East Sussex Safeguarding Adults Board

Overview Report

Thematic Review: Working with Multiple Complex Needs and Trauma

Author: Patrick Hopkinson

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THEMATIC REVIEW: WORKING WITH MULTIPLE COMPLEX NEEDS AND TRAUMA

1. INTRODUCTION AND OVERVIEW OF CIRCUMSTANCES LEADING TO THIS THEMATIC REVIEW

1.1. This Thematic Review concerns four women ranging from the ages of 19 to 51 years old who died between May and November 2020, either from suicide or from causes linked to drug overdoses. Whilst these four women lived in East Sussex, they did not know each other but had contact with a number of the same health and social care services.

1.2. Whilst the four women all had different individual circumstances, a number of parallel themes were present including:

- Experience of trauma in childhood, involving domestic abuse, physical and sexual abuse.
- Poor mental health, including self-harm / known suicide risks / depression / anxiety.
- Domestic violence and abuse.
- Substance misuse.
- Homelessness.
- Being care leavers.
- Having difficulty engaging with services and support.
- The impact of Covid-19 on service delivery as well as people's mental health and wellbeing.

1.3. This review focuses on these themes and examines the approaches taken by services to engage and support the four women. Consequently, the review will only consider chronological events where these show a meaningful pattern from which lessons can be learned or where the value of alternative approaches can be demonstrated.

1.4. The four women who are the focus of this thematic review are referred to within the report using the anonymised names of Amy, Bridget, Christine and Denise. A brief summary of their lives is as follows:

1.5. Amy was a 51-year-old woman who was found deceased in her home after taking her own life through hanging. Amy had complex mental and physical health needs, used drugs and alcohol and was highly vulnerable to abuse and neglect. Amy had experienced trauma in childhood, which is thought to have contributed to her fragile mental health and she experienced frequent episodes of depression and self-harm. Amy was known to a number of statutory and non-statutory services. Whilst Amy could be mistrustful of services and often had difficulty accepting support, she had developed a positive relationship with a Personal Assistant (PA) who provided a package of care during the last eight months of her life. This consistency was an example of good practice on the part of the PA. There were changes in service delivery from March 2020 due to Covid-19 restrictions and Amy received her home care support at a distance or via telephone contact.

1.6. Bridget was 19 years old when she took her own life through hanging whilst residing in temporary accommodation. Bridget was a care leaver, who survived physical and sexual abuse as a child and had a long history of mental health difficulties (including known risks of suicide and self-harm) and drug and alcohol

use. Bridget had been known to Child and Adolescent Mental Health Services (CAMHS) since 2012 and had extensive involvement with Children's Services, latterly provided through the Through Care Team. In the period leading up to her death, Bridget continued to receive regular contact from services, but this was mostly telephone contact given the lockdown restrictions.

1.7. Christine was 37 years old when she died from an intracerebral haemorrhage with amphetamine use. At the time of her death, Christine was living in temporary accommodation. Christine had a longstanding history of mental health difficulties, and experienced significant sexual abuse and domestic violence during childhood. Christine was known to be at risk of self-harm and had made previous suicide attempts. Christine had struggled with drug and alcohol misuse and had difficulty engaging with treatment. Christine also had periods of homelessness and had extensive contact with the criminal justice system.

1.8. Denise was 39 years old when she was found deceased in the bath following a drug overdose. Denise had experienced domestic violence and abuse over a number of years, and her case had been presented to the Multi-Agency Risk Assessment Conference (MARAC) on numerous occasions particularly during the last two years of her life. Denise had a history of trauma, mental ill health, substance misuse and periods of homelessness. Denise received a significant level of multi-agency involvement but found it difficult to trust in, and engage with, services. The pandemic also impacted on Denise who experienced a lack of face-to-face contact from services during the first lockdown of the pandemic.

2. SAFEGUARDING ADULT REVIEWS

2.1. Section 44 of the Care Act 2014 places a statutory requirement on Safeguarding Adults Boards (SABs) to commission and learn from Safeguarding Adult Reviews (SARs) in specific circumstances, as laid out below:

'A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

1) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

2) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect, or the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect'.

2.2. The SAB may also arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

2.3. Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:

a) identifying the lessons to be learnt from the circumstances of the case(s), for example about the way in which processionals and agencies work together to safeguard adults at risk.
b) Review the effectiveness of procedures and their application (both multi-agency and those of individual organisations).

c) Inform and improve local inter-agency practice by acting on learning in order to reduce the likelihood of similar harm occurring again.
d) Bring together and analyse the findings of the various reports from agencies in order to make recommendations for future action.

2.4. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons to the future (s44(5), Care Act 2014).

2.5. The purpose and underpinning principles of this SAR are set out in the Sussex SAR Protocol.

2.6. All members and organisations of the East Sussex SAB involved in this SAR, and all SAR panel members, agreed to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

2.7. The SAR Subgroup considered the cases of the four women in this review as four individual SAR referrals made between May 2020 and February 2021. In considering the referrals the SAR Subgroup recommended that the four cases did not meet the mandatory criteria for a SAR under Section 44 of the Care Act but recommended that a thematic review should take place to explore the common themes across the cases in order to address the areas of multi-agency learning. The Independent Chair of the East Sussex SAB ratified this decision on 26th March 2021.

2.8. The report writer, Patrick Hopkinson, is an independent safeguarding adults review writer, a chair and writer of Domestic Homicide Reviews, and a trainer and consultant in adult safeguarding. He had no connection with any of the organisations that worked with the four women who are the focus of this review.

2.9. The review also considered the learning from the East Sussex Adult C SAR, and East Sussex SAB was aware the Brighton & Hove SAB was also in the process of undertaking a thematic review which would explore similar areas of learning and where possible this should be incorporated into this East Sussex thematic review. The Brighton & Hove review had not been completed at the time that this was review was finalised and so the East Sussex SAB should link in with the outcomes of the Brighton & Hove review where appropriate.

2.10. **Information considered as part of the review**

2.11. A practitioner event, attended by staff from different agencies who had worked directly with, or had made decisions about, Amy, Bridget, Christine and Denise were held to contribute to the process.

2.12. **Terms of reference for the review**

2.13. The following Terms of Reference for this review were agreed by the SAR panel

2.14. To consider how well services identify and respond to women with multiple complex needs who have a history of trauma.

2.15. To consider how well agencies work together and respond to address domestic violence and abuse and whether systems support or hinder practice in this area.

2.16. To consider how well agencies work in partnership, in relation to sharing information, co-ordination of responses and oversight within and across agencies.

2.17. To consider whether professionals and agencies have the knowledge, skills and experience to support people with complex and multiple needs and those who have challenges in engaging with support.

2.18. To consider whether the current systems, policies and processes that are in place to assess and manage risk presented to women with complex and multiple needs are effective and embedded in systems.

2.19. To consider whether the support and services that are available to homeless women with complex multiple needs are accessible and meet those needs.

2.20. To consider the impact of Covid-19 on service provision (including the effectiveness of safeguarding responses) and the impact on mental health and well-being.

2.21. **Information considered as part of the review**

2.22. The review used Summaries of Involvement and chronologies created for the review by the agencies involved and notes of contemporary meetings and other records. A practitioner session was used to engage the practitioners who had worked with Amy, Bridget, Christine and Denise or who had made decisions about them. This session elicited the reflections of practitioners on emergent themes and their contacts with the four women as well as on the way in which their work was facilitated or made more difficult by organisational priorities, demands, policies, procedures and communication and working with other agencies.

2.23. **Other / parallel investigations**

2.24. The review also used information from s42 enquiries, serious incident analyses and coroner's inquests.

2.25. **Family involvement**

2.26. Contact was made with family members of all four women but only one family responded and wished to meet with the reviewer and to participate in the review. The independent reviewer met Bridget's mother and grandmother with the East Sussex SAB Manager as part of this thematic review. They described Bridget as an amazing lady with a great sense of humour who wanted to make a positive difference to the world and had lots of friends. Bridget's mother stated that her daughter had job ambitions Bridget's mother and grandmother explained that Bridget wanted to use her experience to help people that, in her memory, they would like to see change in the way that the needs of people like Bridget are met in the future.

3. BRIEF SUMMARY OF AMY, BRIDGET, CHRISTINE AND DENISE AND THEIR CONTACT WITH SERVICES

3.1. Amy, Bridget, Christine and Denise lived in different areas in East Sussex and were in contact with at least 19 statutory and non-statutory services. Throughout this report acronyms are sometimes used, the most prominent of these being:

3.2. CGL – Change, Grow, Live STAR, providing the drug and alcohol recovery service in East Sussex

3.3. NST – Neighbourhood Support Team, part of Adult Social Care (ASC) in East Sussex County Council (ESCC)

3.4. SPFT – Sussex Partnership NHS Foundation Trust, which includes ATS – Assessment and Treatment Service

3.5. SWIFT – Specialist Family Service, part of Children's Social Care Services in ESCC

3.6. Connecting themes present in childhood and transition from childhood to adulthood

3.7. Amy, Bridget and Christine were known to have been sexually and physically abused by family members during their childhoods. Denise's childhood is less well understood, although given her adult circumstances, the research and practice evidence would suggest that she was also likely to have survived a traumatic childhood.

3.8. Bridget, perhaps because she was the youngest, had the clearest history of childhood contact with services. She was a care leaver and had support with her mental health from childhood through to adulthood. She was known to SPFT since 2012 when she was 12 years old and was open to CAMHS until she was 18 years old. From the age of seven, Bridget had lived in foster homes and when she was 16, Bridget moved into supported accommodation. Bridget was a care leaver and was transferred to Adult Mental Health services when she was 18 years old.

3.9. Connecting themes present in adulthood

3.10. All four women experienced trauma, violence and loss in their adult lives.

3.11. Amy engaged in sex work to fund illicit drug use, pay bills and meet the financial needs of her adult children. This resulted in her being the victim of alleged physical abuse, sexual assaults and financial abuse. On one occasion, Amy was the victim of cuckooing.

3.12. Amy also self-neglected and there was evidence of hoarding in her home. Until 2018 Amy's son lived with her. Their relationship was reported to be difficult and there were instances of physical altercations between them. Amy had limited contact with her daughter and grandchildren and had become estranged from her own mother.

3.13. Amy's last contact with services was in May 2020 when she alleged that rogue traders were banging on her door. The police attended but neighbours gave a different account of events: that the traders were legitimate and had asked permission before carrying out any work. Amy appeared intoxicated and unable to open the door fully, which appeared to be blocked by objects behind it.

