



Still Vulnerable The Impact of Early Childhood Experiences on Adolescent Suicide and Accidental Death

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The views expressed herein are those of the authors.

FOREWORD



As the Northern Ireland Commissioner for Children and Young People (NICCY) it is my primary aim, as set out in legislation, 'to promote and safeguard the rights and best interests of children and young people'. The United Nations Convention on the Rights of the Child (UNCRC), upon which I base all my work, requires government to protect children's rights across all areas of their lives – including their rights to health and welfare and their rights to protection from all forms of abuse, harm and violence. The vision of the Convention is not simply that government meets minimum children's rights standards but that the full implementation of the UNCRC enables children and young people to live in families, communities and societies where they can flourish and where their individual dignity and physical integrity is safeguarded and respected.

The loss of a child or young person due to suicide or accidental death is a tragedy and I am deeply aware of the profound impact of this loss on everyone it touches. Sadly in recent years many stories of teenage suicide and death have been reported in our media and Northern Ireland continues to experience higher rates of suicide among adolescents and young adults than other parts of the United Kingdom. Adolescent suicide and accidental death must also be understood as affecting our wider communities and society as we struggle to reconcile ourselves with the loss of such young life. It challenges us to reflect on how we are currently seeking to meet the needs of vulnerable children and young people and to consider how this could be improved.

Central to my role in safeguarding children's rights and best interests is my statutory duty to keep under review the adequacy and effectiveness of the law, policy and services relating to the rights and welfare of children and young people. As part of my work in fulfilling this duty I consider information from Case Management Review (CMR) reports which are most often conducted following the death or significant injury of a child where abuse is known or suspected to be a factor. The CMR process is in place to ensure there is proper reflection and learning from these difficult and distressing cases.

I was saddened by the number of adolescent deaths due to suicide that were documented in case reviews and in order to more fully explore this complex and sensitive area I commissioned Queens University Belfast in conjunction with the



NSPCC to undertake this research. The authors have completed a thoughtful and considered study which draws on developing knowledge about the impact of adverse experiences, which include child maltreatment but also take account of other significant factors such as parental substance misuse and parental bereavement, on children's lives. The work pays particular attention to the relationship between children's exposure to multiple and enduring adversities and poor outcomes in their later years, including suicide in adolescence.

The research also draws on case reviews conducted in England and a number of Northern Ireland cases and I would like to acknowledge the role of the Health and Social Care Board in facilitating access to this information. The purpose of this was to assess whether collectively across these reviews into the deaths of young people, valuable learning about how we can better support vulnerable children could be identified.

The report raises important questions about how to best engage with children, young people and families and draws attention to a number of concerns which should inform how we plan and deliver services. Central to these is ensuring that a holistic approach is taken to understanding the needs of each young person and that this recognises how experiences of adversity in earlier years can reduce resilience in adolescence and shape underlying needs for support.

Critically this requires an approach that is not simply focused on responding to immediate crisis or presenting issues. Rather it is one which looks beyond this to identify how, in order to improve young people's life chances on an enduring basis, they can be supported by services which are responsive to their needs, are provided from an early stage and are delivered in a sustained and co-ordinated manner. Indeed the research reminds us that while we must, of course, listen to, respect and take account of young people's voices, opinions and decisions as they grow and develop, this should not lead us to simply equate older years in adolescence with increased resilience or divert attention away from young people's ongoing needs for support and protection.

This report is concerned with the most precious and fundamental rights that children and young people should be afforded – the right to life, survival and development. It is vital that we seek to learn from studies such as this and that our arrangements to support and safeguard children and young people respond to emerging research and evidence. This report is an important contribution to that debate and in taking this work forward my office will seek to engage government and statutory bodies, as well as others, in the implementation of the research recommendations.



I would ask, as the research team do, that any reporting or debate about this research reflects the sensitive nature of these issues and is respectful of the children, young people and families whose lives have been touched by adolescent suicide and accidental death.

I commend this report to you and I call on the Northern Ireland Executive and statutory authorities to reflect on their responsibilities in safeguarding children and young people vulnerable to suicide and accidental death and to carefully consider how arrangements can be strengthened in order to fully realise their rights and best interests.



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EXECUTIVE SUMMARY

Introduction

Adolescence is both a challenge and a delight. It is a time when new opportunities present that allow the development of new relationships, new skills and a growing sense of independence and self. However, it can also be a time of challenge as individuals need to negotiate more complex and differentiated social and family relationships, issues of values and attitudes come to the fore, and questions about identity and the future become more apparent. On the whole research has concluded that most adolescents navigate this stage of life with few difficulties, but a minority do find this stage of life challenging, and their ways of coping may have negative consequences for both themselves and others.

Children's rights

The United Nations Convention on the Rights of the Child (UNCRC) places a duty on States parties to ensure that children and young people are supported during childhood in order to attain the highest standard of health and wellbeing, and to respond robustly where factors may be impacting on children's welfare. In the most recent General Comment, the Committee on the Rights of the Child recognises the multiplicity of ways in which children's needs may not be met by both parents and State bodies (CRC, 2011). In Northern Ireland NICCY's 2007/08 Review of Children's Rights identified mental ill health, and high rates of suicide and self-harm amongst children and young people as one of the key areas of children's rights that was being ignored or underplayed. This concern is shared by the other United Kingdom Children's Commissioners as well as the UN Committee on the Rights of the Child which has requested that all States parties provide data on deaths of children due to suicide in their periodic reports, specifically requesting of the United Kingdom Government that it undertake studies on the causes and backgrounds of suicides.

Children who harm themselves

Suicide is a multi-faceted phenomenon involving the interaction between biological, psychological, sociological, environmental and cultural factors. Suicide in adolescents has been identified as a serious public health problem worldwide. However, although adolescent suicide remains a well-researched area it still



remains a poorly understood phenomenon. There has been some research which considers self-harm and suicide among children and young people in Northern Ireland but there are major gaps in the available knowledge and research on how children and young people are positioned in relation to self-harm and suicide. Prevention of suicidal behaviour is often difficult, and poses a major challenge given the relative rarity of the event. Effective prevention therefore requires sound knowledge of the key risk factors with the main target of effective prevention of youth suicides being to reduce suicide risk factors with one of the most significant being the exposure to and experience of adversity in childhood.

The impact of adversity in childhood

It has been recognised by researchers that the experience of multiple adversities in childhood has implications for the ability of individuals experiencing these to resist their deleterious impact upon their lives. Such accumulations appear to have higher predictive power than do singular experiences of adversity, even though the trauma associated with, for example, child sexual abuse, may in some cases have severe and long lasting consequences for the individual. When predicting poor outcomes for an individual it is the multiples which matter, even if researchers have not yet arrived at a definitive list of all adversity factors regarded as increasing risk of poor outcomes for those experiencing them.

It is important to note that whilst suicide is the most tragic of outcomes for a young person, it may be, indeed it is probable, that for others who experience similar numbers of childhood adversities the outcomes will be very poor indeed. Over time the multiple adversities experienced in childhood may come to express themselves in the experience of homelessness, imprisonment, drug and alcohol addiction, physical and mental health problems and early death. Whilst in this report we concentrate on those young people who may be translating at a very early stage the physiological and psychological consequences of the experience of childhood adversities into risk taking behaviours, some of which have resulted in their untimely and tragic death, we need to balance this focus with an understanding of the outcomes for those young people experiencing similar adversity sequelae but whose outcomes are hidden by the passage of time. We might further observe that studies of adolescent suicide impose something of an artificial time span within which the incidence of this phenomenon is captured. We might better conceptualise suicide in adolescence as early completion, with suicide after the age of 18 being later completion.



This gives us a much better picture of the strength of association between the numbers of adversities experienced in childhood and outcomes across the life-course.

Intervening effectively

Nordentoft's primary, secondary and tertiary interventions for suicidation correspond with the Hardiker's model which is used in children's services in Northern Ireland. It also identifies primary (universal), secondary (vulnerable/at risk of social exclusion) and tertiary (in need) prevention and adds a fourth level of rehabilitation (after a child is in state care and/or has complex and enduring needs). The universal, selective and indicated prevention model overlaps the 4 Tier-model of Child and Adolescent Mental Health Services (CAMHS) with Tier 1 including indicated prevention then Tiers 2-4 providing different levels of specialist services. More recently the Department of Health, Social Services and Public Safety (DHSSPS) have confirmed the preferred model for the organisation of CAMHS in Northern Ireland builds on these approaches and should be a stepped care model. It identifies five steps:

1. Universal/prevention
2. Targeted/early intervention
3. Specialist intervention
4. Intermediate care
5. Highly specialist inpatient/secure care.

It has been concluded that interventions with the best evidence for suicide prevention include:

- means restriction, including identification of 'hotspots';
- clinical guidelines for all health and social services staff to use when dealing with people who are at risk of suicide/self-harm; and
- programmes that enhance the coping and problem solving skills of those who self-harm, and which reduce the risk of repeat self-harm.



Case examples

In looking at eight case examples where young people have died by suicide in Northern Ireland it is apparent that the majority of young people had experienced four or more adversities out of a maximum total of thirteen on a research informed checklist of key childhood adversities associated with poor outcomes, with a mean of 5.9. It must be borne in mind that this is likely to be an underestimation as the records examined may not have recorded some information which might have been considered not relevant for the purposes of service involvement. In terms of the types of adversity experienced this was spread right across the full spectrum of issues, with child sexual abuse, parental loss, parental substance misuse and victimisation by peers all appearing in at least five of the eight cases. Some of the adversities, such as living in a deprived neighbourhood or with a parent who misused substances, had been fairly consistent for most of the young people throughout their childhood, whilst other adversities had occurred at a specific moment, even if their after effects were then persistent. Many of the young people had experienced a number of these adversities for the first time in their younger years, with the impact manifesting over a much longer timeframe.

Key themes and learning

From an in-depth analysis of the eight cases in Northern Ireland, and comparing this with a larger sample of similar cases from England, a number of key themes emerge about the young people and their families:

- there has typically been long standing **agency involvement** from a number of different services, that often work with the young person and their family without effective co-ordination between the services.
- involvement is often episodic and based on responding to the latest crisis or incident, rather than interventions being **earlier and more sustained**. The risk of immediate harm rather than the longer term consequences of adversity skew the professional response.
- **thresholds for intervention** often work against earlier intervention, and extenuate the boundaries between services.



- **agency perceptions** of the young people often conceive young people as troubling rather than troubled, and that they are better able to cope with the adversity in their lives and therefore require fewer interventions.
- boundaries between services and unrealistic expectations about how young people use services result in **CAMHS services** not being responsive to some young people's needs.
- in listening to the **voice of the child** professionals need to balance showing young people that they are heard and understood, whilst also helping them to understand that their views must sometimes be qualified for their own protection.

In reflecting on why some young people appear to cope better with adversity than others research has noted that:

- there is strong evidence from longitudinal studies that, where protective factors are present, most children and young people do recover from short term adversity. In this sense we can say that the majority of children and young people have the capacity for resilience so long as the risk factors are limited, and protective factors are in place.
- where risk factors are continuous and severe, only a minority manage to cope. The more serious the adversity, the stronger the protective factors need to be. Thus, under conditions of major risk, resilience is only apparent among a minority who can draw on the strengths gained from protective factors.
- the major risk factors for children tend to lie within chronic and transitional events, rather than in acute risks. Therefore children show greater resilience when faced with acute adversities such as bereavement, or short term illness, and less resilience when exposed to chronic risks such as continuing family conflict, long term poverty, and multiple changes of home and school. The research highlighted in this report also confirms that it is the multiplicity of chronic adversities which are the most dangerous for children and young people.
- resilience can only develop through exposure to risk or to stress. Resilience develops through gradual exposure to difficulties at a manageable level of intensity, and at points in the lifecycle where protective factors can operate. This requires the support of others, typically family and peers. However, for some young people it may be that



family and peers are the source of their stress, and that the stress is overwhelming and persistent.

This study supports a growing body of evidence which highlights what could usefully be done to better meet the needs of these young people based on examples of practice that have been shown to be effective:

- these very vulnerable young people need more creative, more responsive, individually tailored services that extend into their adulthood.
- as these young people are often known to multiple services, there is a need for greater co-ordination between service providers.
- services should be sustained and planned on a long term basis so that they can address root causes and not just respond (or fail to respond) to young people's current distress or challenging behaviours.
- staff need to have a skill set which involves the ability to engage with young people who do not necessarily want to engage, and to be able to motivate the young person to make positive choices in their life.
- there is a need for services in children's social care, health, education and criminal justice to develop better ways of identifying children suffering from depression and being more responsive in addressing any assessed need.
- there needs to be a clear transition from children's services to effective and responsive adult services.
- whilst some young people may present with troublesome behaviour, this should not stop them being seen as troubled. Therefore providing compensatory experiences in order to promote greater resilience must be seen as part of the therapeutic intervention, rather than a reward for inappropriate behaviour.
- since these young people are often extremely challenging to help, excellent training, support and supervision is needed for those providing their care.

In reviewing the eight cases from Northern Ireland we are reminded that some young people have led difficult lives, and that this can manifest itself in poor mental health, challenging behaviours, and a difficulty in accepting support and help from concerned others. The reviews of such cases in both Northern Ireland and England confirms that there are a range of adversities which impact on an adolescent's sense of wellbeing in both the immediate and longer term, and that



professionals and their employing agencies must be mindful of what services they provide as well as how they are provided.

By looking at these cases through the lens of the literature on adversity and the impact of multiple adversities over time, we are better able to see why some young people place themselves at risk and end up dying by suicide. Their natural resilience and ability to cope with life's ups and downs has been compromised, and in the absence of alternative supports, it is unsurprising that some young people feel overwhelmed by the challenges of their particular situations. This review has helped to draw together a body of knowledge that informs our understanding of why young people may feel overwhelmed, and why professionals need to conceptualise young people's needs differently.

Recommendations

Recommendation 1: Assessment

There is a need to support staff to see and understand that there are a range of both presenting and underlying factors which may be impacting on a young person's developmental and coping abilities. Building upon the successful roll out of the UNOCINI (Understanding the Needs of Children in Northern Ireland) assessment framework we would recommend that a structured decision making tool is introduced to support staff in any service to identify the key childhood adversities known to lead to poorer outcomes in later life. This should lead to the aims of UNOCINI as a holistic assessment to be more fully realised. This tool could be piloted and evaluated in one area as a means of assessing its utility. This issue should be considered by the Department of Health, Social Services and Public Safety and the Health and Social Care Board as the lead agencies with regards UNOCINI.

