and effect of peer and family relationships is certainly an area to be investigated further in the future. The young people in the sample had superficial or negative peer relationships and severe family disruption. They had also experienced a number of acute life crises. The young people in the study had a number of adverse personal life experiences that would significantly affect any young person, including childhood abuse. When one considers all of the factors that looked after young people have to contend with, these acute life crises may be significantly more threatening and in every case should trigger additional support systems for the looked after child.

The examination of the social work history of the young people was enlightening.

It was useful to see where the majority of time being looked after was spent.

However, one area that could not be fully explored due to gaps in recording was the location of young people at the time of their deaths and who was with them, which could potentially be crucial to their state of mind and behaviour. It is important that social work services start to log the type, number, and success of contacts and interventions targeted at young people. Similarly, it would be important for residential staff to record outcomes as accurately as possible. Only by gathering data on what work is being done, with whom, and why, can a better picture be developed about what does and does not work. Interventions were clearly occurring but recording was limited to a brief description rather than a full record of what the social worker or young person thought of the contact, or how successful it had been.

In terms of physical and mental health, it was perhaps unsurprising to discover that there were a number of negative indicators. In terms of personality, low self-esteem was a factor in all cases. This is sufficient to demonstrate that work on improving self-esteem should be a priority both in residential placements and in aftercare. Similarly, any type of risky sexual health behaviour could conceivably have subsequent psychological effects and should therefore indicate an area where interventions may be of benefit to the young person.

Perhaps the most sobering data appeared in relation to the history of suicide ideation or attempts. If it were in doubt how seriously this behaviour should be treated, seven of the young people in the study expressed a desire to commit suicide, and 10 had self-harmed. There is sufficient evidence here to suggest that suicide and self-harm were significant enough issues in the lives of these young people to be viewed as an important risk indicator. These instances of suicidal behaviour should be compulsorily recordable and should represent points at which specifically targeted interventions or specific procedures should be used. Recording should clearly and concisely state that suicidal behaviour is regarded as an issue to be shared with other professionals (e.g. Emergency Standby Services) and a record should be kept of what interventions have been used and how successful they have been. Similarly, case files should have a designated section designed to monitor the progress of attempts made to tackle suicidal behaviour for ease of reference, rather than have details hidden amid other, potentially less serious issues in the file.

Consideration should be given to according suicide and self-harm the same priority level as child protection with procedures in place to try to prevent the escalation of harming behaviour. A register of suicide attempts/self-harm may help to monitor or prevent escalation and would focus social work interventions more clearly on this issue. Intervention should be informed by a risk assessment to determine the likelihood of future episodes of suicidal behaviour and to establish its root causes in each individual.

Conclusion

It is important to consider the limits of the research. It was not designed to provide detailed information on the issues that were identified. Several surfaces that have merely been scratched that now require additional work to try to get beneath them to increase our knowledge of this issue as it relates to this group of vulnerable young people.

Risk indicators such as the ones identified cannot be interpreted as causal factors in relation to suicidal behaviour. Similarly, any aggregation of the risk factors should not be taken to mean that suicide is an inevitable outcome. However, any type of suicidal behaviour should be taken seriously, recorded appropriately and responded to using well-monitored interventions.

There is no suggestion or implication that the young people in this research are not alive because of deficiencies in the practice of any social worker or residential staff member. As a service, however, social work must acknowledge suicidal behaviour as a priority issue. As it is, the system is currently letting down the most vulnerable of vulnerable young

people and a debate needs to take place that seeks to change the way the system supports young people in care who exhibit suicidal behaviour.

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