3.14. Bridget had been sexually and physically abused when she was a child. Bridget was known to have thoughts of suicide and attempted suicide by hanging in September 2019. Bridget said that she was having intrusive thoughts about the abuse she experienced. Following this, Bridget was admitted to hospital and discharged on in October 2019 with support from the Crisis Resolution Home Treatment (CRHT) team. Bridget was placed in supported housing for people aged between 16 and 25 years old. This placement broke down in March 2020 when Bridget was evicted after allegations of bullying behaviour and verbal altercations with another resident. It appears that the other resident had been

equally aggressive and bullying too yet had not been evicted. After this, Bridget was moved to alternative temporary housing.

3.15. Bridget continued to experience flashbacks of traumatic events and in March 2020, when she was in bed and breakfast accommodation, she found the screams of young children there distressing and reported experiencing night terrors. In May 2020 Bridget said that staff knocking at her door triggered past emotions and her fear of her abuser

3.16. Bridget's last contact with services was in July 2020 when she received a telephone call from the Assessment and Treatment Team within mental health services regarding a medication error, which Bridget had reported the previous day. Bridget had said that she had, "enough [medication] to kill myself with" and that consequently she had left her medication with her mother. Bridget also had a telephone conversation with a housing-related floating support service. Bridget said that at times she wanted to take herself to the hospital Mental Health team but was worried that she may lose her temporary accommodation if she was admitted to hospital. Bridget was reassured that that this would not happen. Bridget said that she felt trapped by the Covid-19 restrictions and was helped to understand that things were improving little by little. Bridget was advised to use CRHT and her mental health team to manage her mental health whilst also receiving housing support.

3.17. Christine was vulnerable to abuse and exploitation and experienced repeat abusive and violent relationships. She was known to self-harm and had made previous suicide attempts. Christine's last contact with services was in August 2020 when she was seen by a SWIFT worker. There was no evidence at that time of Christine's suicidal ideation or intent. A Skype meeting between East Sussex Children's Services and Christine the same day noted that her "…interactions appear good and appropriate".

3.18. Denise experienced domestic violence and abuse in her long-term relationship with her partner and was heard at numerous MARAC meetings, with her case being heard 18 times overall between 2018 and 2020 (5 in 2018, 5 in 2019 and then 8 in 2020).

3.19. Denise used drugs, had mental health needs and had taken an intentional overdose in 2019. In July 2020, Denise was reluctant to report an assault on her by her partner. Denise's last contact with services was in October 2020 when she contacted East Sussex ASC stating that she wanted a safeguarding enquiry to commence into the sexual assault that she alleged had taken place a few days prior.

4. THE EVIDENCE BASE FOR THE REVIEW

4.1. Preston-Shoot (2019) argues that "Drawing on existing evidence about effective practice would mean that reviewers are not starting out with a blank canvas. What is proposed here is that SARs begin explicitly with the available evidence-base, using it as a lens with which to scrutinise case chronology and explore through panel meetings, interviews and learning events with practitioners and managers what facilitates good practice and what presents barriers to effective practice".

4.2. The advantage of this approach is that "The emphasis then is less on description and more on immediate reflection and systemic analysis of facilitators and barriers, across nationally determined policy, legal and financial systems as well as local arrangements and staff values, knowledge and skills" (Preston-Shoot, 2017).

4.3. Reinforcing this, The Local Government Association (LGA) Analysis of Safeguarding Adult Reviews April 2017 – March 2019 section 3.4 “Type of Reviews” describes a number of “methodological” requirements and related shortcomings of SARs, which can be summarised as follows:

- SARs should connect their findings and proposals to an evidence base. Few SARs compare actual practice with that suggested in guidance and few explore the reasons why there was a difference between the two.

- SARs should be based on research. Over 50 SABs have carried out SARs on the same set of circumstances on more than one occasion but have treated each discreetly. The SARs do not refer to each other, build on each other, or ask why it happened again.

- SARs should be analytical. There is too much description and not enough analysis.

- SARs should not shy away from difficult or sensitive topics. Few SARs engage in the legal and financial context of practice or decision making and should raise the impact of funding cuts, government strategy and reductions in services.

4.4. Consequently, a study was made of both the research evidence and practice evidence that provides insight and guidance when working with women similar to Amy, Bridget, Christine and Denise who had survived adverse childhood experiences (ACE), experienced domestic violence and abuse and mental health problems, used drugs and alcohol and made self-harm and suicide attempts.

5. DISCUSSION AND EVALUATION OF EVIDENCE FROM RESEARCH

5.1. **Adverse childhood experiences and the impact of trauma**

5.2. There are strong evidential, as well as logical and intuitive, links between child sexual abuse, physical abuse and trauma and the experience in adulthood of mental ill health, excessive use of drugs and/or alcohol, self-neglect and chaotic and abusive personal relationships (Lewis et al, 2021; Maniglio, 2019; Greenfield, 2010). These traumatic events in childhood are often referred to, somewhat euphemistically since the term barely captures their extremely disturbing nature, as ACE (Felitti et al, 1998).

5.3. ACEs include growing up in a household with someone who has mental health needs, misuse substances or has been involved in the criminal justice system. They include exposure to child maltreatment or domestic violence and also losing a parent through divorce, separation or death (WHO, 2012).

5.4. Exposure to such ACEs has been associated with poor health outcomes including substance use, mental ill-health, obesity, heart disease and cancer, as well as unemployment and continued involvement in violence. For example, Bridget had started to use alcohol from the age of seven.

5.5. Importantly, the impact of ACEs appears to be cumulative, with risks of poor outcomes increasing with the number of ACEs suffered. Significantly, people who have been exposed to multiple ACEs are more likely to die at a young age from natural causes, suicide or homicide (Bellis et al, 2013).

5.6. Three of the four women (Amy, Bridget, and Christine) were known to have experienced ACEs. Christine was sexually abused by her brother when she was eight years old. Bridget and Christine had both been physically and sexually abused by their stepfathers. Although not well understood, it is likely Denise also had a history of traumatic past experiences.

5.7. There is also considerable practice and research evidence that people with a history of trauma struggle to engage with the services that try to help and support them: all four women were in irregular contact with multiple agencies but had difficulties engaging with the support available to them.

5.8. **Mental health needs and suicide**

5.9. As already highlighted within this report, Amy and Bridget took their own lives through suicide, whilst Christine and Denise died whilst using drugs. It remains unclear whether or not Denise's overdose was intentional. Only Christine, who died of a brain haemorrhage after taking cocaine, is unlikely to have killed herself. Consequently, the research on suicide risk provides a useful context for identifying and understanding risk factors, especially in Amy's, Bridget's and Denise's lives.

5.10. Despite the intuitive association between feelings of depression and suicidal behaviour, only Christine and Amy appear to have been diagnosed with depression, although Bridget was prescribed an anti-depressant. The research shows an association between a wide range of mental health needs and suicide, to the extent that it would appear that suicide is a relevant risk factor in all people with diagnosed or suspected mental health difficulties (Harris et al, 2020).

5.11. All four women experienced prolonged mental distress, which was sometimes exacerbated by their immediate circumstances.

5.12. In July 2019, Amy had been diagnosed with mental and behavioural disorders due to multiple psychoactive substance use, mixed anxiety and depressive disorder and Post-Traumatic Stress Disorder (PTSD). Amy experienced frequent episodes of depression and appeared to be haunted by childhood trauma.

5.13. In June 2020 Bridget was reviewed by a doctor from the ATS and was noted to have diagnoses of Emotionally Unstable Personality Disorder (EUPD), PTSD and anxiety disorder and described as experiencing significant dissociative episodes (periods when Bridget felt disconnected from herself and the world around her. Dissociation is often considered to be a coping mechanism for surviving traumatic experiences including sexual abuse).

5.14. Christine had diagnoses of depression, EUPD, PTSD and obsessive-compulsive disorder (OCD). She had self-harmed, made suicide attempts and used drugs.

5.15. Denise had been detained under the s136 of the Mental Health Act in July 2020 and her mental health needs were considered to be a reaction to her eviction from her accommodation. She was noted by a GP to have PTSD in 2015.

5.16. These factors alone are not necessarily predictive of suicide. The majority of people who have mental ill health do not complete suicide. This presents the difficulty in practice that a diagnosis of mental illness does not necessarily help in identifying the people who may try to take their own lives. It is essential to consider the relevance of other risk factors too.

5.17. Suicide risk tends to increase with age. Amy was in the second highest risk group (50-54 years old, suicide rate of 16.6/1000), Christine and Denise were in the 5th highest (35-39 years old, suicide rate of 12.4/1000).

5.18. **Suicide and younger people**

5.19. Bridget was 19 years old when she took her own life . There is evidence that younger people (defined in the research as up the age of 20 years old) are vulnerable to developing mental health problems in response to the challenges of transitioning from childhood to adulthood. These challenges are compounded by the experience of the childhood trauma that Bridget experienced.

5.20. There is also increasing neurological evidence, which adds to the established psychological research, that the brains of young adults undergo significant changes through adolescence and into young adulthood. These developments are not complete until approximately the age of 25 (Giedd et al, 2004). This mid-twenty mental maturation is further complicated and even delayed by the experience of mental ill health and the underlying life trauma associated with these (Davis and Vander Stoep, 1997).

5.21. There are differences in "executive information processing" between "immature and maturing brains" i.e., those generally under the age of 25 years old, and "mature" brains i.e., those people aged 25 years and over who have not experienced life trauma and have not developed mental health problems (Casey et al, 2008). The features of "immature and maturing brains" include reduced representational knowledge (of rules, conventions and social and cultural norms); reduced operational processing skills (planning ahead, being organised and the ability to connect intentions and goals with the actions necessary to implement and achieve them) and reduced self-regulation (the ability to resist distractions, impulses and to generally resist behaving in unhelpful and unproductive ways), compared to "mature" brains.

5.22. It is unlikely, especially given the impact of her early life experience and her development of mental health problems, that Bridget's brain and consequent executive skills had matured by the time of death at 19 years of age.

5.23. Significantly in Bridget's case, younger people take their own life often have a substance abuse disorder. Whilst there does not appear to have been a formal diagnosis of this, Bridget was reported to be abusing both cocaine and alcohol to moderate her intrusive traumatic thoughts.

5.24. **Emotionally Unstable Personality Disorder (EUPD) and suicide**

5.25. Amy, Bridget and Christine were diagnosed with EUPD and whilst not formally diagnosed there are GP records which record that Denise was noted from 2015 to also have EUPD.

5.26. Amy's diagnosis appears to have been more recent since SPFT noted that in November 2019 she could not access the [1]Thinking Well specialist personality disorder services since she did not have EUPD, yet in April 2020, CGL referred to Amy's diagnosis of EUPD and that she had been offered support by a dual diagnosis worker from the Thinking Well service.