Recommendation 2: Case planning

It was an unsurprising finding that the majority of the young people in the Northern Ireland sample were not subject to either a child protection plan nor were they looked after. Children in such circumstances benefit greatly from the multi-agency co-ordination of interventions and services that result from being on the child protection register or being looked after. However, the majority of the young people were known to a range of services, and professionals did have concerns about the needs and wellbeing of the young people. There is a need therefore to ensure greater co-ordination in the response of professionals and



provision of services. This is most likely to be achieved by the appointment of a lead professional, identified at a case planning meeting, and supported by an agreed and written intervention plan. The lead professional should ordinarily be from the agency with greatest contact with the young person, as the role is both about co-ordinating services alongside developing a therapeutic relationship with the young person. This issue should be considered by the Health and Social Care Board through the Children and Young People's Strategic Partnership, and the Safeguarding Board for Northern Ireland.

Recommendation 3: Identification of depression

The research is clear that earlier identification and response to a young person's poor mental health, and in particular depression, will reduce substance misuse, self-harm, and suicide attempts. There is a need to ensure that professionals having greatest contact with young people in education, social care, health care and criminal justice have greater understanding of what depression is, how to identify it and how to respond. This is particularly the case for young people in various forms of residential care, or where family relationships have broken down. Recently there has been notable roll out of training about suicide, and this should be reviewed to ensure that the broader issue of adolescent depression is also addressed, and the target groups for this training. This issue should be considered by the Department of Health, Social Services and Public Safety and the Public Health Agency in the development of a new service model for the delivery of CAMHS services, and the refreshed *Protect Life* strategy.

Recommendation 4: Reducing the impact of adversity

In an ideal world professionals would rather prevent children from experiencing adversity in the first instance. Whilst this is possible, and interventions such as Sure Start and positive parenting interventions do make a difference, most child welfare professionals will continue to need to respond once a crisis or problem arises. In doing so there is a clear need to manage the twin objectives of reducing any immediate risk a child may be exposed to, alongside providing evidence based therapeutic interventions to attend to the psychosocial impact of the adversity on the child or young person. Professionals need to be mindful of the possibility of the young person having experienced multiple adversities and to see their role as being broader than responding just to the immediate or current issue. There is clear evidence that many therapists continue to deal with the presenting issue, without due consideration of the wider array of adversities the



young person may have experienced. This issue should be considered by the Health and Social Care Board through the Children and Young People's Strategic Partnership, and the Safeguarding Board for Northern Ireland.

Recommendation 5: Pathways to impact

There is a strong evidence base to inform our understanding that a range of experiences in childhood have a negative impact in adolescence and adulthood. We also know that some types of intervention are protective, such as screening for depression and mentoring schemes. We need though to more fully appreciate the trajectories over time for young people who do receive interventions to better understand what works and in what circumstances for whom. For example, it would be useful to compare groups of young people with similar profiles but who are known in the main to different services such as youth justice, CAMHS, substance misuse, looked after services – to identify whether young people with similar needs end up in different service systems by chance, and whether different service systems produce better outcomes for young people with similar needs. This requires a refocusing on the outcomes to be achieved for young people, rather than the outputs of different services and systems. This issue should be considered by the Office of the First Minister and Deputy First Minister in relation to their lead responsibility for addressing social exclusion and the ten year strategy for children and young people in Northern Ireland.



CHAPTER 1: Introduction

It is recognised that children pass through a series of developmental stages from birth through to adulthood. These stages are marked by changes in physical and psychological development, and the degree of dependence between children and their carers. Adolescence is a particular and very important stage of human development, generally occurring between puberty and legal adulthood (typically between the ages of 11 years and 18 years). During adolescence young people undergo significant physiological, psychological and social change: negotiating puberty; completing growth; assuming a sexually dimorphic body shape; developing new cognitive skills; developing and maintaining intimate relationships outside the family; learning to manage a range of complex emotions; thinking independently; and problem solving. Adolescence is an important part of every young person's development, regardless of their physical and psychosocial characteristics (Christie and Viner, 2005).

Adolescence is often a time of great excitement, possibility and opportunity. Most young people negotiate this stage of development with the support of family and peers. It sometimes presents challenges to their sense of identity and self confidence, but the majority of adolescents move from childhood into adulthood all the better for the experience of and transition through adolescence. However, for a minority of adolescents this stage of development is more problematic.

This report has been commissioned by the Northern Ireland Commissioner for Children and Young People (NICCY). The Commissioner's principal role is to safeguard and promote the rights and best interests of children and young people. In doing so she has a central role in ensuring that the needs of all children, and particular groups of children with additional needs, are recognised and addressed.

This study was commissioned to explore the relationship between adverse childhood experiences and early deaths following suicide or accidental death among young people in Northern Ireland. In this report we seek to set out how some adolescents are affected by their experiences of adversity in childhood, and for a small, but significant minority, they end up dying by suicide. We summarise the current knowledge about the impact of adversity in childhood on



later mental health and suicide, and use examples drawn from a small number of case studies to illustrate the points being made.

The report starts by setting out the obligations of nation states towards their children, and the specific international and national legal instruments which aim to highlight and protect these rights. In the next chapter we explore the impact of adversity in both the immediate and longer term, and the growing understanding of the impact of multiple adversities in childhood on longer term social circumstances and physical and mental health. This is followed by a chapter which focuses on one of the very worst outcomes, the death of adolescents by suicide. The report draws upon an opportunistic sample of eight case examples of young people who have died accidentally, or by suicide in Northern Ireland. These case examples are of adolescents whose deaths have been examined through the Case Management Review process. This is supplemented by research on similar cases which have been subject to a Serious Case Review in England. The focus on these cases is illustrative of the points identified within the research literature on the impact of childhood adversity and its association with adolescent suicide. The report concludes with some reflections on how we, as a society, may better meet the needs of children and young people who experience adversity, and how this might ensure that fewer adolescents feel the need to harm themselves or take their own life.

In doing so we are very mindful that each young person who has died by accident, or from suicide has been someone's child, and likely is also a brother, a sister and a friend. Regrettably, too many adolescents die each year in Northern Ireland through suicide. We hope that in exploring this sensitive but important topic we are better able to provide services which can intervene early enough and in a sustained and co-ordinated way to reduce the incidence of this tragic outcome.

Finally, in any reporting of the issues identified within this report we would encourage the media to have regard to the excellent guidance on the reporting of deaths by suicide provided by the Irish Association of Suicidology (http://www.ias.ie/index.php?option=com_rokdownloads&view=file&Itemid=4&id=5:updated-media-guidelines), and the joint statement by the National Union of Journalists and children's organisations on the reporting of child abuse and neglect (<http://www.baspcan.org.uk/northernireland/>).



CHAPTER 2: Child Maltreatment, Suicide and Children's Rights

The United Nations Convention on the Rights of the Child (UNCRC) is an international human rights treaty that grants all children and young people up to the age of 18 years a comprehensive set of rights. The United Kingdom signed the Convention on 19th April 1990, ratified it on 16th December 1991 and it came into force on 15th January 1992. The UNCRC is the most widely ratified international human rights treaty and all United Nations member states, with the exception of the United States and Somalia, have ratified the Convention.

The UNCRC gives children and young people over forty substantive rights. These rights are not ranked in order of importance but instead interact with one another providing an integrated and holistic framework for understanding what every child needs to have a safe, happy and fulfilled childhood. The rights outlined in the UNCRC can be grouped under the following themes:

1. **Survival rights** which include the child's right to life and the needs that are most basic to existence, such as nutrition, shelter, an adequate living standard, and access to medical services.
2. **Development rights** which include the right to education, play, leisure, cultural activities, access to information, and freedom of thought, conscience and religion.
3. **Protection rights** which ensure children are safeguarded against all forms of abuse, neglect and exploitation, including special care for refugee children; safeguards for children in the criminal justice system; protection for children in employment; and protection and rehabilitation for children who have suffered exploitation or abuse of any kind.
4. **Participation rights** which encompass children's freedom to express opinions, to have a say in matters affecting their own lives, to join associations and to assemble peacefully. As their abilities develop, children are to have increasing opportunities to participate in the activities of their society, in preparation for responsible adulthood.



Children's rights to health and welfare/wellbeing are central to, and pervade all elements of the UNCRC with rights to protection, education and appropriate care, amongst others, all having direct relevance to the health and wellbeing of children and young people. The four general principles of non-discrimination, the best interests of the child, the right to life and maximum survival and development and respect for the views of the child, which underpin all other articles, also have especial relevance to the health and wellbeing of children. Specifically Article 6, the right to life, has obvious resonance when considering the issues of children's mental health, self-harm and suicide. Additionally, Articles 23 and 24 provide for the specific care of children with disabilities and outline the responsibility of States parties to invest in preventative health measures as well as responding to ill health when it occurs.

While Articles 5 and 18 recognise that the family is in the best position to care for and support children and young people, Article 19 places a duty on States parties to take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of abuse, neglect and exploitation, including, while in the care of parents or guardians. Article 19 also outlines government responsibility for having in place effective protective measures and social programmes to provide necessary support for the child and for those who have the care of the child. This includes prevention, identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment.

Article 25 places an additional obligation on governments to ensure that all children who are placed in medical or other placement types (for the purposes of care, protection or treatment of physical or mental health) receive periodic reviews of both their placement and the treatment received. Article 27 addresses the right of all children to enjoy an adequate standard of living, recognising that the child's development cannot be divorced from his or her living conditions. Finally, Article 33 places an onus on governments to protect children from the illicit use of narcotic drugs and psychotropic substances, an issue strongly associated with mental illness, self-harm and suicide.

The Children (Northern Ireland) Order 1995 represents the most significant piece of legislation governing the child protection system in Northern Ireland. This legislation places a duty on Health and Social Care Trusts, in conjunction with others, to safeguard and promote the welfare of children who are in need, and to promote children's upbringing within their family where possible (Article 18). Where concerns exist about a child's welfare, under Article 66 the Health and



Social Care Trust has the duty to investigate such concerns to establish whether there is a need to provide services to safeguard or promote a child's welfare, including provision for the child to be looked after.

Box 1: Select UNCRC Articles

Article 6(1) States Parties recognise that every child has the inherent right to life.

Article 6(2) States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 19 States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

Article 23(1) States Parties recognise that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

Article 24(1) States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

Article 25 States Parties recognise the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 27(1) State Parties recognise the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

Article 33 States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.



Article 34 States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

- (a) The inducement or coercion of a child to engage in any unlawful sexual activity;
- (b) The exploitative use of children in prostitution or other unlawful sexual practices;
- (c) The exploitative use of children in pornographic performances and materials.

Article 35 States Parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.

Article 37 States Parties shall ensure that:

- (a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age;
- (b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time; (c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;
- (d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 39 States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

In their General Comment on adolescent health and development in the context of the UNCRC, the Committee on the Rights of the Child (CRC, 2003) drew attention to the particular difficulties faced by adolescents. They expressed concern about the significant occurrence of suicide among this age group noting that mental disorders and psychosocial illness are relatively common among adolescents and that, in many countries, symptoms such as depression, eating disorders and self-destructive behaviours are increasing. This is often linked with the young person's experience of violence, ill-treatment, abuse and neglect, unrealistic high expectations and/or bullying or hazing in and outside school.



At national level, the General Comment calls for close and systematic collaboration and co-ordination within government, recommending that States parties should adopt a multi-sectoral approach to the promotion and protection of adolescent health and development through the facilitation of effective and sustainable linkages and partnerships.

More recently the UN Committee on the Rights of the Child (CRC, 2011) has drawn attention to the continuing high levels of violence against children across the world. It summarises the array of short and long term health consequences of violence against children including emotional and mental health problems such as anxiety and depressive disorders, hallucinations, memory disturbances and suicide attempts. The Committee has sought to strengthen policy and practice implementation in respect of all children, by clearly establishing measurable indicators of structures, processes and outcomes.

In Northern Ireland NICCY's 2007/08 Review of Children's Rights (NICCY, 2008) identified mental ill health, and high rates of suicide and self-harm amongst children and young people as one of the key areas of children's rights that was being ignored or underplayed in Northern Ireland. This concern is shared by the other United Kingdom Children's Commissioners as well as the Committee on the Rights of the Child which has requested that all States parties provide data on deaths of children due to suicide in their periodic reports (CRC, 2005d), specifically requesting of the United Kingdom Government that it undertake studies on the causes and backgrounds of suicides (CRC, 2002a).

In their report to the UN Committee on the Rights of the Child in 2008 the United Kingdom Children's Commissioners drew attention to the particular context of Northern Ireland and the legacy of 20 years of conflict which has led to unique issues impacting on the wellbeing of children and young people. One of the many impacts is that children and young people continue to experience significant violent events and report much higher stress levels than children in the rest of the United Kingdom. While the conflict is over, significant friction continues within and between communities, often resulting in serious abuse of children's physical, emotional and mental wellbeing. This is compounded by the absence of appropriate services to meet, in particular, self-harm and suicide among young people in Northern Ireland. Equally, in their Concluding Observations to the United Kingdom, the Committee on the Rights of the Child expressed concern that, despite the considerable financial investment, especially in England, 1 in 10 children in the State party have a diagnosable mental health problem but only 25



per cent of them have access to the required treatment and care, with some children continuing to be treated in adult psychiatric wards (CRC, 2008). The Committee also expressed particular concern about the situation of children in this respect being 'particularly delicate', recommending that:

'additional resources and improved capacities be employed to meet the needs of children with mental health problems throughout the country, with particular attention to those at greater risk, including children deprived of parental care, children affected by conflict, those living in poverty and those in conflict with the law.' (p.13).

The UN Committee 2011 General Comment on the rights of a child to be free from all forms of violence, recognises that 'a respectful, supportive child-rearing environment free from violence supports the realisation of children's individual personalities and fosters the development of social, responsible and actively contributing citizens in the local community and larger society' (p.7).

In summary, as a society we have a moral and legal duty to ensure that children have the opportunity to grow and develop free from all forms of violence, and with access to services to support their physical, cognitive and emotional development.



CHAPTER 3: Multiple Adversities in Childhood

There is a duty on States to protect children from experiencing harm, and where children have experienced such harm, to provide services to ameliorate negative consequences (UNCRC, 1989). It is important to recognise the effects of the experience of multiple adversities in childhood for two reasons; first because such experiences have been shown to have profound effects upon individuals, realised in different ways, across the life-course, and second because a preoccupation amongst service providers and researchers with singular events, such as child abuse, has served to obscure or hide the effects of cumulative adversity. In this section we will identify the types of adversities known to have influence on the child and young person's development as well as later life outcomes and suggest ways in which such children and young people might be identified at earlier stages to provide services to them. This is in line with the current direction of public policy as informed by the recent reports with respect to early intervention (Allen, 2011), particularly with those children suffering or at risk of suffering maltreatment (Munro, 2011).

Why multiples matter

It has been recognised by researchers that the experience of multiple adversities in childhood has implications for the ability of individuals experiencing these to resist their deleterious impact upon their lives. Such accumulations appear to have higher predictive power than do singular experiences of adversity, even though the trauma associated with, for example, child sexual abuse, may in some cases have severe and long lasting consequences for the individual. When predicting poor outcomes for an individual it is the multiples which matter:

‘In all cases the pattern has been the same – the greater the number of adverse experiences in childhood, the greater the likelihood of health problems in later life.’