5.27. Practitioners at the learning event identified that the formal diagnosis of EUPD takes time and that it is often better clinically to respond to the presentation of

[1] https://www.sussexpartnership.nhs.uk/service-thinking-well

symptoms rather than wait for a formal diagnosis to be made. In addition, practitioners found that sometimes a diagnosis of a personality disorder was refuted by clients and that it was often more helpful not to medicalise their life and experiences. There were suggestions that a label of EUPD could be stigmatising and discriminatory. An EUPD diagnosis does not necessarily capture and convey the complexity of each person's life.

5.28. The significance of EUPD, however, is that it is associated with unstable mood, impulsive behaviour and unstable interpersonal relationships, all of which appear to have been present in Amy, Bridget and Christine's lives. Similar factors were also present in Denise's life.

5.29. This is significant since EUPD is associated with suicide. Up to 10% of people with EUPD die by suicide (Paris, 2019), which potentially makes the presence of EUPD more predictive of suicide than a diagnosis of, for example, depression. Two percent of people who have ever been treated for depression in an outpatient setting will die by suicide. For people treated in an inpatient hospital setting, the rate of death by suicide is twice as high.

5.30. The research also shows confirms an association between the impulsivity and difficulties with emotion regulation associated with EUPD, and suicidal acts particularly for younger people (Bilsen, 2018).

5.31. Finally, and particularly for younger people like Bridget, the shift from suicidal ideation , to suicide attempts and then to completed suicide can occur suddenly (Apter and Wasserman, 2006). A significant factor in progression from depression to suicide is the contemplation of suicide (Bilsen, 2018). A significant factor in progressing from contemplating to actually attempting suicide is the availability of lethal means (Milner, et al, 2017).

5.32. In summary, whilst the experience of mental health difficulties is not a strong predictor, in isolation, of death by suicide, it is a factor in the majority of suicides. This makes the clinical and practical support for identifying those people with mental health needs who lose their life to suicide, both difficult and essential. This is particularly important in the context of a review of 70 major studies which found that 60% of people who died by suicide had denied having suicidal thoughts (McHugh et al, 2019).

5.33. Based on this research, it is likely that Amy, Bridget, Christine and Denise's backgrounds placed them at increased risk of attempted suicide. It is noted that Bridget, Christine and Denise had each attempted suicide.

6. EVIDENCE FROM GUIDANCE

6.1. The Royal College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), published in June 2020, sets out a number of "Risk factors and red flag warning signs". The report states that "A red flag is a risk factor with special significance in that it indicates that a person is at heightened risk of attempting suicide at this particular moment in time. This imminent risk requires an urgent, clinically appropriate and personalised intervention with a Safety Plan".

6.2. While this report was published during the time period covered by this safeguarding adult review and it is only known that Amy and Bridget took their own lives; the Royal College of Psychiatrist's report provides a useful framework for

understanding the risk factors and warning signs in Amy, Bridget, Christine and Denise's lives.

6.3. These risk factors and red flags were specifically formulated for use in primary care settings and are divided into several themes as follows.

6.4. **Demographic and social risk factors:**

- Perception of lack of social support, living alone, no confidants
- Males (may not disclose extent of distress or suicidal thoughts)
- Stressful life events (e.g., recently bereaved, debt/financial worries, loss of attachment/major relationship instability, job loss, moving house)
- LGBTQ+
- Ethnic minority group.

6.5. The extent to which the four women in this review had a *perception of a lack of social support* and *no confidants* is unclear. All, however, were at times in their lives involved in abusive relationships.

6.6. Amy, Bridget, Christine and Denise had experienced extremely *stressful life events*, which were ongoing. Only Amy and Bridget are known to have killed themselves whilst Denise and Christine died whilst using drugs. None were known to identify as [2]LGQTQIA and all were white British females. It does not appear that they had been *recently bereaved*.

6.7. **Personal background risk factors are:**

- Substance misuse: Alcohol and/or illicit drug misuse especially if precipitated by a recent loss of relationship
- Feeling close to someone who died by suicide (family or non-kin) or exposure to suicidal behaviour of key others (family, peers, favourite celebrity)
- Use of suicide-promoting websites or social media
- Access to lethal means; (If unable to remove lethal means ensure mitigation within a robust Safety Plan).

6.8. There were also several risk factors and "red flags" present in Amy, Bridget, Christine, and Denise's personal background. All were involved in "*substance misuse*"; It does not appear that any changes in this were "*precipitated by a recent loss of relationship*" but Denise was known to be in a churning and violent relationship with her partner.

6.9. None of the four women appear to have been "*Feeling close to someone who died by suicide (family or non-kin) or exposure to suicidal behaviour of key others (family, peers, favourite celebrity)*". Neither Amy nor Bridget had notable, "*Access to lethal means*" but were able to hang themselves. All had access to illicit drugs. Bridget and Denise had previously taken overdoses of drugs, which they had attended hospital for. Whether or not Amy or Bridget had made "*Use of suicide-promoting websites or social media*" is unknown.

[2] lesbian, gay, bisexual, transgender, queer, (questioning), intersex, asexual, and (agender)

6.10. **Clinical factors in history. The risk factors are:**

- Previous self-harm or suicide attempt(s) (regardless of intent, including cutting)
- Mental illness, especially recent relapse, or discharge from in-patient mental health care
- Disengagement from mental health services
- Impulsivity or diagnosis of personality disorder
- Long-term medical conditions; recent discharge from a general hospital; pain.

6.11 Amy, Bridget, Christine and Denise had histories of *self-harm and suicide attempts*. Bridget had tried to hang herself in 2019, and she and Denise had a history of self-harm by cutting and taking overdoses. In November 2017 Bridget took a deliberate paracetamol overdose, requiring treatment in hospital.

6.12 All four women had *mental health problems* and were in irregular contact with mental health services. They do not appear, however, to have actively *disengaged from mental health services*, although their engagement with them was inconsistent. Amy, Bridget, Christine and Denise were formally diagnosed with *a personality disorder*. There was evidence that Amy, Bridget, Christine, and Denise all behaved in an impulsive manner.

6.13 Amy and Christine and Christine also had a history of epilepsy, and so had *long-term medical conditions*. Amy was known to experience *pain* as a result. Christine also had a history of epilepsy.

6.14 None had been *recently discharged from a general hospital* after long stays and only Amy and Denise had attended general hospitals or psychiatric inpatient services prior to their deaths: Amy after thoughts of suicide in 2019, for which she was not admitted; Denise in 2020 who was detained under s136 of the Mental Health Act after feeling suicidal but was not admitted to hospital for assessment or treatment since she was considered to be reacting to the stress caused by her recent eviction from her accommodation.

6.15 **Mental state examination and suicidal thoughts. The risk factors are:**

- High degree of emotional pain and negative thoughts (hopelessness, helplessness, guilt – e.g. 'I'm a burden')
- Sense of being trapped/unable to escape (sense of entrapment) and/or a strong sense of shame
- Suicidal ideation becoming worse
- Suicidal thoughts with a well-formed plan and/or preparation
- Psychotic phenomena, especially if distressing; persecutory and nihilistic delusions, command hallucinations perceived as omnipotent (pervasive).

6.11. Amy, Bridget and Denise, thought and talked about suicide. There is, however, no known evidence that Amy, Bridget or Denise's *suicidal ideas were becoming worse* even in the days immediately preceding their deaths. This may have been because of the limited contact they had with services at the time meant that an escalation was not spotted.

6.12. Despite this, Bridget's degree of *emotional pain and negative thoughts* were increasing over an extended period of time. Bridget may have felt *a sense of entrapment* or a *strong sense of shame but* may have experienced *psychotic phenomena*.

6.13. Consequently, there is evidence that all four women were at risk of suicide and that they presented a number of the risk factors and red flags identified in the Royal

College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults.

6.14. The report states that, "*…any patient with suicidal thoughts or following self-harm needs a Safety Plan. No one is ever ineligible for an intervention and Safety Plan*" and that, "*If there are red-flag warning signs/immediate risk of suicidal behaviour, the patient will require*":

- Immediate discussion with/referral to mental health services
- A robust Safety Plan
- Adequate support
- Removal of access to means

The components of a Safety Plan are:

- Reasons for living and/or ideas for getting through tough times
- Ways to make your situation safer
- Things to lift or calm mood
- Distractions
- Sources of support, to include anyone you trust

6.15. It is important that Safety Plans are co-created with patients and encourage communication with family and friends. There is little evidence that a Safety Plan of this type was developed for Amy, Bridget, Christine, or Denise.

6.16. **Mental Capacity**

6.17. The Mental Capacity Act sets out the process for assessing and determining whether or not someone with an "*an impairment of, or a disturbance in the functioning of, the mind or brain*" is able to make a specific decision at a specific time. Impairments and disturbances include drug and alcohol use and addictions to them. Mental capacity assessments can be made for any decision by anyone, although it is best if the person making the assessment has a good understanding of the decision to be made and what it involves.

6.18. **Decisional and Executive Capacity**

6.19. Whilst the Mental Capacity Act does not explicitly recognise the difference between decisional capacity (the ability to make a decision) and executive capacity (the ability to turn that decision into action), it is an important distinction in practice.

6.20. There is growing evidence of the impact of both long-term trauma and of alcohol and substance use on cognitive ability and especially on executive brain function (which includes working memory, mental flexibility, and self-control and regulation) which in turn impacts on mental capacity. Of relevance is that, compared with control groups, people with frontal lobe damage caused by alcohol use and traumatic experiences:

6.21. Are significantly slower and less accurate at problem solving when it involves planning ahead.

6.22. Persisted with riskier behaviours for longer and were less responsive to negative outcomes.

6.23. Were no different when identifying what the likely outcome of an event would be.

6.24. As a result, people with frontal lobe damage caused by alcohol use and traumatic experiences might have the mental capacity to predict what might happen but are less likely to be able to take action to prevent it from happening.

6.25. Significantly, these cognitive deficits are unlikely to be detected using the verbal reasoning tests frequently used in mental capacity assessments. Amy, Bridget, Christine and Denise are likely to have had prolonged exposure to drugs and alcohol which may have affected their executive capabilities. Combined with their histories of trauma, there may have been some impacts upon how they understood, retained, used and weighed information and communicated their decisions.

6.26. **The false conflict between freedom and protection**

6.27. All the contacts with Amy, Bridget, Christine and Denise took place within a policy context that emphasises choice, independence and personal control (essentially the Article 8 Rights set out in the European Convention on Human Rights) and which form part of an overall neo-liberal approach to adult health, social care and welfare (Ward et al, 2020).

6.28. Safeguarding Adults Reviews (amongst others Adults B and C, South Tyneside; Mr I, West Berkshire and W, Isle of Wight) have increasingly focused on the challenges of practicing in a way which balances the principles of freedom of choice and self-determination with the duties, public expectations and moral imperatives of public services. These take place within a legislative context that includes the Human Rights Act 1998, the Care Act 2014, the Mental Capacity Act and the Mental Health Act 1983.

6.29. At the intersection of all these factors is the question of the extent to which adults should be left by public services to behave in a way that is objectively detrimental to their health and wellbeing or which threatens their lives. More fundamentally it is question of prioritising freedom of choice or prioritising protection from harm (essentially Article 2 of the European Convention on Human Rights).

6.30. Amy, Bridget, Christine, and Denise were all assumed to make mentally capacious decisions, even though the results of these decisions were harmful to them. Whilst only Amy was considered to be self-neglecting, the guidance on working with people who self-neglect helpfully challenges the either/or nature of the question of the right to protection and the right to autonomy by asking practitioners to consider:

6.31. **Is a person really autonomous when:**

- They do not see how things could be different.
- They do not think they are worth anything different.
- They did not choose to live this way, but adapted gradually to circumstances
- Their mental ill-health makes self-motivation difficult.
- They have impairment of executive brain function.

6.32. **Is a person really protected when:**

- Imposed solutions do not recognise the way they make sense of their behaviour.
- Their 'sense of self' is removed along with the risks.
- They have no control and no ownership.
- Their safety comes at the cost of making them miserable.

6.33. Amy had a history of self-neglect and found managing day to day tasks difficult. In the three months before her death, Amy was struggling to keep her home uncluttered. In April 2020, the NST (Neighbourhood Support Team from the local council) noted that

Amy and a worker had built a very positive relationship, and that Amy was accepting support with keeping her home clean and with other areas such as shopping and medication and with general companionship and wellbeing. There may, however, have been a deterioration in Amy's situation before took her own life. In May 2020, for example, the police noted, when attending in response to Amy's report about rogue traders, that Amy appeared to be intoxicated and could not fully open the door due to things placed behind it.

6.34. Practitioners recognised that people with similar backgrounds to Amy, Bridget, Christine and Denise often have few real choices and often fall into patterns of behaviour.

6.35. **Housing and homelessness**

6.36. There is substantial, as well as intuitive, evidence that the well-being of both individuals and families is substantially affected when the need for satisfactory housing is not met. According to the United Nations (UN) Committee on Economic, Social and Cultural Rights, satisfactory housing consists of legal security of tenure; availability of accessible services, facilities and infrastructure; habitability; accessibility (e.g. access to employment, health services, schools, etc); cultural adequacy; and affordability.

6.37. It would appear that Bridget, Christine and Denise's accommodation rarely met these criteria. Despite often, but not always, having a roof over their heads, neither Bridget, Christine nor Denise had any security in retaining temporary accommodation and were homeless.. Practitioners understood that temporary accommodation was rarely suitable for this cohort of people with complex multiple needs.

6.38. The Homelessness Reduction Act 2017 introduced a duty on certain public authorities to refer service users who they think may be homeless or threatened with homelessness to a housing authority . The housing authority has a duty to provide advice and information about homelessness and the prevention of homelessness and the rights of homeless people or those at risk of homelessness, as well as the help that is available from the housing authority or others and how to access that help. Housing authorities have a duty to carry out an assessment in all cases where an eligible applicant is homeless or threatened with homelessness and must work with the person to develop a personalised housing plan which will include actions (or 'reasonable steps') to be taken by the authority and the applicant to try and prevent or relieve homelessness. Bridget, Christine and Denise were all in intermittent contact with housing services but appear to have remained living without any form of security or stability.

6.39. There is a strong interrelationship between mental health and homeless, such that housing can be considered to be "foundational" to good mental health and wellbeing (Padgett, 2020). Without stable and secure housing, other efforts to support people with their mental health needs, their drug and alcohol use, their chaotic and risk-taking behaviours are unlikely to be successful.

6.40. Bridget had lived at number of temporary addresses. She had lived in foster homes from a young age, . During 2017/18, Bridget lived in young person's supported accommodation and then moved into accommodation with her boyfriend after his behaviour ended the placement there. During 2019 Bridget lived locally but later in 2019 moved in with family in a neighbouring LA. .

6.41. Bridget moved to supported accommodation for young adults but was evicted in March 2020 after allegations of bullying behaviour and verbal altercations with another resident. It appears that the other resident had been equally aggressive and bullying

too yet had not been evicted. Bridget's mother and grandmother considered this grossly unfair and to have had a significant impact on Bridget's mental health.

6.42. Bridget returned to live with her mother for 6 days and in March 2020 moved into emergency temporary accommodation. In April 2020, Bridget was informed that she should apply for private rented accommodation, which Bridget did not think was feasible or safe as she needed additional support.

6.43. In July 2020, Bridget was third on waiting list for supported accommodation and was living in a flat. In August 2020, Bridget took her own life there.

6.44. This pattern of short-term temporary accommodation, often punctuated by having to leave/move on was also apparent in Denise's life. Denise was accommodated in temporary accommodation and moved frequently. Denise continued to allow her partner to stay with her, resulting in her being asked to leave, only for the Council to accept its full homeless duty and to again provide accommodation for Denise. This accommodation was lost by Denise due to her behaviour and the Council considered its homeless duty to have been discharged.

6.45. Denise was then provided with further accommodation after a review but this was lost again due to having her partner and alcohol on the premises.

6.46. The Council continued to support referrals of Denise to supported housing and Denise and her partner attended in February 2020 following his release from prison. They wanted to make a homeless application together but this was not permitted.

6.47. Later, under the severe weather emergency protocol Denise and her partner were placed at separate addresses.

6.48. In October 2020 Denise telephoned the police in a distressed state. Denise, who was described as intoxicated and under the influence of drugs, explained that she was currently homeless and had paid the occupant of the flat £200 to stay there until the end of the month. Denise alleged that she had been sexually assaulted by the occupant of the neighbouring flat, who was subsequently arrested.

6.49. The police were told that Denise was not welcome at the flat she was staying in due to her behaviour.

6.50. Homelessness is also often combined with other problems. Multiple Exclusion Homelessness is the term used to describe people who have been homeless (including the experience of temporary, unsuitable accommodation as well as street sleeping) and who have also experienced one or more of the following additional domains of social exclusion:

6.51. Institutional care (prison, local authority care, psychiatric hospitals, or wards); or

6.52. Substance misuse (drug problems, alcohol problems, abuse of solvents, glue, or gas); or

6.53. Participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work).

6.54. People who meet this definition are likely to be homeless for longer, have escalating health and care needs and have a reduced life expectancy compared with other homeless people who do not have multiple exclusions. Given what is known of Bridget, Christine and Denise's' backgrounds and life experiences it would seem that they met the definition of Multiple Exclusion Homelessness.

6.55. Bridget had been a looked after child and had spent time in foster homes as well as living with family members. Christine was in temporary accommodation with many other substance users and did not receive help and could easily be manipulated.

6.56. Christine had served time in prison and was released in 2019 and was initially provided with accommodation with her daughter via the Parole Board and then in a flat on her own. This was later deemed to be unfit for habitation and so Christine moved again to temporary accommodation. This proved to be unsuitable since Christine was sharing with people who used drugs and alcohol and exposed her to violence. The probation service was working to find more appropriate accommodation for Christine, and she was offered an appointment for supported accommodation for people with mental health needs but died before this took place.

6.57. In 2019 and 2020, Denise was frequently in temporary accommodation, which she was frequently evicted from since she tried to smuggle in her partner and alcohol. Denise was also reported to be sleeping rough with her son and her partner.

6.58. In summary, the research and practice evidence and guidance suggest that Amy, Bridget, Christine and Denise were at risk of self-harm and suicide, significantly exacerbated by their past and present traumatic experiences, which include ACE, mental health needs, unstable personal relationships, loss, violence and abuse, self-neglect and instability of housing. All these factors affected their ability to engage with the services that may have helped them and all were considered to be able to make mental capacious decisions about their welfare and wellbeing despite the long-term evidence that they frequently placed themselves at risk. Whilst only Amy and Bridget are known to have taken their own lives, and it is unknown whether or not Denise's fatal drug overdose was intentional, the risk of suicide was a factor in the lives of all four women in this thematic review.

6.59. **Learning from previous safeguarding adults review**

6.60. In 2020, the East Sussex Safeguarding Adults Board published a safeguarding adults review following the death of Adult C. There are a number of similarities between Adult C and Amy, Bridget, Christine and Denise. Adult C experienced significant levels of domestic violence and coercive control, which were particularly severe during the last 12 months of her life. Adult C had multiple complex needs as a result of drug and alcohol dependency, fluctuating mental health (including patterns of self-harm and periods of poor mental health) and homelessness. Adult C was involved in criminal behaviour at times to fund her substance misuse. She started a relationship with a partner in 2015, who was volatile and violent. He also had drug and alcohol problems and experienced periods of street homelessness.

6.61. Adult C was found deceased by a friend in December 2017. A Coroner's inquest concluded that the medical cause of death was mixed drug toxicity. The relevant findings of this review will be considered in the conclusions and recommendations section of this thematic review.

7. THEMATIC ANALYSIS

7.1. Using this research and practice evidence base it is possible to analyse the way in which the different organisations involved worked with Amy, Bridget, Christine and Denise.

7.2. **Recognition of the impact of adverse childhood experiences**

7.3. As predicted by the evidence of the impact of ACEs, Amy, Bridget and Christine experienced relationship difficulties and violence in adulthood. Denise was also in a persistently violent relationship as an adult, although there are no records of adverse experiences in her childhood. This may be due to a lack of recognition by services, rather than an absence, of these experiences.

7.4. Practitioners were aware that Amy, Christine and Bridget had survived highly traumatic adverse childhood experiences. For Bridget, these had been recent and she experienced flashbacks and re-emerging emotions often sparked by otherwise innocuous events. For Amy and Christine, these experiences were rather more distant but still to an extent appeared to shape their adult lives. Amy, Christine and Bridget were all diagnosed with PTSD.

7.5. The impact of these experiences on Amy, Christine and Bridget presented challenges to services. Practitioners recognised that they were often waiting for stability in the lives of Amy, Christine and Bridget, when in fact, the women's lives were too unstable for them to engage with services. Consequently, service responses tended to be reactive in response to crises and were hampered by housing instability involving frequent changes of accommodation and moves to different areas, as Bridget's case illustrates.