(Center on the Developing Child at Harvard University, 2010, p.6.)

Whilst researchers have not yet arrived at a definitive list of all adversity factors regarded as increasing risk of poor outcomes for those experiencing them, there



is general agreement on a number of core factors. Sabates and Dex (2012, pp.5-6) observe:

‘Well recognised risk factors for children include poverty, mental illness of a parent, instability in the relationships of parents, war, maltreatment and being a premature baby. Each of these individual risks has been noted in longitudinal studies to be associated, on its own, with undesirable effects in later life. More recently, there is the further recognition that multiple risks matter.’

Perhaps counter intuitively, researchers have found that the simple counting of un-weighted risk factors produces an apparent cause and effect scale wherein the acquisition of each additional factor increases the probability that an individual will experience a poor outcome. Such findings are, perhaps, at odds with an instinctive response that the combination of physical abuse and domestic violence, for example, would be more likely to produce a poorer outcome for an individual than say, being born prematurely and having a parent experiencing poor mental health. In truth, such reactions may not be wrong; it may simply be that we have not as yet developed more nuanced tools to better understand the impact of particular combinations of risk factors experienced by individuals at particular junctures along the developmental continuum. In the absence of such tools, however, the simple counting of risk factors (or adversities) experienced by an individual should alert professionals to the predictive implication that they are at increased risk of experiencing poor outcomes across the life-course. Such calculation may further inform the provision of services at targeted populations of those experiencing multiple adversities in childhood whose outcomes are predictably poor, as Feinstein and Sabates (2006, pp.20-21) observe:

‘By age 5 it is possible to identify over one third of those who will experience multiple deprivation 25 years later in adulthood. By age 10 it is possible to identify between 44% and 87% of those who will experience multiple deprivation as adults...the true picture is likely to be around 70%, that is roughly 70% of individuals who will experience multiple deprivation at age 30 can be identified at age 10.’

What are Adverse Childhood Experiences?

It is important to note that exposure to adversity is not deterministic in terms of cause and effect. In other words, it is not inevitable that individuals experiencing



high numbers of adversities go on to experience poor outcomes, either later in childhood or as an adult. There is strong evidence, however, that there is a graded increase in the probability of experiencing poor outcomes associated with the number of adversities experienced in childhood. For example, the Adverse Childhood Experiences (ACE) study, a collaborative research project between the US Centre for Chronic Health Disease Prevention and Health Promotion and the Kaiser Permanente hospital in San Diego, California, has demonstrated strong associations between the experience of adversities in childhood (up to the age of 18 years) and later poor health and social outcomes in adulthood. In this study the ten counted adversities comprise of five concerned with the direct experience of physical, emotional and sexual maltreatment and physical and emotional neglect, and a further five concerned with exposure to the wider family circumstances of domestic violence, loss of parent, parent using drugs or alcohol, parent suffering mental illness or having a parent in prison. The ACE score is a simple count of such experiences, with higher scores, 'repeatedly showing a positive graded relationship to a wide variety of health and social problems' (Anda et al., 2010, p.95). For an individual, the more adversities experienced the greater the chance of experiencing poor outcomes.

With respect to the question of prevalence of such adversities in the general population, evidence provided by a study of the citizens of Washington State in the US indicates that 62% of adults have an ACE score of one or more, with one in four reporting an ACE score of three or more (Anda and Brown, 2010, p.9). In an ACE prevalence study involving students attending a university in Northern Ireland it was found that more than half the study population (56%, n=429) reported at least one adversity with 12.4% reporting an ACE score of four or more. In response to a question regarding past family involvement with social services, 103 respondents (13.5%) answered affirmatively, with 40 of this number recording ACE scores of 4+ (38.9%) (McGavock and Spratt, 2012). It may consequently be argued that those children or young people coming to the attention of social workers are more likely to have significantly higher ACE scores than are found in the general population. This is an important finding, demonstrating both the successes and limitations of the child protection system. The system does reach children whose probability of realising poor outcomes in life are high, but privileges the experience of maltreatment as a trigger for prioritised intervention and so young people experiencing multiple adversities, but not including the direct experience of maltreatment, may not be offered services. Maltreatment or abuse (the terms are synonymous in meaning and are used interchangeably in the literature to refer to the direct experience of the child) may



be regarded as having an adverse effect upon the child, but so do family circumstances, such as the loss of a parent, where the harm is not directed at a child but nonetheless may be seen to have a similar adverse effect. A more general point may be made to the effect that such services that are offered often concentrate on the continued protection of the young person at immediate risk and not usually on the reduction of identified adversities which remain indicators for the increased risk of future poor outcomes. We will return to the issues of how young people facing multiple adversities may be identified and effective services delivered to them in the concluding chapter of this report.

What are the outcomes associated with exposure to multiple adversities in childhood?

It is important to note that whilst suicide is the most tragic of outcomes for a young person, it may be, indeed it is probable, that for others who experience similar numbers of childhood adversities the outcomes will be very poor indeed. Over time the multiple adversities experienced in childhood may come to express themselves in the experience of homelessness, imprisonment, drug and alcohol addiction, physical and mental health problems and early death. In this way, such individuals experience outcomes where associations between childhood experiences and later adult outcomes become obscured by the passage of time. It may be therefore that in identifying and considering how best to respond to those young people experiencing multiple adversities, we might think of our purposes in so doing as seeking to prevent suicide and a range of other poor outcomes, including early death brought about by the consequences of the experience of early multiple adversities being realised in the longer term.

The key, perhaps, to appreciating why some adolescents experience such tragic outcomes beyond their developmental years lies in better understanding the associations between the experience of multiple adversities in childhood and adult outcomes. The ACE study found that those experiencing multiple adversities in childhood had increased probability of experiencing health problems in later life, including liver and heart disease and cancer (Dong et al., 2004). Understanding why this is so involves an examination of the effects of early stress on human physiology. Cumulative adversities may impact upon the developing child to cause:

‘...lasting alterations in stress responsive neurobiological systems, and these lasting effects on the developing brain would be expected to affect



numerous human functions into adulthood, including emotional regulation, somatic signal processing, substance abuse, sexuality, memory arousal, and aggression. The ACE score appears to capture cumulative exposure of the developing brain to the activated stress response'.
(Anda et al., 2010, p.96).

Individuals living with such early exposure to physiological stress may seek to mollify the psychological sequelae by finding ways of dealing with such feelings which are intolerant of delay in gratification. Thus, temporary cessation of symptoms may be achieved by sexual gratification, or the use of drugs or alcohol.

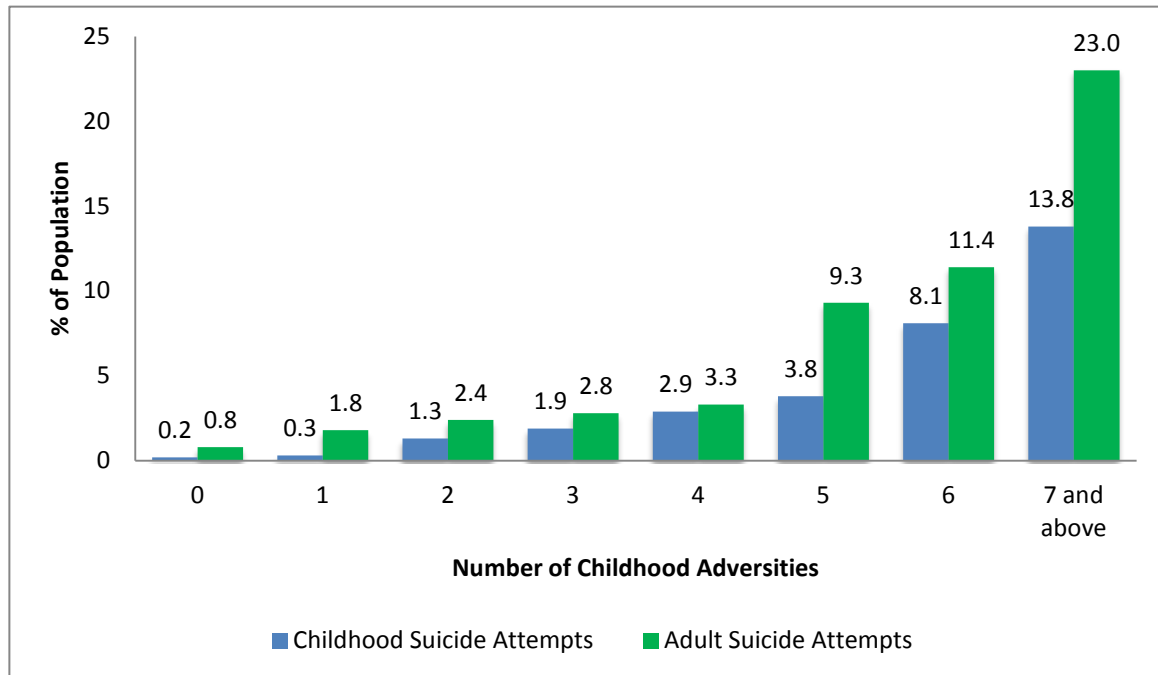
The longer term costs of such behaviours are high, however, as they become translated over time into various forms of health problems. The relatively long time frame involved in such processes creates a tendency to mask cause and effect; so adults being treated for serious disease are advised to cease harmful behaviours, such as smoking, which are known to be linked with the disease in question. This is usually the end point of the enquiry into the causal chain of effects, with the reasons for smoking in the first place being left unexplored. Researchers in the ACE study, however, found that experience of multiple childhood adversities greatly increased the probability that an individual became a smoker in later life (Felitti et al., 1998). The long term outcomes associated with experiences of multiple adversities in childhood may only be fully realised many years later, with such linkages often going unrecognised by the individuals concerned, or indeed by the professionals working with them. Physical health problems experienced in later life are not, however, the only way of tracking the translation of the experience of multiple adversities in childhood into later problematic outcomes, with involvement in criminal activity, unemployment, poor mental health and greatly increased probability of self-harm and suicide (Anda et al., 2006).

Whilst in this report we concentrate on those young people who may be translating at a very early stage the physiological and psychological consequences of the experience of childhood adversities into risk taking behaviours, some of which have resulted in their untimely and tragic death, we need to balance this focus with an understanding of the outcomes for those young people experiencing similar adversity sequelae but whose outcomes are hidden by the passage of time. We might further observe that studies of adolescent suicide impose something of an artificial time span within which



incidence of this phenomenon is captured. We might better conceptualise suicide in adolescence as early completion, with suicide after the age of 18 being later completion. This gives us a much better picture of the strength of association between the numbers of adversities experienced in childhood and outcomes across the life-course. For example, Figure 1 illustrates that the probability of suicide attempts rises in relation to the number of adverse childhood experience scores in the ACE study (Dube et al., 2001). Those individuals experiencing a score of zero adversities in childhood having an approximately 2% probability of suicide completion, those with one = 3%, with two = 5%, with 3 = 10% and those with a score of four or more having a nearly 20% probability (Felitti and Anda, 2008).

Figure 1: Number of childhood adversities and subsequent suicide attempts in childhood/adolescence and adulthood



The latest findings from the ACE study offer something of an empirical counterweight to our examination of death in childhood, pointing to the larger numbers of individuals dying prematurely in adulthood. Brown and colleagues observe that ‘People with six or more ACEs died nearly 20 years earlier [mean: 60.6 years] on average than those without ACEs [mean: 79.1 years]’. They further argue that ‘Studies that examine only one or two types of stressors may underestimate the burden of exposure; fail to recognise the interrelationships among different types of traumatic stressors during childhood (see Dong et al.,



2004); and/or incorrectly attribute long term consequences to single types of childhood traumatic stress despite convincing evidence suggesting that exposure to multiple forms of abuse and traumatic stressors appears to influence health behaviours and outcomes through a cumulative process' (Brown et al., 2009, pp. 389 and 395).

We see something of this tendency in practice in the prioritisation of the response to cases of child maltreatment, both by practitioners, who are more likely to respond to those cases where maltreatment has occurred rather than to cases where multiple adversities may be present but do not include maltreatment, and by researchers who have concentrated on the associations between experience of singular types of maltreatment and later outcomes. Such practitioner prioritisation may be seen as a way of filtering cases within statutory social services, often aided by assessment frameworks, to identify those cases where most immediate risk to children may be identified (Hayes and Spratt, 2009).

Avoiding the single indicator error

The reasons for the prioritisation of child maltreatment cases in practice is largely as a result of the view of government as to the role and remit of statutory agencies. This is further reinforced by public and media concern that agencies and professionals sift referred cases to identify those cases where the risks indicated point to the possibility of the very worst outcomes for the children concerned, foremost amongst these being cases where the death of a child may be predicted and imminent. The deaths of children in tragic circumstances have been influential in driving policy in the United Kingdom with respect to interventions with children and families over the past 40 years (Devaney et al., 2011). Starting with the inquiry into the death of Maria Colwell in 1973, public interest in the protection of children has been periodically stimulated by subsequent inquiries, the most notable of which have been Jasmine Beckford, Victoria Climbié and Peter Connelly. This has caused distortions in agency and professional practice, whereby the system for the protection of children has come to be judged, especially in the popular press, on its effectiveness or otherwise in calculating which children are most likely to die and in preventing such deaths. As enshrined in the UNCRC and in The Children (Northern Ireland) Order 1995 the system, however, has a broader purpose of helping a much wider population of children either predicted to, or actually experiencing, a much greater range of risks and harms. Despite repeated attempts by policy makers, for example, the refocusing debate of the 1990s', to encourage social workers to consider how



risks to children might be mitigated by the provision of earlier preventive services to families to meet their needs, and the publication of Every Child Matters (Department for Education and Skills, 2004) to encourage local authorities in England to implement the intentions of the Children Act 1989 to safeguard the developmental interests of a wider range of children, such intentions have not been realised (Hayes and Spratt, 2009). Indeed, in recent times we have witnessed, in response to the death of Peter Connolly, a renewed concentration on those cases at the sharper end of the child protection system (Munro, 2011). Such developments may reflect a retrenchment with regard to the wider safeguarding agenda in light of public sector funding cuts in response to the world economic downturn. Additionally, practitioners do not possess assessment tools with the calculative power to predict which cases are most likely to result in the death of a child, and such cases are actually so rare that the ability to identify which child is most likely to die is extremely hard to do accurately. This reinforces the importance of society at large taking greater responsibility for supporting children and young people, and responding in instances when it is apparent that a child needs support or protection.

For researchers, the concentration on the narrow set of harms associated with child maltreatment has been one consequence of this focus on worst cases. A second effect, however, has been for the preoccupation with child deaths noted above, to influence the ways in which research priorities are arrived at and the types of outcomes measured (Davidson et al., 2010). The net effect has sometimes been to examine the collated evidence available from the cases where children have died to seek common predictive factors. Such efforts, however, tend to produce lists of factors which are often the common experiences of children and young people in contact with agencies. The fact that most of these children do not experience the most severe, and immediate consequences, does not of course mean that they do not experience very poor outcomes in the longer term. There is consequently a need for an understanding by politicians, the general public and professionals of the range of adversities experienced in common by children and young people in contact with agencies as a precursor to numerically counting such adversities to include, but not to prioritise, child maltreatment. For example, a young person coming to the attention of statutory services where assessment revealed a history of their mother suffering from depression, following the imprisonment of her husband for domestic violence and resulting in a diminution in her ability to meet the emotional needs of her child, might not reach the current threshold for immediate agency action, but nevertheless exhibits the number of adversities predictive of



very poor outcomes for the young person concerned. Greater understanding of the impact of multiple adversities would help managers and practitioners identify in this way both those at risk of the most immediate of poor outcomes and those where these may be realised later in life. In doing so professionals can offer timely help to reduce or buffer the number of adversities that these children are exposed to. In this way we might avoid the single indicator error, which concentrates either on one risk factor or on one outcome to the exclusion of others. This strategy would be in keeping with the intentions of the UNCRC to promote the best interests and rights of the child and, The Children (Northern Ireland) Order 1995 with respect to the duties for local authorities to identify and provide support to children in need and in need of protection.

Using the identification of multiple risk factors as a way of prioritising interventions

Whilst we must take care to avoid the single indicator error, it is equally important to avoid its twin, which we might term the inclusive indicator error. This is the mistake of including every possible risk factor which, however tenuously, may be associated with a poor outcome. For example, maternal smoking during pregnancy has been associated with increased behavioural problems in pre-school children (Sabates and Dex, 2012), but has a weak association with predicting risk of poorer outcomes in adulthood. This has the effect of giving all such indicators equal weight, which is not justified in terms of the provenance of research underlying each factor. In other words, the inclusion of an indicator requires research evidence demonstrating the strength of association with particular outcomes. Whilst the science is quickly evolving in this field and there is no universally agreed set of indicators, the risk factors we use in this study are validated in their predictive power and have been widely used by others undertaking comparable research on the impact of adversity in childhood.

In terms of prioritising interventions the identification of risk indicators has two advantages; it enables practitioners to develop predictive tools for identification and enables agencies to target resources towards those individuals and families with the most assessed risk indicators, and therefore the greater probability of experiencing poorer outcomes. As Hansen and Plewis (2004, p.24) observe 'the reasoning behind the adoption of an "at risk" approach is that it is possible to identify a group who are clearly at risk', whilst acknowledging that 'from a policy perspective it is important to pinpoint those children most at risk' (Hansen and Plewis, 2004, p.18). So, while we might consider that all children referred to



social workers, are likely to have experienced some childhood adversities, some will have experienced more than others. Whilst it is likely that this later group will go on to experience the most serious of negative outcomes, they are unlikely to be currently recognised in a system which predicates the likelihood of significant harm on the occurrence of some form of child maltreatment. So, the young person experiencing the number of adversities identified in the example above may not be identified, using current assessment criteria, as a service priority. The practice of counting risk factors to identify children in the most serious of circumstances is not currently normative within the system for assessment. Making it so, provides considerable challenges as there is a cultural intolerance to those most serious of outcomes for children, including suicide. There is also a reflexive instinct on the part of politicians and the public that identifying such cases should be the chief priority of services, with attribution of blame to professionals often accompanying press reporting. In such circumstances it would be naive to think that agencies may embrace scientifically validated practices which may be difficult to explain in the face of public opprobrium in the aftermath of a child death. The cultural shift to support such changes in practice is more likely to happen over an extended period of time, much in the way public health campaigns have changed attitudes and behaviours with regard to phenomena as diverse as smoking and smacking. In the meantime, this report and others like it, have the cumulative effect of producing evidence as a challenge or counterweight to the current tendency in policy and practice noted above, to mute the wider safeguarding agenda in favour of a more narrow concentration on those cases involving acute child maltreatment.

Considering what might be achieved by services once such adversities are identified leads us into difficult and problematic areas beyond the remit of any single agency to address. Clearly the goal is to reduce the numbers of adversities that any child experiences in order both to prevent immediate pain and distress and in order to decrease the probability of poor outcomes occurring in the future. However, as Sabates and Dex (2012, p.23) observe:

‘The multiple risks experienced by some families were not found to group together very comfortably....the wide range and varying nature of multiple disadvantages...suggests it will be extremely difficult to tackle simultaneously all of these disadvantages in order to reduce family risks for the benefit of children.’



There are, however, some areas which are amenable to change. With policy initiatives such as Think Family (Social Exclusion Task Force, 2008) prompting services to keep all family members in mind when making interventions we have the opportunity to tackle in more informed ways the adversities children may experience, for example, when they have a parent with a mental illness.

Using a multiple adversity screening tool with Case Management Review reports

In this study we have used the 10 item ACE questionnaire with additional questions derived from the study by McGavock and Spratt referred to above; these are concerned with victimisation by peers and experience of neighbourhood and family deprivation as indicated within case management reports. As with the other adversities, it is unlikely that all these will be recorded as a matter of course within reports, but where they have been, we will record peer victimisation (for example, bullying or assault) and neighbourhood and family deprivation (for example, unemployment) when these have been noted either by family members or professionals. With regard to peer victimisation, the Northern Irish study found that of the 194 students (25%) reporting this, 78.4% had an ACE score of one or more, and 38.8% a score of four or more (McGavock and Spratt, 2012). This finding echoes warnings from the literature that whilst 'peer victimization [is] associated with deleterious effects, multiple victimization substantially heightened an individual's risk of poor psychological and academic functioning' (Holt et al., 2007, p.512). The questions on deprivation are concerned with having grown up in a neighbourhood characterised by high levels of economic and social deprivation, or within a family experiencing high levels of economic and social deprivation. As Finkelhor and colleagues (2009, p.317) argue, living in such conditions 'may place stresses on families that bring out coercive family behaviour...neighbourhood chaos and lack of social support may also lower the inhibitions against abusive behaviour within the family.'

In using these questions to interrogate the selected sample of cases subject to a Case Management Review we have sought to elucidate these risk factors, where evidence for them exists, which cumulatively portray the adversities faced by the young persons who are the subjects of these reports. The emerging evidence serves to demonstrate the considerable psychological and social challenges such young people face and help us understand more clearly the reasons underlying the tragic outcomes in these cases. The young people who are the subjects of this study appear to conceptually fall into the group of young people referred to



elsewhere in this report as amongst the group of 'hard to help' young people identified in overview studies of Serious Case Reviews in England, who had experienced multiple adversities (Brandon et al., 2011). Such young people are often identified as being particularly resistant to services, however, this may be because such services are not well designed to meet their needs or the interaction with other vulnerabilities such as disability or poor mental health. Therefore we should refer to these young people as 'hard to reach' as the onus must be on services adapting in how they engage these young people.

It is important to remember that any retrospective analysis of documents has limitations (Hayes and Devaney, 2004). Firstly, not all cases of concern come to the attention of child welfare professionals. Parents, extended family and the wider community have primary responsibility for identify children and young people who require further support and protection. For those cases which do come to the attention of child welfare professionals the case management reports themselves seek to elucidate all the pertinent facts, but the determination of what is pertinent is subject to perceptions shaped by how we come to identify adversities and their impact upon young people, shaped, as we have already observed, by prioritisation of child maltreatment indicators. In a similar way, what is recorded in agency records (upon which much of the evidence provided to Case Management Review Panels is built) is unlikely to capture in any systematic sense the range of adversities we have included in our study instrument. This is likely to mean that the numbers of adversities we have identified as present in the case reports are likely to be an underestimate of the true levels of adversities present in the lives of the young people concerned. Such underestimation will inevitably also reflect the lack of young persons' voices telling the stories of their lives, and the restriction on their ability to tell us of the things that have impacted upon them.



CHAPTER 4: Adolescent Suicide and Accidental Death

Suicide is a multi-faceted phenomenon involving the interaction between biological, psychological, sociological, environmental and cultural factors. Suicide in adolescents has been identified as a serious public health problem worldwide (Kessler et al., 1997; McGirr et al., 2009; Beautrais et al., 2010). However, although adolescent suicide remains a well-researched area it still remains a poorly understood phenomenon. Prevention of suicidal behaviour is often difficult, and poses a major challenge given the relative rarity of the event (Gould et al., 2003). Effective prevention therefore requires sound knowledge of the key risk factors with the main target of effective prevention of youth suicides being to reduce suicide risk factors which, as the previous chapter has highlighted, include adverse childhood experiences (Beautrais, 2003).

In this report the literature on adolescent suicide, deliberate self-harm (DSH) and accidental death will be reviewed, with operational definitions of suicide and accidental death clarified, and consideration will be given to international and Northern Ireland data on the incidence of adolescent suicide and accidental death. The specific literature on the associations between childhood adversity, and adolescent suicide and accidental death will then be critically reviewed before discussing possible service and policy responses. There were several main sources of information for this review of the literature. The first was previous work conducted by the research team on both multiple adverse childhood experiences (Spratt, 2011a; Spratt, 2011b; Houston et al., 2010; Davidson et al., 2010; Spratt, 2009; Spratt and Devaney, 2009) and on suicide prevention for children and young people (Macdonald et al., 2012). The second main source was previous related literature reviews including: Bursztein and Apter (2008) on adolescent suicide; Davidson et al. (2010) on the associations between childhood adversities and later outcomes; Crowley et al. (2004) on suicide prevention; Leitner et al. (2008) on suicide prevention; Arensman (2010) on the evidence base for the Northern Ireland suicide prevention strategy; and Robinson et al. (2011) systematic review of interventions for young people presenting at clinical settings. The third main source of information was from electronic database searches. This was not a systematic review of the literature but a purposive process of identifying relevant literature to identify the range of issues involved in this complex area. The search strategy for this section of the report was therefore



more focused (using combinations of adverbs* AND adolescence/young people AND suicide/self-harm/accidental death). The databases that were searched included: the Cochrane Library, Embase, Medline, PsycInfo, the Campbell Library, SocIndex and the Web of Science. The fourth component of the review was to identify relevant grey literature. This was mainly through internet searches focusing on relevant sites especially the DHSSPS, the Northern Ireland Statistics and Research Agency (NISRA) and the National Confidential Inquiry into Homicides and Suicides by People with Mental Illness websites.

Numerous studies have examined the relationship between adolescent suicide and mental health problems such as depression (Beautrais et al., 2010; Kessler et al., 1997; McGirr et al., 2009). Although the rates vary among different countries, suicide is currently one of the top three causes of death for adolescents aged 15–19 years (Shain, 2007), posing a significant challenge for nations in meeting their obligations under the UNCRC. Suicide attempts are relatively common among adolescents, with evidence from an international systematic review of population-based studies estimating a mean proportion of 9.7% of adolescents reporting having attempted suicide at some point in their lives (Ford et al., 2003).

Within Northern Ireland deaths classified as ‘events of undetermined intent’ and ‘intentional self-harm’ are reported jointly as suicide. In 2011 there were 289 such deaths, across all ages (NISRA, 2012), registered in Northern Ireland; 216 were males and 73 were females (Figure 2). Northern Ireland has seen a sharp increase in suicide rates. In 2002, 76% of all suicides in Northern Ireland were male, and 60% were aged between 15 and 34 years old. By 2008 77% of suicides were male, but the proportion aged between 15 and 34 years old had risen to 72%.

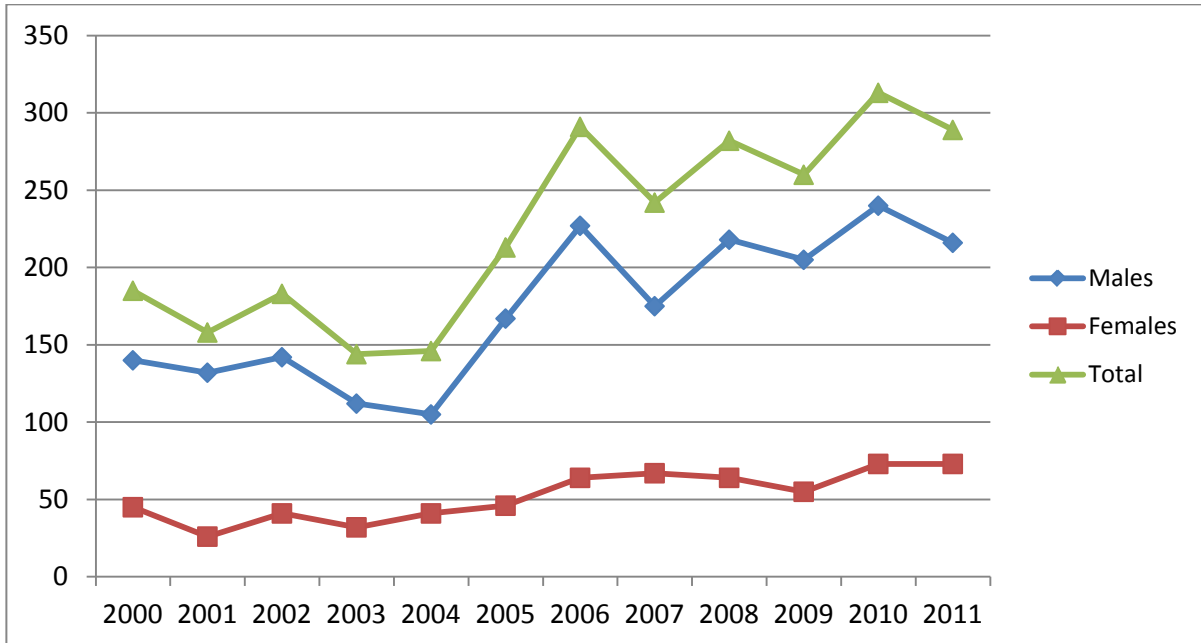
Figure 3 shows that in Northern Ireland, the age group with the highest suicide rate are males and females aged 30-34 years and 40-44 years respectively. NISRA gives a detailed breakdown of age groups by five year groups. This shows the suicide rate for males and females is at its highest in the first part of adulthood, unlike in Scotland where the suicide rate is higher towards the middle age groups and lower at either end of the age spectrum. However, similarly to Scotland, there are also high rates in those in mid-life, from 40-59 years.