7.6. When she was 16 years old, Bridget had been moved from her family home by Children's Services into supported accommodation. This placement broke down and she returned home to live with her mother but at 17 years old, Bridget was living in supported accommodation, where she met her boyfriend. There had been extensive involvement with Bridget from SPFT, the Through Care Team in Children's Social Care (CSC) and the Police. Bridget experienced frequent crises, harmed herself and was at risk of suicide. Bridget only received minimal support after her 18th birthday. There were delays in Bridget accessing mental health support, which were further complicated by her case being transferred between a number of teams in response to Bridget's multiple moves across and out of the county.

7.7. This pattern continued. Upon discharge from hospital after attempting suicide in 2019 when she was 18 years old, Bridget was placed in accommodation which provides secure supported housing for people aged between 16 and 25 years old. This placement broke down and Bridget was moved to temporary accommodation where she completed suicide.

7.8. Bridget was a care leaver and was supported as a Looked after Child under s.20 of the Children Act and received support from a PA from the Through Care Service and from a Placement Support Worker. This support continued under the Children and Social Work Act 2017, which sets out in "Extending Personal Adviser support to all care leavers to age 25 Statutory guidance for local authorities February 2018" the option to provide Personal Adviser (PA) support to all care leavers up to age 25, if they accept it.

7.9. East Sussex Adult Social Care and Health carried out two safeguarding enquiries in 2019 and 2020 following concerns that Bridget had been sexually and physically abused and was self-neglecting. A social care assessment was conducted in 2019 but Bridget was assessed not to have eligible care and support needs despite her background. This suggests a need to consider "transitional" safeguarding approaches to people in similar circumstances to Bridget's.

7.10. The 2020 report, "Bridging the Gap: Transitional Safeguarding and the role of Social Work with Adults", builds on the evidence base set out in this thematic review and focuses on the harm associated with the sexual and criminal exploitation of young

people and states, "*Where young people are experiencing coercion and other forms of control and exploitation under 18, these experiences and the impact they have rarely stop when a person turns 18. Young people's brain development continues to mature cognitively and emotionally well into their twenties. This has important implications regarding, for instance, potential ongoing coercive influence of exploiters. The transitional nature of maturation after 18 requires us to take a nuanced approach to the 'age of maturity' and to take account of young adults' individual experiences and circumstances in how we protect their rights and understand their capacity to take particular decisions*".

7.11. Transitional safeguarding approaches recognise the influence that past experiences have on present behaviours and challenge the assumption that just because a young adult is safe they do not need any additional support to help them to adjust to adult life.

7.12. **Engagement with and by services**

7.13. Practitioners identified that people with complex, traumatic family backgrounds, do not easily fit into treatment pathways and believed that there were high numbers of people with a diagnosis, indicators or traits of EUPD in East Sussex. Clients like Amy, Bridget, Christine and Denise were described by practitioners as the type of client whose needs they struggle the most to meet. Throughout her engagement with STAR, Amy, for example, often presented as chaotic and distressed and required support in an unplanned way when in a crisis.

7.14. Amy was described as mistrustful of social workers and often felt victimised by professionals who were tried to help her and would disengage from them. Although it was extremely difficult to contact Amy by telephone it appeared that her reluctance to answer the telephone was based on her fear of answering unknown numbers rather than as a means to avoid contact with services.

7.15. Whilst practitioners recognised and understood the impact of life trauma on their clients, this does not appear to have influenced organisational policy responses. The practice of discharge following missed appointments, for example, does not fit well with people who are disorganised because of their traumatic life experiences and is a factor that has been identified in other Safeguarding Adults Reviews.

7.16. It is likely that Amy, Bridget, Christine and Denise were not able, rather than were unwilling, to comply with requirements to attend appointments regularly and to comply with expectations and routines. This was recognised by Denise herself when she told an Independent Domestic Violence Advocate that she was not very good with appointments. Practitioners recognised that in many cases younger adults like Bridget were frequently not in the right place emotionally or cognitively to fit in with the demands of traditional services. Flexibility and different approaches are often required. Outreach based models were considered by practitioners to be helpful since booking appointments could be too difficult for some people. Outreach services, willing to meet people where it suits them, were thought by practitioners be more effective than expecting people to come to fixed locations.

7.17. Practitioners considered that clients often found it difficult to participate consistently with therapeutic approaches and found the experience overwhelming. Practitioners identified that there were also risks when reliving traumatic memories which clients still found hard to manage. Bridget, for example, experienced intrusive memories when she heard knocks on her door. Clients frequently disengaged from therapy since they could not cope with the emotional consequences. Practitioners considered that a balance was needed between assertiveness and allowing people to engage on their own terms.

7.18. Relationship based approaches, which aim to build familiarity and trust, often in one individual practitioner can be helpful. Denise, for example, found it difficult to trust agencies and to engage with them. The “lead practitioner” model, where any service or practitioner able to build and maintain a trusting relationship, can take the lead can be helpful for this and the development of trust may help clients to be more open to suggestions and offers of support. Such an approach would require support for and recognition of the lead practitioner’s role across organisations. There had been discussions, for example, about whether Amy should have been overseen by mental health services, but she did not fit their criteria. A Neighbourhood Support Team worker developed a good relationship with Amy but struggled to support her mental health and behavioural problems and lacked confidence and expertise in how to respond to suicidal ideation.

7.19. Joint working and communication between agencies were considered by practitioners to be vital. It was important to share key information about how to engage clients (Amy and Christine, for example, would not respond to “number withheld” calls) and to reduce the number of appointments across different services in order not to overburden them.

7.20. As a result of the problems of engagement, interventions often take place at a time of crisis and do not involve therapeutic input. Consequently, the police were frequently the first point of contact during a crisis. This presents problems for the police when dealing with domestic abuse, including taking statements whilst the victim is intoxicated and is unwilling to engage or be supported, as was the case with Denise and Amy, and can also weaken developing therapeutic alliances and relationships between practitioners and clients.

7.21. Christine had the most extensive contact with the Police. Since March 2009, Christine had been recorded as a victim of crime in incidents relating to theft, assaults including domestic abuse, criminal damage and being a missing person. Christine was also a suspect or charged in relation to theft, assault, burglary and public order offences and may have also been involved in the supply of drugs. Christine had been imprisoned three times: in 2012, in 2014 and had been recalled to prison in 2018. The Recall Notice recognised Christine’s vulnerability, stated that Christine suffered from poor mental health, PTSD and had previously stated she would take her own life on a number of occasions.

7.22. **Responses to mental health needs and the risk of suicide**

7.23. The research evidence set out in section 3 of this report shows that on the basis of their backgrounds, characteristics and involvement with services, Amy, Bridget, Christine and Denise were at risk of self-harm and suicide. Despite this, Amy and Bridget completed suicide, whilst Christine and Denise died as a result of the use of illicit drugs, although Denise’s overdose may or may not have accidental.

7.24. Both Amy and Bridget, who are known to have taken their own lives, were prescribed psychoactive medication. Amy was prescribed Mirtazapine (an anti-depressant, also effective in anxiety) and Quetiapine (an anti-psychotic), Zopiclone, Diazepam (for anxiety) and Methadone. In 2019, Amy received support from CRHT and was known to experience suicidal thoughts and distress. Therapeutic interventions, however, seemed to intensify Amy’s distress. Writing her thoughts down, for example, was identified to increase the “chaos” in Amy’s mind.

7.25. Amy had, however, been accessing treatment for substance use (heroin/crack cocaine, benzodiazepines and alcohol) since 2014 and was prescribed methadone. Amy had been offered support from a dual diagnosis worker at STAR for EUPD but does not appear to have been actively involved with mental health services prior to her

death. There does not appear to have been any further exploration of suicide and self-harm risk, instead the focus was on Amy's drug use.

7.26. Amy attended a Non-Medical Review by telephone in April 2020 and said that she was not using opiates, had last used cocaine the week before and was using benzodiazepines. Amy said that her mental health was stable and that she was in regular contact with her Personal Assistant from the Neighbourhood Support Team three days per week.

7.27. Amy was last seen by a STAR Recovery Worker in April 2020 at home. Amy said that she was feeling unwell and was advised to self-isolate in line with Government guidelines for Covid-19 infection and arrangements were made for STAR to collect and deliver her methadone to her at her home address. Despite appearing unwell, Amy said that she was '*fine otherwise'*. This contact took place at the beginning of the first Covid-19 "lockdown" and whilst a home visit rather than a telephone call indicated that Amy's needs were prioritised there appears to have been a lack of consideration of Amy's mental health needs and impact on her of the Covid-19 restrictions.

7.28. Bridget was prescribed sertraline (an antidepressant), propranolol (anti-anxiety medication) and promethazine (an antihistamine with antipsychotic properties). Bridget had used quetiapine (an anti-psychotic) but had gained weight and so had discontinued it. Between October 2014 and April 2015 Bridget was prescribed Fluoxetine (an anti-depressant) for social anxiety and panic attacks.

7.29. In July 2020, Bridget was prescribed risperidone (an antipsychotic) and an increased dose of propranolol. Bridget was also going to restart on quetiapine on an as required basis, since this was described as lifting her mood and helping to manage her aggression. Bridget was known, however, to have stopped taking risperidone shortly afterwards.

7.30. Bridget had been known to CAMHS since 2012, as she had a been subjected to abuse from her early childhood resulting in complex mental health needs related to chronic trauma. Bridget had also experienced frequent mental health crises. Bridget was known to be at risk of suicide and self-harm. Bridget continued to have suicidal thoughts and had attempted suicide in 2019, after which she was admitted to Hospital and discharged with CRHT support.

7.31. Bridget was described as at risk of acting impulsively and that her behaviour could be unpredictable particularly during dissociative episodes. Bridget's risk of violence and aggression towards others was rated as moderate. There was exploration of Bridget's suicidal and self-harming intentions. Bridget said that she wanted to live and did not want to kill herself and that her goals for the future including gaining control over her moods, emotions and actions. In July 2020, however, Bridget told SPFT that her nightmares were increasing in frequency. In response, Bridget appears to have been sent a number of self-help resources by email.

7.32. Whilst not being actively treated for her mental health needs, Denise had taken an intentional overdose in 2019. There were reports in May and in July 2020 that Denise was feeling suicidal, but these were considered at the time to be reactions to her circumstances. For example, Denise was evicted from her accommodation, threatened suicide and was detained under s136 of the Mental Health Act in July 2020. Denise was described as "highly intoxicated" and not to have a mental disorder that required admission to hospital. Instead, she was identified as alcohol dependent and reacting to acute social stressors. Denise refused temporary accommodation and wanted to return to her partner.

7.33. In hindsight, it appears that there was a prevailing belief that Denise's mental health needs were a direct response to her immediate circumstances. Whilst this might have accurately described the way that Denise's' s needs were presented at the time, this may have prevented further exploration of the impact of underlying problems in Denise's life and is a factor that has been found in other safeguarding adults reviews such as that of Tyrone Goodyear (London Borough of Lewisham Safeguarding Adults Board 2020).

7.34. Christine had diagnoses of depression, EUPD, PTSD and obsessive-compulsive disorder. She had self-harmed, made suicide attempts and used drugs, although at the time she was in contact with the STAR service in October 2019 she was described as illicit drug free. Christine was prescribed Espranor (an opiate analgesic used in the treatment of opioid addiction), which she collected daily. Christine was also known to have experienced domestic violence . There does not appear to have been any further exploration of the risk of self-harm or of suicide. Christine, however, died of a brain haemorrhage following drug use.

7.35. **Substance misuse**

7.36. Amy, Bridget, Christine and Denise all had significant histories of substance use. Practitioners recognised that people use drugs and alcohol to manage their mental health needs but that this also impacts on their ability to use therapy services and pointed to a lack of rehabilitation services for people who use drugs and alcohol. Practitioners identified that sometimes sex work is used as a means of raising money to fund drugs and that this is frequently in context of abusive relationships. This appears to have been a particular factor in Amy's life.

7.37. Amy had a long-standing history of poly-substance misuse and reportedly began using heroin and crack cocaine intravenously in her 20s. . Amy had been accessing treatment for poly-substance misuse issues (heroin/crack cocaine, benzodiazepines and alcohol) since April 2014. Amy as described as opiate dependent and was prescribed methadone.

7.38. Bridget was described as abusing alcohol to cope in 2018 and under the influence of cocaine in August 2019. She was also reported to have been using alcohol and cocaine as a child.

> Christine used Espranor (an opioid analgesic) daily, had a naloxone pen and was given harm minimisation advice about the increased risk of overdose should she resume heroin use due to having a lower tolerance to it. A naloxone pen is a pre-filled syringe which you inject into a person's leg, through their clothes if you need to, when someone has had an opioid overdose and reverses the effects of an overdose for a while.

7.39. The last face to face contact with Christine was in August 2020 with her probation officer, with whom she kept contact every week (except during the lock down due to Covid-19, when these appointments were held by telephone and then when restrictions were relaxed, every two weeks). In June 2020, 14 days' worth of Espranor had been delivered to Christine at home. Christine was with friend at this time which meant that this contact was short. Christine's last communication with STAR was in July 2020 when, via telephone, Christine appeared to be in good spirits and said that she had a new partner who was supporting her. The partner also spoke on the telephone and advised the STAR worker that he was helping to support Christine and they were helping each other. Christine said that her flat had been made safer and more secure following an assault in May 2020 when she had asked another man to leave her home. Christine did not want this to be investigated further.

7.40. Denise's "entrenched and toxic" relationship with her partner was described at MARAC to be fuelled by alcohol, drug use and poor mental health. Denise had been referred to a substance misuse service in 2015 for support to address alcohol and cocaine use.

7.41. **Domestic Violence and Abuse and victimisation**

7.42. Amy had a history of being sexually and physically victimised. Amy had been supported by East Sussex Council Adult Social Care and the police in response to 'cuckooing' and allegations of sexual assaults in 2018 and 2019.

7.43. Amy also reported problems with neighbours and traders. In April 2020, for example, Amy reported to the police that a neighbour had threatened to pour a bucket of water over Amy's head, accusing her of leaving dirty needles in the area. The neighbour and a witness said that Amy had been told to go away but had not been threatened.

7.44. In May 2020, Amy reported to the police that men were banging on her door demanding money for gardening work which she had not requested. Again, neighbours gave a different version of events. The police noted that Amy appeared to be intoxicated and could not open door fully due to things placed behind it. This suggests potential problems associated with hoarding, but it seems the incident was not considered by East Sussex County Council to be a safeguarding concern and no further exploration was made or action taken.

7.45. Bridget also had a history of being involved in violent and abusive relationships, with numerous reports of sexual and physical assault and she had been referred to MARAC in March 2019.

7.46. Christine told ~~a~~ STAR worker in May 2020 that she had been assaulted the previous weekend, had informed the police and was pressing charges as she had known her assailant. Christine had also reported this assault to her social worker.

7.47. Denise had been discussed at least nine times at the MARAC between November 2019 and September 2020 as the victim of violence from her partner.

7.48. The approach taken to domestic violence and abuse in Denise's life illustrates the cyclical and escalating nature of coercive and controlling relationships, especially when combined with drug and alcohol use and the co-dependency that develops between the abuser and the victim.

7.49. Denise's partner's release appears to have led to a repetition of violence in Denise's life. In February 2020, the police received a report of possible domestic violence between Denise and her partner. Denise's partner was apparently struggling with alcohol addiction and re-adapting to life outside prison. He said that he had been unable to obtain medication for his mental health issues. Denise's partner confirmed that he had been arguing with Denise throughout the evening about a wide variety of subjects. Denise's partner explained that he was attending STAR in the morning for his first appointment to "*help with his issues*." No further action was taken.

7.50. There was also evidence of escalation in the severity of violence. In March 2020, Denise reported to the Police that she had been assaulted by her partner but then ended the telephone call and did not respond to return calls. Denise's grandmother telephoned the Police later to say that Denise was in hospital having x-rays and scans as she might have a fractured skull from the assault.

7.51. A day later, Denise denied that the incident had taken place but showed officers a large bruise behind her left ear. Denise's grandmother said that this head injury was

sustained when her partner hit Denise's head on to a kerb stone. Denise refused to make a statement. Denise's partner was arrested and an investigation was begun.

7.52. Denise told an IDVA (Independent Domestic Violence Advocate) that she wanted help from STAR with her drinking and explained that she was not very good with appointments and had not attended them in the past but she would like to attend STAR. Denise also wanted support to be provided to her partner, who also wanted help for anger and drinking. Denise had asked her partner's probation officer if there was a course he could attend. Denise said that she was well supported by SWIFT, was currently at the drop-in and was homeless.

7.53. The IDVA contacted STAR about this, which confirmed that it had no appointments until April and requested a referral form. The IDVA explained that they had not had enough contact with Denise to be able complete a referral form and did not know enough about her drinking.

7.54. In August 2020, Denise had once more been violently assaulted by her partner, who was subsequently arrested, and Denise moved to a women's refuge. Denise, however, did not support a prosecution, stating that whilst she was no longer in a relationship with her partner, she loved him, relied on him, was actively seeking a relationship with him and described herself as bonded to him through trauma. Denise refused further domestic abuse support, said that violence in their relationship was fuelled by alcohol and that she was trying to reduce her alcohol intake. Denise's decisions were judged to be capacious.

7.55. Denise and her partner had apparently separated but there were further concerns about their contact during September 2020, when Denise was once more reluctant to report an assault by him. The East Sussex Council Safeguarding Development Team raised a safeguarding concern about this, describing Denise, as very vulnerable because of her own substance misuse issues and relationships where she was a victim of domestic abuse. The safeguarding enquiry was subsequently closed. Denise was described as having the capacity to make decisions about the safeguarding concerns and since the alleged perpetrator was serving a custodial sentence, support was being provided by SWIFT and an application of housing was in place no further safeguarding action was taken.

7.56. These examples from Denise's life show how coercive and controlling relationships can prevent abused people from accepting help, how the escalating impact of violence can be minimised and how a single factor, in this case alcohol, can be identified as the key cause, which once resolved, will somehow solve all the problems. Given the level and duration of violence and alcohol use in their relationship, it is unlikely that Denise or her partner's intentions to seek help would be effective without considerable external input and support. Such support, however, was often refused or not complied with.

7.57. Practitioners recognised that support services for domestic violence and abuse have limited capacity to meet demand. Practitioners described how IDVAs made three contact attempts and then closed cases if there was response. Practitioners also noted that the practice of placing women fleeing domestic violence and abuse in refuges outside of their area meant that there is a risk of losing contact with services, further exacerbating problems with engagement in therapeutic interventions.

7.58. **Mental Capacity**

7.59. It does not appear that Amy, Bridget, Christine or Denise's mental capacity was assessed in any of their contacts with services. Whilst a principle of the Mental

Capacity Act 2005 is the presumption of capacity unless demonstrated otherwise, there were instances where completing a specific capacity assessment would have been justified and a reasonable response .to for example an appointment being missed, support being declined or repeat patterns of behaviour..

7.60. There does not appear to have been an operational understanding of the impact of addiction upon decision making. Amy, Bridget, Christine and Denise's dependence on alcohol and drugs could have been considered to have a coercive and controlling influence on their mental capacity, even when they were sober. This approach is promoted by the Alcohol Change UK December 2020 report, "Safeguarding Vulnerable Dependent Drinkers".

7.61. The approach described by Alcohol Change UK is to consider mental capacity as a "video" rather than as a "snapshot". This recognises that all interventions need to be within the context of an understanding that people addicted to substances will often not have the mental capacity to make free decisions that are unaffected by the controlling and coercive influence of their addiction.

7.62. Practitioners interpreted Amy, Bridget, Christine and Denise's refusals to engage to be capacious decisions. Instead they may have been indicators of the coercive and controlling influence of addictions, of mental health needs, or of responses to traumatic events and which might have impacted upon Amy, Bridget and Christine and Denise's ability to understand, retain and use and weigh information to make decisions.

7.63. **Use of adult safeguarding processes**

7.64. A number of safeguarding concerns had been raised about Amy, Bridget, Christine and Denise during the last years of their lives but the majority were closed down without further action, either because the s42 criteria were not met or because there was no consent for a safeguarding enquiry to proceed or for an intervention to be made.

7.65. The local authority is the lead agency for adult safeguarding under the Care Act 2014 and must act when it has "reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)":

- Has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect.
- and as a result of those care and support needs is unable to protect themselves from the risk or experience of abuse or neglect.

7.66. When these criteria were considered to have been met, there does not appear to have been further decisive action. During 2019, for example, five safeguarding planning/ professionals' meetings were held following concerns about Amy but her case was closed in December 2019 for review in six months' time.

7.67. These may have been missed opportunities for reconsidering whether the approaches being taken to support Amy, and similarly those for Bridget, Christine and Denise, were working and to consider whether different approaches might be required to protect them.

7.68. Whilst not being actively treated for mental health needs, Denise had taken an intentional overdose in 2019. There were reports in May and July 2020 that Denise was feeling suicidal but these were considered at the time to be reactions to her circumstances. For example, Denise was evicted from her accommodation, threatened suicide and was detained under s136 of the Mental Health Act in July 2020. Denise

was described as “highly intoxicated” and not considered to have a mental disorder that required admission to hospital. Instead, she was identified as alcohol dependent and reacting to acute social stressors. Denise refused temporary accommodation and wanted to return to her abusive and violent partner.