Most countries within the United Kingdom have followed a similar trend over the last ten years, with all experiencing fluctuations; the United Kingdom and each of



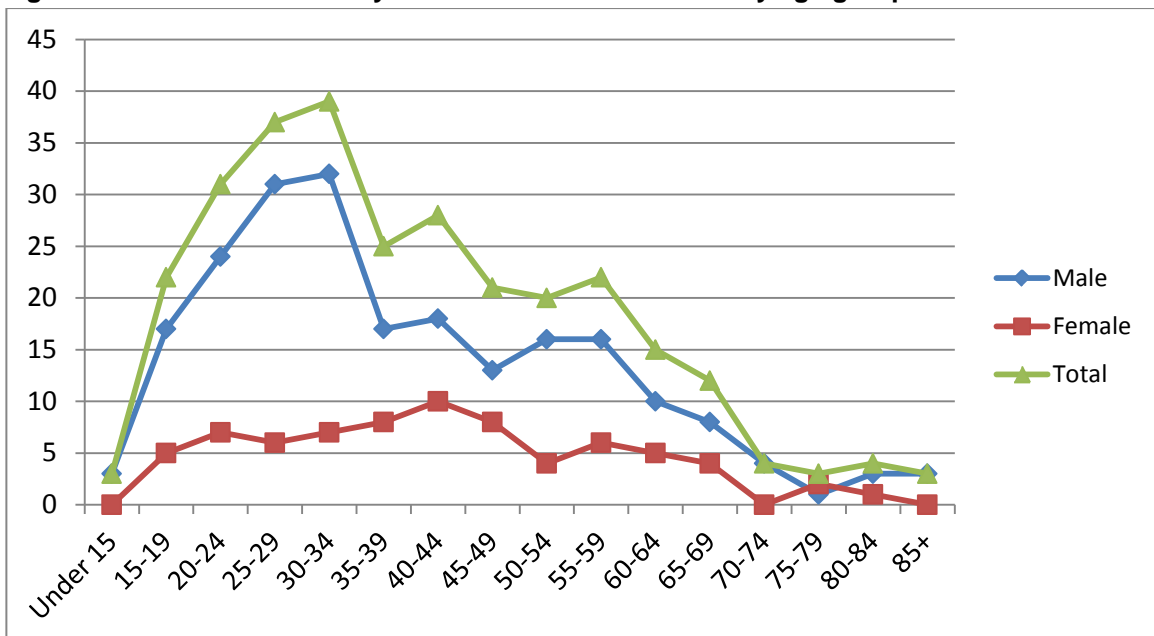
the constituent jurisdictions, apart from Northern Ireland, have experienced an overall decrease in the suicide rate per 100,000 over the last 10 years.

Figure 2: Numbers of deaths by suicide in Northern Ireland by gender 2000-2011



Source: Northern Ireland Statistics and Research Agency (2012) *Statistical Bulletin: Deaths in Northern Ireland (2011)*. Belfast: NISRA.

Figure 3: Number of deaths by suicide in Northern Ireland by age group 2011



Source: Northern Ireland Statistics and Research Agency (2012) *Statistical Bulletin: Deaths in Northern Ireland (2011)*. Belfast: NISRA.



Generally, the rates among women have remained stable or shown a small decrease, while the rates among men have decreased. However, the Northern Ireland figures show that for both males and females there has been an increase in the suicide rate since 2000. The group that deviates most from the general trend is males in Northern Ireland, in which rates have increased markedly in the last five years.

In Northern Ireland the trend for male suicides has fluctuated over the last ten years, but overall has shown an increase over time (NISRA, 2012). The female rates for suicide have remained more stable. Overall for males there has been an increase over the ten year period of 10 per 100,000; for females there has been an overall increase of less than 3 per 100,000 suicides. The trend in Northern Ireland is therefore different to the United Kingdom as a whole and the other countries within the United Kingdom, as it has seen an increase in suicide rates over the last 10 years.

Retrospective knowledge around suicide has been gathered through psychological autopsy studies (Schaffer et al., 1996; Hawton et al., 1998) which rely on a procedure for retrospectively reconstructing the life history, behaviour, and social and psychological features of the deceased person, as well as the events preceding the suicide, using interviews with key persons who knew the deceased individual. These studies have shown that mental health problems such as severe anxiety and depression, as well as the effects of substance misuse are strongly associated with completed suicide (Fergusson and Lynskey, 1995). Despite this body of evidence of a link between mental health problems and adolescent suicide, some important questions remain unanswered. Firstly, we still know little of the longitudinal and life span nature of completed suicide and childhood mental health problems. Only a few prospective, population-based cohorts have provided information about childhood mental health problems that extend into adulthood (Sourander et al., 2009). There is evidence however, that for a significant proportion of young people who die by suicide, the event represents the culmination of a lengthy suicidal process (Van Heeringen, 2001). This has been described as a series of pathways whereby individuals experience negative life events or adversities, often at an early age, which increase their vulnerability to external stressors, leading to thoughts of suicide and/or wishing they were dead.

Risk factor domains which may contribute to suicidal behaviour include: social and educational disadvantage; childhood and family adversity as discussed in the



previous chapter; psychopathology; individual and personal vulnerabilities such as family divorce and poverty; exposure to stressful life events and circumstances; and social, cultural and contextual factors. Several risk factors at the individual level are related to suicidal ideation and suicide attempts which include: a tendency to engage in behaviours such as the use of alcohol and drugs (Patel and Andrew, 2001); feelings of hopelessness and low self-esteem; and the risk of physical and sexual abuse (Krug et al., 2002). Jenkins et al. (2002) found physical and sexual abuse to be more common among suicide victims than among matched controls. Family factors include low levels of family support; and living in a house where domestic abuse and drug and alcohol misuse are visible. Family conflicts, social maladjustments, breakdown of intimate relationships and exam failure are some of the social factors associated with suicide. Extra-familial factors that seem important to examine are social isolation, that is, lack of friends (Van Heeringen et al., 2001) and a lack of positive experiences in school (Schoon, 2006).

Defining suicide and accidental death

Although suicide and accidental death following non-suicidal self-harm are both being considered in this report it is important to acknowledge that they may raise distinct as well as overlapping issues. Bursztein and Apter (2008, p.1) argue that:

‘Suicidal behaviour is probably a set of non-continuous and heterogeneous spectra of behaviours. Thus, suicidal ideation, suicidal threats, gestures, self-cutting, low lethal suicide attempts, interrupted suicide attempts and near fatal suicide attempts and actual suicide may or may not be related to each other, depending on the context in which they are studied...preventive methods may be different for the different subtypes of suicidal behaviours in adolescents.’

In this report, when we discuss accidental death we are not referring to accidents or death from high risk activities such as driving at speed. In our work self-harm refers to non-suicidal self-injury which nonetheless may result in accidental death, and suicidal behaviour refers to behaviour that is motivated by the desire to die, although this may not result in death. As Macdonald et al. (2012, p.139) identified ‘there is variation in how these terms are used internationally’, for example, deliberate self-harm (DSH) in North American literature sometimes includes attempted suicide (Bethell and Rhodes, 2008). The World Health Organisation (cited in Nordentoft, 2007, p.311) has defined suicide as ‘an act with



a fatal outcome which the deceased, knowing or expecting a fatal outcome had initiated and carried out with the purpose of provoking the change that he desired'. Parasuicide commonly used to refer to all non-fatal suicidal acts is defined as 'an act with a non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences'. Hawton and James (2005) have suggested that 'the term DSH is preferred to 'attempted suicide' or 'parasuicide' because the range of motives or reasons for this behaviour includes several non-suicidal intentions. Although adolescents who self-harm may state they want to die, the motivation in many is more to do with an expression of distress and a desire for escape from troubling situations, therefore, even when death is the outcome of self-harming behaviour this may not have been the intended outcome (p.891). Leitner et al. (2008, p.17) have provided a set of definitions that distinguish between the main terms used see Box 2.

Box 2: Definition of Terms

Suicide: The termination of an individual's life resulting directly or indirectly from a positive or negative act of the victim himself which he knows will produce this fatal result (Durkheim 1857).

Attempted Suicide: A potentially self injurious action with a non-fatal outcome for which there is evidence, either explicit or implicit, that the individual intended to kill him/herself (Moscicki 1997).

(Deliberate) Self-Harm: An acute non-fatal act of self-harm carried out deliberately in the form of an acute episode of behaviour by an individual with variable motivation (Gelder et al. 2001).

Suicidal Ideation: The existence of current wishes and plans to commit suicide (Steer et al. 1993).

The association between adversity in childhood and adolescent suicide and accidental death

Evidence suggests that the main aetiological factors for suicide include genetic predisposition and early and ongoing childhood adversities (Beautrais et al., 2010). Importantly childhood adversities have been found to be significantly associated with an increased risk for suicidal ideation and suicide attempts (Enns et al., 2006), as well as increased rates of co-morbidity in mental disorders such as depression (De Graaf et al., 2004). Childhood adversity may also influence the



severity and age of onset of depression, potentially mediated by greater vulnerability to existing biochemical or neural mechanisms (Velupillai et al., 2008). A neuro-developmental perspective on the processes involved in how adversities impact on mental health suggests that they may result in:

‘dysfunctions in the neural systems that do not receive appropriately timed and patterned stimulation, and abuse/trauma results in alterations in brain systems that mediate the stress response.’

(Perry in Beauchaine and Hinshaw, 2008, p.94).

There is much evidence showing that the long term effects of childhood adversities on mental and physical health are considerable (Davidson et al., 2010). This relationship between childhood or past adverse events and poor adult mental health, and suicide attempt is therefore widely acknowledged in the general population and primary care population (Bebbington et al., 2009). However, there is less information on the cumulative effects over the life trajectories of young people who completed suicide.

Moreover, Hawton and James (2005) highlight that the common characteristics of young people who die by suicide are: parental separation, divorce, or death; family psychiatric disorder or suicidal behaviour; psychiatric disorder or behavioural disturbance; substance misuse (alcohol or drugs); and previous self-harm. This reinforces the possible overlaps between self-harm and suicide. Hawton and James (2005) also suggest that the possible reasons for the rise in young male suicides in the United Kingdom from the 1960s to 1990s may include: increased rates of family breakdown; increasing rates of substance misuse; increasing rates of depression; greater instability of employment; increased availability of means for suicide; media influences (thought to contribute to 5% of suicides in adolescents); and awareness of suicidal behaviour in other young people. Interestingly, the proportion of mental health outcomes attributable to physical abuse, sexual abuse, to witnessing domestic violence or being a victim of domestic violence appears to vary between studies which perhaps reflects the complexity of the issues involved and the complexity of researching these issues (Davey et al., 2004). The other broad area of research which may help understand these trends and variations in the impact of multiple adversities across individuals, families and communities is work on strengths or possible protective factors such as resilience (Rutter, 2007) and social capital (Morris et al., 2008).

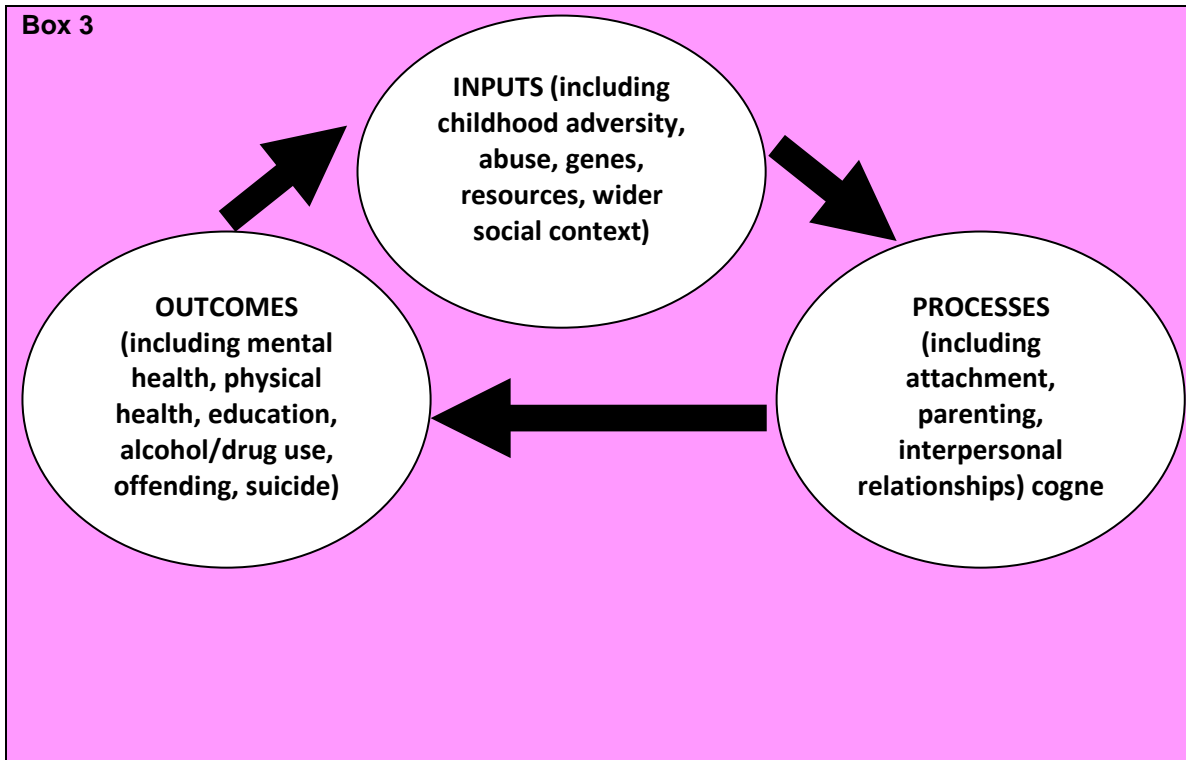


Previous research has demonstrated that a connection between childhood abuse and suicide exists (Glowinski et al., 2001; Roy, 2003). In a large and representative research study (Bruffaerts et al., 2010) it was revealed that both physical and sexual abuse were strongly related with suicidal risk behaviour. Another study found that a history of childhood maltreatment is likely to play a key role in the onset and recurrence of suicide attempts (Perroud et al., 2007). Research suggests that abuse and neglect doubles the risk of attempted suicide for adolescents (Brown et al., 1999; Evans et al., 2005; Brodsky and Stanley, 2008). The systematic review by Evans and colleagues (2005) found a strong link between physical/sexual abuse and attempted suicide/suicidal thoughts occurring during adolescence. The authors suggested that sexual abuse could be specifically related to suicidal behaviour because it is closely associated with feelings of shame and internal attributions of blame (Brodsky and Stanley, 2008). In addition to childhood sexual and physical abuse, other forms of childhood trauma also potentially contribute to increased tendency towards suicidal behaviours. There is some evidence to suggest that witnessing violence in the home or elsewhere also contributes to an increased risk for suicidal behaviour (Dube et al., 2001). An adolescent witnessing domestic violence may have an increased risk of suicidal behaviour, and are more likely to self-harm (Anda et al., 2010). Suicide is usually preceded by anti-social behaviour, such as inappropriate use of alcohol or engaging in high risk behaviours such as staying away from home or coming into conflict with the law. Older children who witness violence between their parents are at a greater risk for developing anti-social behaviors (Fergusson and Horwood, 1998), which in turn can lead to suicide or suicide attempts in adolescence. The immediacy of the stress and pain of witnessing domestic violence are experiences not easily escaped by adolescents, and this makes suicide appear to be the only solution to a problem that they cannot control (Anda et al., 2010). The relationship between domestic violence and suicide attempts among adults demonstrates how these childhood exposures have a long term impact on the risk of suicide attempts.

One model, developed by Joiner (2005) suggests that 'few people want to die by suicide, but also, and perhaps more importantly, few people can'. The central idea of Joiner's theory is that high risk suicidal behaviour requires each of three interpersonal psychological precursors: (1) the acquired capability, through habituation to pain and fear, to enact lethal self-injury; (2) the sense that one is a burden on loved ones; and (3), which may relate to and interact with (2), the sense that one does not belong to or is not connected with a valued group or relationship.



This theory is compatible with and adds to other prominent models of suicidality (for example, Baumeister, 1990; Beck, 1996; Linehan, 1993).



Difficult life events such as childhood abuse, especially when severe, may have the potential to be extremely painful and fear-inducing. According to Joiner's model, then, more severe and painful forms of childhood abuse should be greater risk factors for suicide than less acute or enduring forms of abuse, adversity and maltreatment. According to this theory, repeated exposure to pain and provocation may cause habituation to the "taboo" and prohibited quality of suicidal behaviour, thus diminishing the fear and pain associated with self-harm. Researchers have begun to test hypotheses regarding combinations of adversities that may play a particularly important role in the development of suicidal ideation and behaviour. Case control and longitudinal studies (Reinherz et al., 1995; Beautrais et al., 1996; Gould et al., 1996) have indicated that adversities such as poor family relationships and stressful life events remain associated with suicidal behaviour after other risk factors are taken into account. Certain combinations of maladaptive parental behaviours, such as affectionless and overprotective parenting, have also been reported to be associated with risk for suicide (Wagner and Cohen, 1994). As discussed in the previous chapter, the



complex interactions and impact of multiple adversities does appear to have an increased impact on outcomes. A possible basic model for understanding some of the complexities involved in how adversities may be associated with suicide is provided in Box 3.

Evidence about suicide in young people in Northern Ireland

Jordan et al. (2011, p.3) in their recent report on suicide and young men in Northern Ireland stated that:

‘After remaining relatively static throughout the latter half of the 20th century, between 1999 and 2008, there was a 64% increase in suicide in Northern Ireland. In large part, the dramatic increase has been fuelled by a rise in male suicide, particularly marked in the 15-34 year age group. In 2002, almost 76% of all suicides were male, with 60% of these occurring in the 15-34 year age group; by 2008, 77% of all suicides were male and the percentage occurring in the 15-34 age group had increased to 72%.’

The complexities and possible direct, indirect and trans-generational impact of the Northern Ireland context are important to consider in relation to suicide. Tomlinson (2007a, p.116) in his report *The Trouble with Suicide*, which reviewed the evidence on mental health, suicide and the Northern Ireland conflict, concluded that:

‘One of the issues around which there needs to be more clarity is ‘trauma’ and its transmission horizontally and through the generations...In conclusion, the evidence reviewed in this report points to a general conclusion that the conflict shaped the suicide problem in significant ways in the past and its legacies continue to influence the challenge of reducing suicide in the future. In particular, changes in the relationships between state bodies and the communities and individuals most affected by the conflict have impacted on the registration of suicides, the recognition of the suicide problem and the speed and nature of the responses to it.’

There has been some research which considers self-harm and suicide among children and young people in Northern Ireland but, as Tomlinson (2007b) concludes ‘there are major gaps in the available knowledge and research on how children and young people are positioned in relation to self-harm and suicide in Northern Ireland’ (p.441). He recommended various research priorities including



‘to monitor relevant hospital attendances for Parasuicide... exploring how families and local communities cope with depression, self-harming and suicide...the processes that lead to suicide clustering...[and] the role of popular culture, new communications and the Internet in mediating ideas about suicide’ (p.441). Cousins et al. (2008. p.51) reported that:

‘Suicide rates in Northern Ireland have steadily increased over the last three decades leading to the recognition of suicide as a major public health issue in the region. Statistics relating to hospital admissions for self-harm in Northern Ireland indicate that the number of such admissions has increased by 9% since 2000. In 2006 the Northern Ireland Suicide Prevention Strategy was launched with the strategic aim ‘to reduce the Northern Ireland suicide rate, particularly among young people and those most at risk.’

Most recently Tomlinson (2012, p.464) has argued, based on his analysis of the suicide trends in Northern Ireland over the past 40 years, that:

‘...the key finding is that the cohort of children and young people who grew up in the worst years of violence, during the 1970s, have the highest and most rapidly increasing suicide rates, and account for the steep upward trend in suicide following the 1998 Agreement. Contrary to Durkheim, the recent rise in suicide involves a complex of social and psychological factors. These include the growth in social isolation, poor mental health arising from the experience of conflict, and the greater political stability of the past decade. The transition to peace means that externalised aggression is no longer socially approved. It becomes internalised instead.’

The National Confidential Inquiry into Homicides and Suicides by People with Mental Illness 2011 report on Northern Ireland found that the largest difference between suicide rates in Northern Ireland and other United Kingdom countries was in young people and it recommended that they should now be a priority for suicide prevention. The Inquiry report on Northern Ireland also found that:

‘In all, 332 suicides occurred in people under 25 during 2000-2008, 37 per year. Young people who died by suicide were more likely than other age-groups to be living in the poorest areas in Northern Ireland and had the lowest rate of contact with mental health services (15%). The young



mental health patients who died by suicide tended to have high rates of drug misuse (65%), alcohol misuse (70%) and previous self-harming features (73%).’

(The National Confidential Inquiry into Homicides and Suicides by People with Mental Illness, 2011, p.18).

‘For the same time period, the Inquiry was notified of 78 suicides and probable suicides for children and adolescents aged under 18. This included 75 cases where the recorded cause of death was suicide and 3 cases where death was of undetermined intent. The average annual rate of suicide among young people was 4.2 per 100,000. Fifty-five (71%) were male, giving a male to female ratio of 2.4:1. Younger male suicides were proportionally more likely to be in the ten percent most deprived areas.’

(The National Confidential Inquiry into Homicides and Suicides by People with Mental Illness, 2011, p.29).

Cousins et al. (2008) also highlight that there are increased rates of suicide in young people in state care in other parts of the United Kingdom. They report that the Northern Ireland Suicide Prevention Strategy makes no specific mention of young people who live in state care when previous research has shown that this is a particularly marginalised group of vulnerable young people. Meltzer et al. (2003) compared the self-reported incidence of self-harm and suicide among children in care across Scotland, England and Wales. Of the children surveyed, 22% of children and young people in local authority care in Scotland, 24% in England and 26% in Wales reported that they had either harmed, hurt or tried to kill themselves. Older children (aged 11–17 years) and those in residential care were most at risk. A longitudinal study from Sweden, which followed up former child welfare clients, found that they were four to five times more likely than their peers in the general population to have been hospitalised for suicide attempts (Vinnerljung et al., 2006). Cousins et al. (2008, p.54) in their survey of the social work case files of children in state care in Northern Ireland found that:

‘The Meltzer study...which used self-reports from young people themselves found rates of self-harm and suicidal behaviour in almost twice those indicated in the present study. Therefore it is possible that there may be substantial under-reporting from adult professionals. Nevertheless, in almost half of the young people there were strong indications of emotional and behavioural difficulties as indicated by the [Strengths and Difficulties



Questionnaire] and a high prevalence of self-harm (12.7%) and attempted suicide (10.3%).’

Evidence of interventions to prevent adolescent suicide and accidental death

The main target of effective prevention of adolescent suicide is to reduce suicide risk factors. Recognition and effective treatment of psychiatric disorders, for example, depression, are essential in preventing child and adolescent suicides. Although the risk of suicide attempt, suicidal ideation and self-harm is high among young people, as yet there is limited evidence which exists regarding effective interventions, particularly from randomised controlled trials (RCTs), although this is not the only form of evidence needed. Macdonald et al. (2012) in their review of the evidence reported that interventions to prevent suicide and self-harm are extremely diverse and provided across a range of levels and settings. A common theme throughout the literature is that unfortunately there is no single approach to the prevention of self-harm and suicide (Pitman, 2007), and that there needs to be careful consideration of the developmental context of the particular children and young people (Daniel and Goldston, 2009), their cultural context (Joe et al., 2008 and Goldston et al., 2008) and their social context (Burrows and Laflamme, 2010) (p.140):

‘Nordentoft (2007) discussed three possible models for organising these interventions. The first is to distinguish between primary, secondary and tertiary interventions. Primary prevention is aimed at people who have not yet shown any indication of self-harming or suicidal behaviour. Secondary prevention aims at early intervention with those who are identified as being at risk so involves interventions such as screening. Tertiary intervention targets people who are known to be self-harming or who have engaged in suicidal behaviour. An alternative model is to distinguish between universal, selective and indicated prevention. Universal interventions would be aimed at the whole population in question (all children and young people, all school age children, all children in specific areas). Selective prevention is targeted on preventing the development of self-harm and suicidal behaviour in specific high-risk groups. Indicated prevention then would focus on people who have been identified as showing the early signs of self-harming or suicidal behaviour. A third possible way of classifying preventive interventions is to distinguish structural (such as



restricting means, addressing social exclusion) from individual measures (such as media campaigns, counselling and treatment).’ (Macdonald et al., 2012, p.140).

Nordentoft’s (2007) primary, secondary and tertiary interventions correspond with the Hardiker et al.’s (1991) model which is used in children’s services in Northern Ireland. It also identifies primary (universal), secondary (vulnerable/at risk of social exclusion) and tertiary (in need) prevention and adds a fourth level of rehabilitation (after a child is in state care and/or has complex and enduring needs). The universal, selective and indicated prevention model overlaps the 4 Tier-model of Child and Adolescent Mental Health Services (CAMHS) as set out in the Bamford Review (2006b) report with Tier 1 including indicated prevention then Tiers 2-4 providing different levels of specialist services. More recently the DHSSPS (2012a) have confirmed the preferred model for the organisation of CAMHS in Northern Ireland builds on these approaches and should be a stepped care model. It identifies five steps:

1. Universal/prevention
2. Targeted/early intervention
3. Specialist intervention
4. Intermediate care
5. Highly specialist inpatient/secure care.

Arensman (2010) in her review of the evidence base for ‘*Protect Life – A Shared Vision: The NI Suicide Prevention Strategy*’ identified a wide range of possible interventions (see Box 4).

Box 4: Potential interventions to reduce suicidal behaviour

Public information campaigns; community-based programmes; gatekeeper training; multi-level community based suicide prevention programmes; means restriction; support for parents; support networks; school based prevention and anti-bullying; early identification and access to services; suicide awareness/positive mental health/wellbeing and substance misuse training for relevant staff; brief problem solving intervention; school-based programmes to promote positive mental health; guidelines for health staff; targeted information campaign for the workforce; media guidelines; psychological treatments for self-harm; crisis teams; support for carers; protocols for assessing people who are intoxicated; early identification of and support for survivors of abuse; support for marginalized and/or high risk groups.



Arensman (2010) concluded that interventions with the best evidence include:

- means restriction, including identification of 'hotspots';
- clinical guidelines for all health and social services staff to use when dealing with people who are at risk of suicide/self-harm; and
- programmes that enhance the coping and problem solving skills of those who self-harm, and which reduce the risk of repeat self-harm.

Her review also highlighted the benefit of the Northern Ireland Registry of Deliberate Self-Harm in Accident and Emergency Departments in identifying and responding to young people who may be at increased risk.

Crowley et al. (2004) provided a review of suicide prevention strategies specifically for young people (Box 5). They concluded that multi-year (interventions with young people that extend over many years of their lives) and multi-component strategies to address high-risk behaviour in school among young people should be further evaluated. The impact of reducing access to the means of suicide and the role of media should be further researched. The evidence from a systematic review and meta-analysis of all randomised controlled trials testing interventions for adolescents and young adults who have presented to a clinical setting with any of these behaviours has recently been completed (Robinson et al., 2011).

Box 5: Suicide prevention strategies specifically for young people

Curriculum-based suicide prevention programmes; recognition, management and prevention of youth suicidal behaviour by primary care practitioners; interventions targeting family risk factors; suicide prevention programmes for at-risk groups; potential points of access to those contemplating suicide; prevention of access to means; media restrictions; and psychosocial and pharmacological treatments for deliberate self-harm.

The exclusive focus of this review was therefore on the results of randomised controlled trials and so other important research, which did not use this methodology, were not included. Nonetheless, for the review the Cochrane Central Register of Controlled Trials, Medline, EMBASE and PsycINFO were searched for articles published from 1980 to June 2010. The following keywords formed the basis of the search strategy: 'self-injurious behaviour', 'attempted suicide', 'suicide', 'suicidal behaviour', 'self-inflicted wounds', 'self-mutilation', 'self-harm'. Hand searches were also undertaken of conference abstracts from two major suicide prevention conferences and the reference lists of all retrieved articles and previous reviews. There were 15 trials included in the review, with six



ongoing trials also identified. In general, the reporting of the conduct of trials was poor, making it difficult to assess the risk of bias. The reporting of outcome data was also inconsistent. No differences were found between treatment and control groups except in one study (Slee et al., 2008) that found a difference between individual cognitive behavioural therapy and treatment as usual (which included psychotropic medication, psychotherapy and psychiatric hospitalisations). The conclusions drawn suggest that the evidence regarding effective interventions for adolescents and young adults with suicide attempt, deliberate self-harm or suicidal ideation is extremely limited. Many more methodologically rigorous trials are required. However, in the meantime Cognitive Behaviour Therapy (CBT) shows some promise, but further investigation is required in order to determine its ability to reduce suicide risk among young people presenting to clinical services.

Shaffer et al. (1996) found that the majority of young people who die by suicide have a mental illness, mostly depression. Based on retrospective parent information they found that 59% would have met the criteria for a psychiatric diagnosis and 46% had been in contact with a mental health professional. Identifying and treating depression forms an integral part of treatment and intervention. Depression is relatively easy to identify and there are effective psychotherapeutic treatments [for reviews see; Harrington et al., 1998; Merry et al., 2004; Compton et al., 2004] notwithstanding the current debate about the risk/benefit ratio of treating depressed adolescents with medication, particularly selective serotonin re-uptake inhibitors (SSRIs) (Whittington et al., 2004). On balance, the strategy of detecting and treating depression gives a coherency and clarity to service planning.

There has been tremendous advancement in the treatment of adolescent depression and many studies have assessed the use of CBT, interpersonal psychotherapy (IPT) and medication (Jenkins, 2002; Scocco and De Leo, 2002; Conwell and Duberstein, 2001; Jenkins, 2002). A recent Cochrane systematic review of the research on psychological and educational interventions for preventing depression in children and adolescents (Merry et al., 2011, p.2) concluded that:

‘Compared with no intervention, psychological depression prevention programmes were effective in preventing depression with a number of studies showing a decrease in episodes of depressive illness over a year. There were some problems with the way the studies were undertaken but



despite this the results are encouraging. We found data to support both targeted and universal programmes, which is important as universal programmes are likely to be easier to implement.'