7.69. A safeguarding concern was raised about this. Denise was described as difficult to engage and as being very vulnerable because of her own substance misuse issues and relationships where she was a victim of domestic abuse. Denise also had known mental health needs and known to have taken an intentional overdose in 2019. The safeguarding enquiry was subsequently closed since Denise did not want additional support and wanted to remain in the relationship, a decision which it was judged she had the mental capacity to make. Denise was receiving support from SWIFT and from housing to try and identify permanent accommodation for her. The duty under section 42 of the Care Act 2014 was considered to have been discharged in August 2020. This might have been an opportunity for using a safeguarding enquiry to call a multi-agency meeting to review the approaches being used to engage with and support Denise and to consider if any other interventions might be useful.

7.70. The Care Act Statutory Guidance makes provision for non-statutory adult safeguarding enquiries and interventions where the “three-part test” is not met, but where there is sufficient concern that someone may come to harm. It is likely that Amy, Bridget, Christine and Denise met at least the criteria for a non-statutory adult safeguarding enquiry and that either this or a S42 enquiry might have been an opportunity to reconsider the extent to which the current interventions and approaches were proving effective. This in turn might have led to the use of different interventions and approaches to meet their needs or might have reprioritised the need for an assessment of their needs.

7.71. **Impact of Covid-19**

7.72. The deaths of Amy, Bridget, Christine and Denise all happened during the Coronavirus pandemic and the resulting restrictions on freedom of movement and on the availability of services. Following its identification in the UK on 29/01/2020, the first death of a UK subject from the Covid-19 illness on 08/02/2020, there was a surge in infections through March 2020. Restrictions to limit the spread of the virus were introduced rapidly. On 16/03/2020, the Government advised against non-essential travel and encouraged working from home in all but exceptional circumstances. On 20/03/20, entertainment venues were ordered to close. On 23/03/20, the government restricted contact between households and the UK population was ordered to "stay at home". The only permissible reasons to leave home were food shopping, exercise once per day, meeting medical needs and travelling for work when absolutely necessary. All shops selling non-essential goods were told to close and gatherings of more than two people in public were banned. These 'lockdown' measures legally came into force on 26th March 2020. They did not begin to be lifted until 10th May 2020. Amy took her own life a week later..

7.73. Despite increasing relaxation of the “lockdown” restrictions through August 2020, with an effective end to restrictions on 14th August. Bridget and Christine both died around a week prior to these restrictions being lifted.

7.74. Covid-19 infection rates began to increase and restrictions began to return in September. A localised tier-system of restrictions on movement and association was introduced on 14th October and a second national “lockdown” was imposed between 5th November and 2nd December. Denise died following a few days prior to these lockdown restrictions being opposed in November.

7.75. This rapid restriction of movement and contact impacted on services and the people who used them. Face to face contact between practitioners stopped or was significantly curtailed, some services closed entirely. This included both universal and specialist services that might provide distractions for people who used drugs and alcohol. Places in which Bridget liked to meet practitioners were closed and contact was maintained with Bridget by telephone instead between April and August, at which time Bridget was in temporary accommodation.

7.76. Nationally, staff in health and social care were redeployed from specialist to more generalist work to support the Covid-19 effort and it is likely that there was an impact on the workload, ways of working, availability and accessibility of staff in East Sussex. Practitioners did hold face-to-face meetings, in line with regulations and guidance, where the situation required these. Amy was being supported by telephone but where necessary STAR workers could see service users face to face in limited circumstances. Practitioners noted that one of the difficulties with remote therapeutic working was not being able to see body language.

7.77. Staff were self-isolating, in accordance with government guidance, reducing the number of staff available to meet increasing demand. This included providing food for clients were also self-isolating. Face-to-face contact decreased yet demand for services, sometimes to replace those that had been closed or limited by other agencies' responses to coronavirus, increased. For example, Christine was described by practitioners as experiencing difficulties seeing her GP during Covid-19 (although there had been a pattern of not-attendance before this). Practitioners recognised that those services closed or changed.

7.78. There was an increase in mental health need, which had been predicted at the time but in hindsight seems to have been even greater in younger people (Ford et al, 2021; Ashton et al, 2021). There was also an increase in drug and alcohol related problems.

7.79. The national and local response to the pandemic also impacted on housing and support. Practitioners identified a potential impact on Christine of not being able to leave temporary accommodation to escape violence.

7.80. The lockdown was noted, however, to have a positive impact on Christine's risk of infection following surgery since she was unable to go out.

8. SUMMARY AND CONCLUSIONS

8.1. Amy, Bridget, Christine and Denise shared a number of similarities in their backgrounds. Amy, Christine and Bridget were known to have been sexually and physically abused by family members during their childhoods. Denise's childhood is less well understood, although given her adult circumstances, the research and practice evidence would suggest that Denise was also likely to have survived a traumatic childhood.

8.2. These adverse childhood experiences appear to have impacted on Amy, Bridget, Christine and Denise's adult lives which involved violence, loss, sexual assaults, physical assaults and financial abuse. Amy, Bridget, Christine and Denise experienced mental health problems, self-harm and suicide attempts, drug and alcohol use, homelessness, unstable and temporary housing and a lack of safety in their homes.

8.3. Amy, Bridget, Christine and Denise struggled to engage with services, finding the experience too distressing at times and services struggled to find ways to engage with them. From the perspective of research and practice findings, all were at risk of self-harm and suicide but only Amy and Bridget are known to have taken their own lives.

Christine and Denise died whilst taking drugs, although Denise's overdose might not have been accidental.

8.4. Amy, Bridget, Christine and Denise appear to have been assumed to have the mental capacity to make decisions about their welfare and safety, but given what is known of their backgrounds, life experience and use of alcohol and drugs, this may not always have been the case.

8.5. The terms of reference of this review will be used to structure the conclusions and, in turn, to develop recommendations:

8.6. **How well did services identify and respond to women with multiple complex needs who have a history of trauma?**

8.7. Amy, Bridget and Christine's traumatic histories were recognised by services. There was less recognition that Denise had, or may have, survived adverse childhood experiences, although the research evidence suggests that this may have been the case. Recognition of a history of trauma and of its impact on adult life, however, did not necessarily lead to more effective service responses, which tended to be reactive to crises rather than active in reducing their likelihood.

8.8. **How well did agencies work together and respond to address domestic violence and abuse and whether systems support or hinder practice in this area.**

8.9. Amy, Bridget, Christine and Denise all experienced domestic violence and abuse. The MARAC process was used for Bridget in March 2019 and for Denise nine times between November 2019 and September 2020. Denise's life illustrates the cyclical and escalating nature of coercive and controlling relationships, especially when combined with drug and alcohol use and the co-dependency that develops between the abuser and the victim. There was also evidence of escalation in the severity of violence.

8.10. Despite this, interventions to support Denise were episodic, hampered by Denise's refusal to support the prosecution of her abusive partner and to accept further support. The role of IDVA's does not appear to have been well understood (for example, in March 2020, an IDVA had been asked to refer Denise to STAR, for example, despite having only begun the process of engaging with Denise) and practitioners recognised that support services for domestic violence and abuse had limited capacity to meet demand. Practitioners described how IDVAs made three contact attempts and then closed cases if there is no response. Practitioners also noted that the practice of placing women fleeing domestic violence and abuse in refuges outside of their area meant that there is a risk of losing contact with services, further exacerbating problems with engagement in therapeutic interventions.

8.11. **How well did agencies work in partnership, in relation to sharing information, co-ordination of responses and oversight within and across agencies?**

8.12. There was evidence of joint working but there is a need to share key information that might support clients to engage with services and to reduce the number of appointments to not overburden people who already struggle to attend them.

8.13. Overall case leadership was made more difficult by the intermittent nature of Amy, Bridget, Christine and Denise's contact with services.

8.14. **Did professionals and agencies have the knowledge, skills and experience to support people with complex and multiple needs and those who have challenges in engaging with support?**

8.15. Clients like Amy, Bridget, Christine and Denise were described by practitioners as those whose needs they struggle the most to meet. They often present as unstable and distressed and required support in an unplanned way when in a crisis. Whilst practitioners were knowledgeable and skilled this did not necessarily transfer to being able to work with hard to engage clients who were mistrustful and unable to comply with the requirements to attend appointments regularly and to comply with expectations and routines.

8.16. Rather than a matter of skills, a change in ways of working may be required, which is flexible and uses different approaches to increase the chances of engagement. Outreach based models, mobile services, willing to meet people where it suits them and relationship-based approaches, which aim to build familiarity and trust, often in one individual practitioner can be helpful.

8.17. A lead practitioner role, where an individual who has a good relationship with a client is supported collectively by the different organisations involved to maintain contact may be useful.

8.18. **Do the current systems, policies and processes that are in place to assess and manage risk presented to women with complex and multiple needs are effective and embedded in systems.**

8.19. Whilst practitioners recognised and understood the impact of life trauma on their clients, this does not appear to have influenced organisational policy responses. The practice of discharge following missed appointments, for example, does not fit well with people who are unstable because of their traumatic life experiences and is a factor that has been identified in other Safeguarding Adults Reviews.

8.20. This review echo's the 2020 East Sussex Safeguarding Adults Board safeguarding adults review following the death of Adult C, which found that, "*Current service set ups locally are not joined up or tailored to the needs of a small cohort of women who struggle with a combination of needs related to chronic trauma, drug and alcohol dependencies, homelessness and domestic violence and abuse. This leaves some of the most vulnerable women either excluded from services altogether based on eligibility criteria, or unable to access them because of the lack of proactive, flexible and intensive outreach support*". The Adult C safeguarding adults review action plan included the need to "Agree a common definition of multiple-complex needs and a multi-agency assessment and care planning tool that supports practitioners to identify and respond effectively to this cohort" As a result, a Multi-Agency Risk Management (MARM) Protocol was launched in January 2022.

8.21. **Are the support and services that are available to homeless women with complex multiple needs accessible and do they meet those needs?**

8.22. It would appear that Bridget, Christine and Denise's accommodation rarely met UN criteria for satisfactory housing, **something** which could be considered to be a key foundation for good mental health and wellbeing. From what is known of Bridget, Christine and Denise's' backgrounds and life experiences it would seem that they met the definition of Multiple Exclusion Homelessness.

8.23. Bridget, Christine and Denise lived in temporary accommodation which was rarely suitable for this cohort of people with complex multiple needs. Consequently, it would appear that there is a need for safe accommodation and to consider how people who experience instability and are hard to engage can be provided with security of accommodation .