CBT has emerged as a well established treatment approach for children and adolescents (David-Ferdon and Kaslow, 2008). However, although the number of efficacy studies for depression has increased, there is still little evidence-based information indicating how or why these treatments work. Despite suicide being a serious public health problem, there are no empirically supported individual psychotherapies for adolescents shown effective in reducing suicidal behaviour through randomised controlled trials (Gould et al., 2003). Importing empirically-supported treatments for depressed adolescents to suicidal adolescents may not be appropriate because the trials in which efficacy was established excluded suicidal teens. In an effort to target the suicidal adolescent population, Dialectical Behavioral Therapy was adapted (DBT-A) (Rathus and Miller, 2002). DBT-A employs individual therapy and group skills training and targets suicidal behaviour. A quasi-experimental investigation of DBT-A versus usual care in suicidal adolescents with borderline personality disorder features reported that in the DBT-A group, although not statistically significant, fewer subjects made suicide attempts, fewer subjects were hospitalised, and the completion rates for treatment were higher. However, this was not an RCT and focused only on adolescents with borderline symptoms.

In addition, treatment trials for adolescents with suicidality are few in number, and their efficacy to date is limited, especially with regard to repeat suicidal behaviours (David-Ferdon and Kaslow, 2008). A definitive treatment of adolescent suicide attempters has yet to be established, but the limited literature suggests that suicidal thoughts and behaviour should be directly addressed for optimal treatment outcome. Training adolescents in specific coping skills and affect regulation techniques that can be applied to thoughts and behaviours associated with suicidality, shows some initial promise. However, future trials are necessary to inform best practices in treating this high-risk population (Spirito and Esposito, 2008). The key message from the research on the effectiveness of suicide prevention interventions is that there are a range of evidence based approaches but there is no magic bullet or one size fits all approach as interventions are needed across the different levels, tiers or steps and across all aspects of life including parenting, education, employment, health and social care.



Northern Ireland policy and practice context

The Bamford Review's report (2006a, p.92) on mental health promotion reinforced the need to prevent suicide. It stated:

'According to Fay et al (1997)...in the 25 years from 1969 to 1994, more people died here by suicide than as the result of the conflict. On average since 2000, deaths due to suicide have exceeded deaths on the road. Suicidal behaviours place a heavy human and financial burden on society in Northern Ireland. Figures from DHSSPS (2002) indicate that there are on average 150 suicide deaths every year in Northern Ireland, 80,000 working days are lost to illnesses related to attempted suicide; and that there are over 4,000 hospital admissions annually as the result of suicidal behaviour. The estimated annual cost to the economy of suicidal behaviour is £170m. Although suicide accounts for 1% of all deaths annually it equates to 7% of potential years of life lost, indeed the expected years of life lost to suicide is estimated to be 4,400'.

The Bamford Review's (2006b) report on child and adolescent mental health services highlighted the chronic under investment in this area of need in Northern Ireland and emphasised the role of schools in primary prevention. It recommended the "healthy schools" approach combined with more targeted initiatives; it also highlighted the particularly high rates of self-harm and suicidal behaviour among lesbian, gay, bisexual and transgendered young people. At the secondary level, it suggested that 'there is a need to address the prevention of suicide through multi-modal programmes, probably best delivered via education services' (p.46), and at the tertiary level, it highlighted the needs of children who have experienced abuse and children who are looked after.

In their review of progress on the three main relevant strategies (the Bamford Review of Mental Health and Learning Disability; the Promoting Mental Health: Strategy and Action Plan 2003-2008; and the Protect Life: A Shared Vision - The Northern Ireland Suicide Prevention Strategy and Action Plan 2006-2011), Leavey et al. (2009) recommended that the mental health promotion and suicide prevention strategies should be merged and that the priorities for intervention should include early years intervention and parenting strategies, as well as supporting schools to promote resilience and wellbeing. In particular groups to target specifically include those vulnerable to mental illness such as women living with domestic or sexual violence, those living in poverty, those who self-harm,



those affected by the 'troubles' or those individuals who are victims and targets of paramilitary activity.

Jordan et al. (2011, p.17), in their report on young men and suicide in Northern Ireland highlighted that one of the key issues for suicide prevention is ensuring that whatever services are provided they are accessible to young people and pro-actively engage them:

'The evidence from our study highlights the importance of implementing a 'package' of measures. These include Northern Ireland wide, population-level public health measures directed at reducing the stigma and discrimination associated with suicidal behaviour and related help-seeking. In addition, measures should be targeted specifically at the 'at risk' population of young men themselves (for example, care which is specifically configured around the help-seeking preferences of young men). These measures are inextricably linked; put basically young men have to 'turn up' for care in order for that care to have a chance of being effective. They will continue not to attend services they perceive as both stigmatised and stigmatising irrespective of the quality of care these services may provide. However...there is growing evidence that, once implemented, such measures can be effective in reducing young male suicide.'

The DHSSPS (2012b) has recently published the 'refreshed' *Protect Life: A Shared Vision - The Northern Ireland Suicide Prevention Strategy 2012 - March 2014*. It reinforces the need for a cross government and society approach to preventing suicide. In the associated Action Plan (DHSSPS, 2012c) there are a number of actions which relate specifically to children and young people. These include the need to further develop suicide and self-harm awareness and positive mental health and wellbeing training for the key people working with children. The Action Plan also identifies the need to include promoting mental health as a key part of the schools' curriculum and to protect children and young people from bullying. It also aims to promote a culture of help seeking behaviour, especially among young people.

In summary, a significant number of young people in Northern Ireland experience poor mental health, resulting in their deliberate self-harm of themselves or suicide. The research literature indicates that there are interventions which can make a positive difference, but that society and professionals must be proactive in identifying who might benefit, and in responding proactively.



Chapter 5: The Case Management Review Process

When a child dies or is seriously injured, and abuse or neglect is known or suspected to be a contributing factor, it is important for professionals to ensure that other children who may be at similar risk are protected from experiencing similar harm. This may be children in the same family, children who may have ongoing contact with the person believed to have caused the harm, or children living in similar circumstances but who may not be directly connected to the child who has been harmed. In May 2003 the Department of Health, Social Services and Public Safety in Northern Ireland introduced a new system for reviewing such cases (DHSSPS, 2003).

The purpose of a Case Management Review is to:

- establish the facts of the case;
- establish whether there are lessons to be learned from the case about the way in which professionals and statutory and/or voluntary agencies work together to safeguard children; and
- identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence
- improve inter-agency working and thus provide better safeguards for children.

The primary responsibility for undertaking a Case Management Review is vested in the new Safeguarding Board for Northern Ireland¹, a high level committee of senior managers from organisations with responsibility for working with children, families and adults. The role of the Safeguarding Board is to develop a strategic approach in addressing child protection across services in Northern Ireland.

¹ In 2008 the Regional Child Protection Committee was established to replace the four Area Child Protection Committees as part of the Review of Public Administration in Northern Ireland. The Regional Child Protection Committee was a standing committee of the Health and Social Care Board, and was chaired on behalf of the Board by the Assistant Director for Social Services (Children). This committee has now been superseded by the Safeguarding Board for Northern Ireland which was launched in September 2012.



The policy guidance for the Safeguarding Board for Northern Ireland in respect of Case Management Reviews is currently being finalised at the time of writing this report. The current guidance states that a Case Management Review should always be undertaken when a child dies including death by suicide, and abuse or neglect is known or suspected to be a factor in the child's death.

In addition, the Regional Child Protection Committee (which preceded the Safeguarding Board for Northern Ireland) should always consider whether to undertake a Case Management Review where:

- a child has sustained a potentially life-threatening injury through abuse (including sexual abuse) or neglect;
- a child has sustained serious and permanent impairment of health or development through abuse or neglect; or
- the case gives rise to concerns about the way in which local professionals and services worked together to safeguard children.

The policy guidance states that the review should be conducted in such a way that the process is a learning exercise. Case Management Reviews are not intended to be inquiries into how a child died or who was culpable. Rather these are a matter for the Coroner and criminal courts respectively to determine as appropriate. The guidance states that there must be clarity about the interface between the different processes of investigation (including criminal investigations); case management, including help for abused children and immediate measures to ensure that other children are safe; and review, i.e. learning lessons from the case to lessen the likelihood of such events happening again. The processes while different should inform each other. Therefore any proposals for review should be agreed with those leading any other types of investigation to make sure that the review does not prejudice possible criminal proceedings against family members or disciplinary proceedings involving staff.

The Review Panel must involve, as a minimum, a chair who is independent of any agency involved with the child and their family and representatives from social services, health, education and the police. There is no automatic agency entitlement to be represented on a Review Panel, but representatives from other disciplines and agencies may be included depending on the specific nature of the issues under review. Therefore the membership must have sufficient seniority and professional child care expertise to be able to offer a professional opinion on the management and practice in a specific case. The balance of representation



must be such that the Review Panel can achieve impartiality, openness, independence, and thoroughness in the review of the case. The individuals who become members of the Review Panel must not have had any line management responsibility for the specific case under consideration. The Review Panel must include members who are independent of the Health and Social Care (HSC) Trusts and other agencies concerned.

The Chair of the Regional Child Protection Committee/Safeguarding Board should agree the scope of the review and the terms of reference with the Review Panel. Relevant issues and questions to consider should include:

- What appears to be the most important issues to address to identify learning from this specific case?
- How the relevant information can best be obtained and analysed?
- What is needed to bring in an outside expert at any stage, to shed light on crucial aspects of the case?
- Over what time period should events be reviewed, i.e. how far back should enquiries cover and what is the cut-off point? What family history/background information will help to better understand the recent past and present which the review should try to capture?
- Which agencies and professionals should contribute to the review, and who else (for example, playgroup leader, community/youth group leader, Chair of a Board of Governors) should be asked to submit reports or otherwise contribute?
- Should family members or concerned individuals, who may have referred the case to social services be invited to contribute to the review?
- Will the case give rise to other parallel investigations of practice, for example, a mental health homicide or suicide inquiry, and if so, how can a co-ordinated review process best address all the relevant questions which need to be asked, in the most efficient and effective way?
- Before (date of event leading to review) was there a need to involve agencies/professionals from other Area Child Protection Committees' areas and what are the respective roles and responsibilities of the different Area Child Protection Committees' with an interest?



- How will the review process take account of a Coroner's inquiry, and (if relevant) any criminal investigations or proceedings related to the case?
- Is there a need to liaise with the Coroner and/or the Director of Public Prosecutions?
- Who will make the link with relevant interests outside the main statutory agencies, for example, independent professionals, independent schools and voluntary organisations?
- What is the timescale for the completion of the review?
- How should any public, family and media interest be handled, before, during and after the review?
- Does the Regional Child Protection Committee need to obtain independent legal advice about any aspect of the proposed review?

Case Management Reviews will vary widely in their breadth and complexity, but in all cases the policy guidance states that lessons learned should be acted upon quickly, with a view to ensuring that any issues identified are quickly considered and acted upon by policy makers, managers and practitioners. As such, upon receiving a Case Management Review report the Regional Child Protection Committee/Safeguarding Board for Northern Ireland must develop an action plan to take forward the key learning from each review, and regularly monitor implementation of any recommendations.



CHAPTER 6: Suicide and Reviews into Child Deaths

Currently systems exist across the United Kingdom to review cases when abuse and/or neglect are believed to have resulted in the death or serious injury of a child, including deaths by suspected suicide. The process in England and Wales, known as Serious Case Reviews (SCRs), was established in 1991; the current Northern Ireland system, referred to as Case Management Reviews (CMRs) was introduced in 2003; and the Scottish system of Significant Case Reviews in 2007 (Vincent, 2009). Over the past twenty years more than twenty five overview reports collating the findings from Serious Case Reviews and inquiries into abuse related child fatalities have been published in the United Kingdom. Reports published in the last decade are illustrative of a more systematic approach to learning from review processes, providing ongoing analysis of the trends and keys issues identified in such reviews since the Millennium (OFSTED, 2011a, 2011b, 2010, 2009 and 2008; Brandon et al., 2011, 2010, 2009, 2008; Rose and Barnes, 2008). While the vast majority of overview reports relate to English SCRs, research has been ongoing in Northern Ireland to analyse the key issues and learning from CMRs conducted between 2003-2008 (Devaney, Bunting, Hayes and Lazenbatt, 2012). This section examines the learning specifically in relation to child suicides/suspected suicides from both SCR overview reports and CMRs in Northern Ireland.

Serious Case Reviews involving suicide/suspected suicide/self-harm

The ongoing accumulation of data from SCRs has considerably aided the identification of recurring patterns over time. In their summary of the findings from three biennial reviews covering 618 SCRs conducted between 1st April 2003 and 31st March 2009, Brandon et al. (2010) highlight consistency in terms of the demographic characteristics of the children and families who were subject to SCRs (see Table 1 for selective overview of statistics taken from the report). Although the bulk of SCRs continue to be conducted in relation to younger children aged five years and under with those aged under one year comprising the largest group, deaths or serious injury of older young people also regularly make up a quarter of all such reviews. The findings show that adolescents are much less likely to be harmed by physical assault and much more likely to be harmed by their own hand with death by suicide or serious injury through self-



harm accounting for, on average, one in ten cases reviewed. In some cases the cause of the young person's death was uncertain and it was unclear whether this was a result of an accident or suicide, a point elaborated upon later in this report. The high proportion of deaths involving adolescents has led to a specific focus on them and the practice issues to be considered when working with this group.