8.24. **What was the impact of Covid-19 on service provision (including the effectiveness of safeguarding responses) and the impact on mental health and well-being.**

8.25. The deaths of Amy, Bridget, Christine and Denise all happened during the Coronavirus pandemic and the resulting restrictions on freedom of movement and on the availability of services. Face to face contact between practitioners stopped or was significantly curtailed, some services closed entirely. This included both universal and specialist services that might provide distractions for people who used drugs and alcohol. Christine had difficulties seeing her GP during Covid-19 (although there had been a pattern of not-attendance before this) and her contact with SWIFT was more limited. The venues in which Bridget liked to meet practitioners were closed and telephone contact was used instead Bridget between April and August, at which time Bridget was living in temporary accommodation.

8.26. Practitioners did hold face-to-face meetings, in line with regulations and guidance, where the situation required these and provided telephone support otherwise. Practitioners noted that one of the difficulties with remote therapeutic working was not being able to see body language.

8.27. In addition to these terms of reference, the following conclusions are also drawn.

8.28. **Suicide prediction and prevention requires consideration of multiple factors including background, events and stressors.**

8.29. From the perspective of research and practice findings, Amy, Bridget, Christine and Denise were at risk of self-harm and suicide but only Amy and Bridget are known to have taken their own lives. Christine and Denise died whilst taking drugs, although Denise's overdose might not have been accidental.

8.30. The Royal College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), cautions that suicide risk should be assessed on an individual basis and that the absence of risk factors does not mean the absence of any risk of suicide: "*…a person may be imminently at risk of suicide even though they are not a member of a 'high-risk' group. Conversely, not all members of 'high-risk' groups are equally vulnerable to suicide. Moreover, suicidal thoughts (and risk) can vary across a relatively short time period. The presence of red flag warning signs indicates that someone may be particularly at risk of suicide. Neither risk factors nor red flag warning signs can or should, however, be used to predict or rule out an individual suicide attempt*."

8.31. Consequently, suicide and self-harm prediction and prevention requires a thorough understanding of each person's circumstances and of how events and stressors might cumulatively build up and impact on each other. Embedding a trauma-informed approach alongside comprehensive self-care and supportive and reflective supervision for practitioners could be useful when working with any clients with complex needs and significant histories of trauma.

8.32. In order to support this, the Health Education England Self-harm and Suicide Prevention Competence Framework (October 2018) should be promoted and used, in partnership with NHS and local authority commissioners and training departments, as a means of equipping staff with the skills necessary to identify and work with people who are at risk of self-harm and suicide.

8.33. The Royal College of Psychiatrists' Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), published in June 2020 and the Department of Heath's "Information sharing and suicide prevention consensus statement" should also be

promoted, perhaps by inviting a representative from the Royal College of Psychiatrist to attend a safeguarding adults board meeting to present the report. With permission this could be recorded and distributed to staff in partner organisations.

8.34. SPFT has a Towards Zero Suicide Strategy (updated in 2020) which identifies a broad range of actions to improve the responses of its services to suicide risk. The East Sussex Safeguarding Adults Board should ask for a report on the progress of this strategy and should lead consideration of how its principles could be applied more widely outside of SPFT's services.

8.35. **Organisational policies and practices will need to change to support hard to engage people who have traumatic life histories.**

8.36. Whilst practitioners recognised that closing cases due to lack of engagement could be detrimental to people who found it hard to engage with services, policies, procedures and ways of working will need to change to allow cases to be kept open and not passed from service to service. Similarly, avoiding cyclical patterns of homelessness will involve alternative approaches to tenancy and accommodation support.

8.37. A number of these factors remained present in the way that services responded to the needs of Amy, Bridget, Christine and Denise and were also identified by practitioners as problems that still need to be resolved.

8.38. The Adult C review also found that, "*There is not currently an established multi-agency protocol or supporting tools for the proactive collection of third-party evidence of patterns of domestic violence and abuse. This leaves police responding reactively to incidents of domestic violence and abuse and trying but struggling to gather viable third-party evidence and leaves the voluntary sector frustrated at inaction against known perpetrators*". A protocol and tools are now being developed across Sussex, in conjunction with the Changing Futures Programme, to improve outcomes for adults experiencing multiple disadvantages, including combinations of homelessness, substance use, mental health needs , domestic abuse and contact with the criminal justice system.

8.39. Whilst there did not appear to be problems with gathering evidence of domestic violence and abuse, especially in Denise's case, challenges remained in effective responses to it when she refused interventions. Police contacts remained reactive and contacts with an IDVA were unsuccessful in supporting Denise to think that change might be possible. There was also evidence that the role of the IDVA was not necessarily understood by other professionals when the IDVA was asked to complete a referral form for mental health services in March 2020.

8.40. Organisations working with Amy, Bridget, Christine and Denise also identified challenges in joint working and communication, including not being invited to meetings, and identified the need to create joint and overarching care plans. The emphasis should be on not letting people who struggle to engage with services disengage from them entirely.

8.41. In order to support this change examples of alternative approaches to meeting needs and supporting engagement should be examined by partners in East Sussex. Examples include the Core Team model currently under development in the London Borough of Camden; the Adder Project in Hastings, which supports people who use opiates and or crack cocaine and the Serenity Integrated Mentoring programme in London in which the police and mental health services work together to support people with mental health needs.

8.42. **Think Family approaches may be useful to support engagement and harm prevention**

8.43. There appears to have been little joint working with Amy, Bridget and Christine and Denise's families or friends to support, encourage or identify risks. Some family relationships were strained but this should not necessarily have deterred efforts to rebuild and harness relationships to support efforts to help Amy, Bridget, Christine and Denise. Where there are concerns about safety and the risk of suicide, the Royal College of Psychiatrists states that all health and social care professionals should be aware of the "*Information sharing and suicide prevention consensus statement*" (Department of Health, 2014) and adapt their practice as necessary to work with family and friends and prevent suicide. This guidance sets out the circumstances in which concerns about suicide can and should be shared even in situations where permission to do so has not been given by the person at risk.

8.44. Bridget's mother and grandmother described how they felt that they were blamed when they could no longer support her at home when she had a "breakdown" and felt that they were not involved in decisions about the services provided.

8.45. A "Think Family" approach might also help to support engagement and risk assessment. This approach builds the resilience and capabilities of families to support themselves (Wong et al, 2016) and recognises that individuals rarely if ever exist in isolation and that whole-family approaches are often necessary to meet individual and family wide needs. The core principles of the "Think Family" approach are that practitioners:

- Consider and respond to the needs of the whole family, including the poverty, drug and alcohol use, domestic abuse and mental health difficulties of everyone in the home (including frequent visitors) in all assessments and interventions

- Work jointly with family members as well as with different agencies to meet needs

- Share information appropriately according to the level of risk and escalating concerns if they are not otherwise being responded to.

8.46. Such an approach may have led to greater consideration of the family circumstances of Amy, Bridget, Christine and Denise and may have helped to identify motivating and protective factors including friends and relatives.

8.47. Transitional safeguarding processes should be implemented so that the needs of people who have survived adverse childhood experiences are met after they reach the age of 18 years old.

9. RECOMMENDATIONS

9.1. **Recommendation 1**: *The ESAB should promote the Royal College of Psychiatrist's Final report of the Patient Safety Group, Self-Harm and Suicide in Adults (CR229), published in June 2020 and the Department of Heath's "Information sharing and suicide prevention consensus statement".*

9.2. The ESAB could consider inviting a representative from the Royal College of Psychiatrists to attend a Safeguarding Adults Board meeting to present the report in collaboration with the East Sussex Suicide Prevention Group. With permission this could be recorded and distributed to staff in partner organisations.

9.3. As outlined in the Royal College of Psychiatrist's report, agencies in East Sussex should use Suicide Safety Plans, completed with the person at risk of suicide or self-ham who has thoughts of suicide and self-harm or who has attempted suicide and self-harm.

9.4. The ESAB could also promote the Health Education England Self-harm and Suicide Prevention Competence Framework (October 2018), in partnership with NHS and local authority commissioners and training departments, as a means of equipping staff with the skills necessary to identify and work with people who are at risk of self-harm and suicide.

9.5. **Recommendation 2** *The ESSAB should ask for a report on the progress of SPFT's Towards Zero Suicide Strategy, the aims of which are to reduce the suicide rate within SPFT's services in line with national trends and to work with the 'Sussex Health and Care Partnership' to reduce suicide rates across Sussex.*

9.6. The ESAB could lead consideration of how the principles and approaches set out Towards Zero Suicide could be applied and shared more widely outside of SPFT's services to create alternative approaches aimed at supporting people who find it hard to engage with services.

9.7. **Recommendation 3**: ESAB *should consider the use of outreach and flexible approaches to meet the needs of individuals over the age of 18 years old who find it hard to engage with services and who services consider having multiple complex needs and/ or have had experienced adverse childhood experiences.*

9.8. This could include developing trauma informed approaches which recognise and respond to the continuing impact of ACE during adulthood. These should include challenging the concept of "lifestyle choice", understanding the coercive and controlling effects of substance dependency upon decision making and mental capacity and not making assumptions about, but support the development of, resilience.

9.9. Health, social services and criminal justice partners should build on and developing existing models such as "Fulfilling Lives", "Changing Futures" and the commissioning intentions for future services. A 'blended approach' including the use of virtual methods for engagement as an adjunct to face-to-face contact to support clients to engage with services should be used.

9.10. Health, social services should also adopt approaches such as the Core Team model currently under development in the London Borough of Camden to avoid closing cases due to lack of engagement by people who find it hard to engage with services.

9.11. **Recommendation 4**: E*SSAB seeks assurance that collaborative working of agencies prevents clients from falling through gaps between services and is supported by commissioning.*

9.12. For example, health, social services and criminal justice partners could identify how a lead practitioner approach might operate with people who are hard to engage. This would involve the person with the best relationship with a client taking the lead on maintaining contact, assertively engaging them and initiating support from other services.

9.13. **Recommendation 5:** *The ESSAB seeks assurance that transitional safeguarding processes are meeting the needs of people who have had adverse childhood experiences but are struggling to engage with services, are met after they reach the age of 18 years old.*

9.14. This should build on the work of the Adder Project in Hastings, which supports people who use opiates and or crack cocaine and the Serenity Integrated Mentoring programmes on the Isle of Wight and in London, in which the police and mental health services work together to support people with mental needs. Links with the strategic priorities of early intervention and prevention in children's services should be identified and use of the MACE (Multi-Agency Child Exploitation) group should be considered to better coordinate children's and adult's services so that transition is not a sudden change.

9.15. Health, social services and criminal justice partners should pilot a "Think Family" approach aimed at increasing the involvement of family members in the supporting people who are otherwise hard to engage.

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