Table 1: Characteristics of Serious Case Reviews in England

	2003-05 (n=161)	2005-07 (n=189)	2007-09 (n=268)
Child Age			
< 1 year	76 (47%)	86 (46%)	119 (45%)
1-5 years	33 (21%)	44 (23%)	59 (22%)
6-10 years	11 (7%)	18 (10%)	25 (9%)
11-15 years	26 (16%)	20 (11%)	35 (13%)
16-17 years	15 (9%)	21 (11%)	30 (11%)
Child Gender			
Male	88 (55%)	106 (56%)	137 (51%)
Female	73 (45%)	83 (44%)	130 (49%)
Child Ethnicity			
White	101 (74%)	125 (72%)	195 (77%)
Mixed	8 (6%)	23 (13%)	23 (9%)
Black/Black British	17 (13%)	13 (8%)	24 (9%)
Asian/Asian British	8 (6%)	8 (5%)	11 (4%)
Other Ethnic Group	2 (1%)	4 (2%)	2 (1%)
Child has Disability	14 (8%)	8 (5%)	21 (8%)
Child Protection Plan (CPP)			
Index child had CPP at time of the incident	-	29 (17%)	42 (16%)
Index child previously had CPP	-	19 (11%)	33 (13%)
Category of Index Child's CPP (current or past)			
Neglect		30 (65%)	44 (59%)
Physical abuse		11 (24%)	25 (33%)
Emotional abuse		7 (15%)	21 (28%)
Sexual abuse		7 (15%)	9 (12%)
Death/Serious Injury			
Death	106 (66%)	123 (65%)	152 (57%)
Serious injury	55 (34%)	66 (35%)	116 (43%)



Suicide/Injury through Self-harm	23 (12%)	14 (9%)	24 (9%)
Parent Characteristics			
Domestic violence		49 (26%)	91 (34%)
Mental health problems - parent		32 (17%)	73 (27%)
Drug misuse – parent		28 (15%)	60 (22%)
Alcohol misuse – parent		19 (10%)	58 (22%)
Child of teenage pregnancy		18 (10%)	19 (7%)
Parent has history of being in care		9 (5%)	19 (7%)
Child Characteristics			
More than one child abused		39 (21%)	50 (19%)
Serious illness		15 (8%)	18 (7%)
Drug or alcohol misuse - child		10 (5%)	18 (7%)
Mental health problems - child		8 (4%)	17 (6%)
Factors Related to Case			
Physical abuse		58 (31%)	147 (55%)
Long-standing neglect		33 (17%)	67 (25%)
Recent neglect		31 (16%)	48 (18%)
Sexual abuse		29 (15%)	38 (14%)
Shaken baby syndrome		19 (10%)	22 (8%)
Emotional abuse		15 (8%)	30 (11%)

Case Management Reviews in Northern Ireland involving suicide/suspected suicide/self-harm

Between January 2003 and December 2008 there were 24 Case Management Reviews undertaken in Northern Ireland on 45 children. Of these reviews 8 involved the death of a young person through suicide or accident, evenly split between male and female children. The youngest child was nearly fourteen years old, whilst the eldest was seventeen years old.

The cases included in this study were an opportunistic sample, and are not intended to be representative of young people who die by suicide in Northern Ireland, or of young people known to children’s social care. The group only refers to a sample of the Case Management Reviews undertaken during a five year period. It is also important to stress that the number of reports analysed is small and the group of children and their individual circumstances is heterogeneous. Therefore caution should be taken in using these cases as a barometer of the wider child welfare system. Rather the analysis provides an opportunity to reflect on a very specific type of case. The learning from this review must be placed



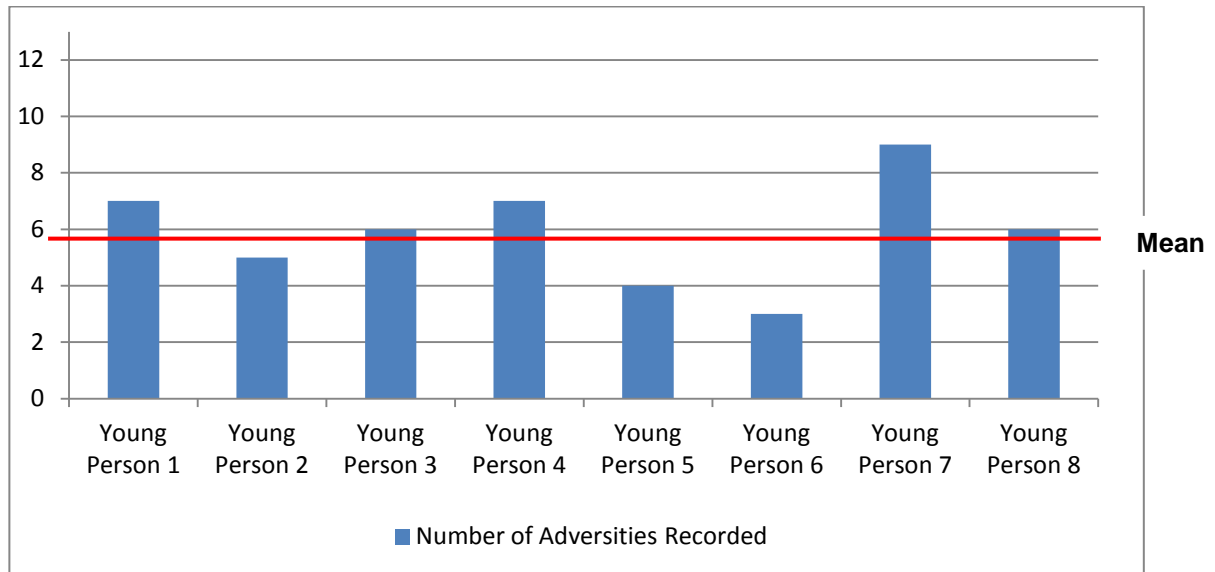
alongside the other information on young suicide and on the operation of the wider child protection system in Northern Ireland, such as routinely collected statistics, audits of practice and research findings, to provide a more rounded and therefore robust understanding of how children are identified as being at risk of experiencing harm, and responded to.

In studying the eight cases members of the research team had access to the full case management report and the associated individual agency reviews and chronologies. The researchers did not have access to the original records made by individual professionals, nor did we speak to either family members or professionals involved with the cases. As noted by Hayes and Devaney (2004) using written records has certain limitations and therefore the picture we have been able to assemble of the children and their lives is partial. However, given the preceding chapters it is appropriate to reflect on the lives of this small group of young people as a way of furthering our understanding about how young people are affected by childhood adversity, and how services and professionals respond to their needs.

Seven of the eight young people were known to social services at the time of their death, with six in receipt of ongoing services. This is unsurprising as Case Management Reviews are more likely to occur in instances where social services are involved. None of the children were subject to a child protection plan at the time of their death, although three were looked after at the request of their family due to concerns about the young person's behaviour, or the breakdown in family relationships. It is of note that only one of the young people had ever been subject to a child protection plan, whereas only three of the young people had never been looked after. The Case Management Review reports suggest that the young people were more likely to become the subject of professional intervention at a later point in time, and the basis for involvement to be focused on their troublesome behaviour, rather than the underlying causes of their troubled lives.



Figure 4: Number of adversities recorded in childhood per young person

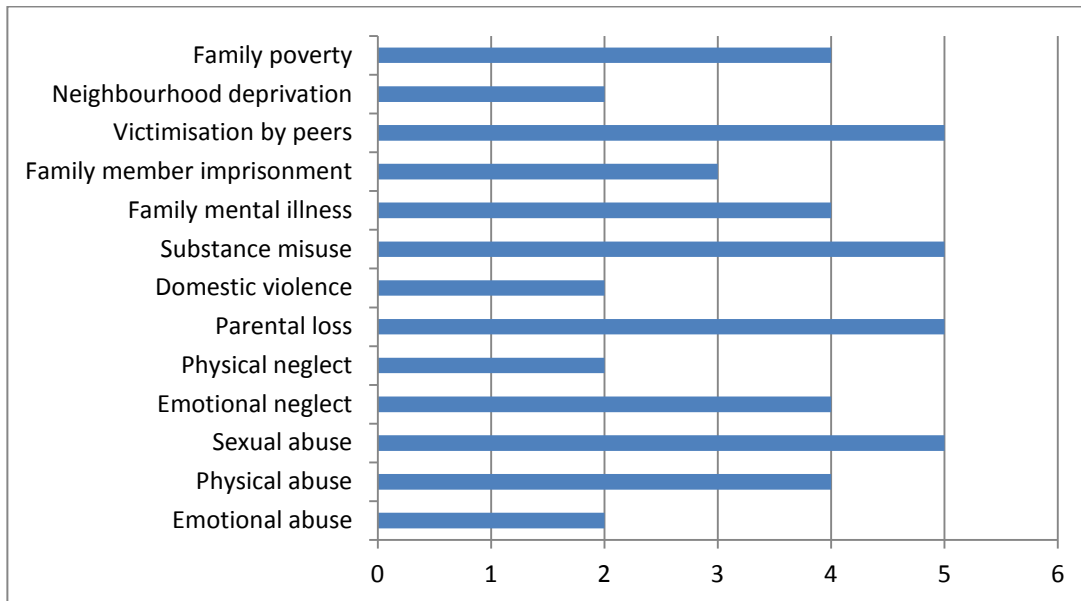


In applying the amended ACE questionnaire (Appendix 1) to this group of young people it was clear that they had suffered a significant number of adversities in their lives. In Figure 4 it is apparent that the majority of young people had experienced four or more adversities out of a maximum total of thirteen, with a mean of 5.9. It must be borne in mind that this is likely to be an underestimation as the records examined may not have recorded some information which might have been considered not relevant for the purposes of service involvement or the Case Management Review, even though there is an evidence base to indicate the relevance, for example, of neighbourhood deprivation.

In terms of the types of adversity experienced this was spread right across the full spectrum of issues, with child sexual abuse, parental loss, parental substance misuse and victimisation by peers all appearing in at least five of the eight cases (Figure 5). Some of the adversities, such as living in a deprived neighbourhood or with a parent who misused substances, had been fairly consistent for most of the young people throughout their childhood, whilst other adversities had occurred at a specific moment, even if their after effects were then persistent. Many of the young people had experienced a number of these adversities for the first time in their younger years.



Figure 5: Types of adversities in the eight cases



Given that the sample of cases in Northern Ireland is so small it is important to look at studies where the number of adolescents who have died by suicide or accident is larger and therefore where issues relating to the young people and their experiences are more apparent.

Adolescents and multiple adversities

As highlighted in Figure 5, the adversities experienced by family members in the Northern Ireland cases included, in particular the ‘toxic trio’ of parental mental health problems, domestic violence and parental substance misuse, which were also common features of the SCRs in England across all age groups (Brandon et al., 2010). These factors often co-existed and in the 2003-2005 analysis in England all three were found to be present in a third of cases, a further third of cases had two factors present and one in five cases one factor. In a much smaller proportion of cases the children themselves demonstrated mental health and/or substance abuse problems, although experiences of sexual abuse, long standing neglect, physical and emotional abuse were much more prevalent. Issues relating to disability were also present in the cases from Northern Ireland. Five of the young people had mental health difficulties to such a degree that referral to CAMHS had been made, with some of the young people in receipt of services. In the other three cases it was recorded that the young people had cognitive disabilities such as a learning disability or Attention deficit hyperactivity disorder (ADHD). In addition five of the young people who were subject to a CMR



in Northern Ireland lived with an adult with a significant mental health problem, and one young person lived with an adult with a severe physical disability.

A group of adolescents who were perceived as 'harder to help' emerged powerfully from the review processes in both England and Northern Ireland as experiencing a high number of multiple adversities both throughout their childhood as well as their early teens. These young people tended to have a long history of high level involvement from children's social care and other specialist agencies, including periods of state care. In many cases they shared a history of parental rejection and loss, usually coupled with severe maltreatment over many years. Parental mental health and substance use were particularly common amongst this group. As noted in the earlier chapters, these factors are consistently associated with suicidal ideation.

By adolescence young people within the 'hard to reach' group were typically harming themselves or neglecting themselves, and misusing substances. The 2007-2009 biennial analysis (Brandon et al., 2010) noted how the risky behaviour of the young people who were seriously harmed or died in a community context often involved excessive consumption of alcohol or dangerous drug use. In some cases deaths occurred after a night out with friends or taking drugs at a party. A number of suicides occurred after heavy drinking, sometimes following the break-up of a relationship or disputes with family members, making it difficult to assess if the cause of death was excessive consumption of drugs or alcohol or a deliberate suicide attempt. As noted earlier, adolescence is a time of great social and physiological change for young people, and therefore the process of maturation and how individuals navigate this is difficult to predict and therefore control for.

Placement breakdown was also a frequent occurrence, as was persistent running away, often leading to an increased risk of sexual exploitation and risky sexual activity. Brandon et al., (2008, p.12) citing Rutter note that 'this catalogue of risk factors reinforces the view that it is the cumulative interaction between these difficulties that produces the most harmful effects'. This report supports this conclusion.

Agency involvement

Many of the adolescents subject to SCRs in England and CMRs in Northern Ireland tended to have a history of long standing involvement from children's



social care and other specialist services, including periods of being looked after in state care. Agency involvement often extended well beyond the key agencies of children's social care, health, the police and education to include youth offending and probation services, drug and alcohol misuse services and housing, Leaving Care Teams, the Child and Adolescent Mental Health Service (CAMHS) and organisations in the voluntary and community sector (OFSTED, 2011). Brandon et al. (2008) also highlighted that eight young people were in residential or foster care or another closely supervised setting at the time of the serious harm or suicide and a further small number were care leavers in supported lodgings. However, they also noted that, for some of the neediest young people, services were being withdrawn or scaled down at the time of the young person's death through suicide. This was less apparent in the Northern Ireland cases, where a key feature appeared to be the inability of some services to engage young people who had been referred for assessment and support.

A smaller proportion of young people in England were exhibiting only lower level problems (being bullied and/or bullying) at the time of the incident and were known to fewer agencies (Brandon et al., 2008). However, additional information gleaned from the review processes revealed other, deeper problems like experiences of loss and bereavement and difficulties at home. In the Northern Ireland sample experience of peer victimisation was apparent in five of the eight cases. Not all of the young people who experienced bullying were considered victims and it is noted in the English sample that some young people were thought to be as likely to bully as be bullied. Being a bully was not thought to be a 'vulnerability' and young people who were popular at school appeared to give the impression of resilience despite known problems at home.

Early and sustained intervention

Although problems in the family had often been evident for some years agencies were identified as being particularly poor at addressing the impact of chronic neglect on children and intervening at an early stage to prevent problems from escalating. Early opportunities to co-ordinate a multi-agency response and provide support, which may have helped to prevent the escalation of problems, were missed because of the lack of timely information sharing between agencies (OFSTED, 2010) or because of a lack of inter-agency working and planning (OFSTED, 2011). For example, in one of the Northern Ireland cases the commencement of appropriate therapeutic work with one young person was seriously delayed, and in the interim the young person's emotional life became



more complex and complicated by the death of a parent, and the increasing negative influence of their peer group.

Equally, despite the length and array of professional involvement, there were frequent failures to respond in a sustained way to the young people's extreme distress which manifested itself in their very risky behaviour. It was clear from various overview reports that behaviour exhibited by many of the perceived 'hard to help' adolescents was very challenging for the professionals involved. Several overview reports in both Northern Ireland and England identify a focus on the management and control of the young person's behaviour to the exclusion of consideration of the underlying causes as a particular practice shortcoming. In other cases from Northern Ireland it was apparent that professionals did recognise the need to support a young person to address the factors underlying their difficulties, but that the young person found it difficult to engage. There was a tendency to then refer the young person to a different service, without adequately considering how a young person might be supported to engage rather than focus solely on attendance. The importance of early, more sustained and better co-ordinated intervention not just for younger children but older children and adolescents is therefore stressed as being central in both reaching out to young people, but also embracing them within a service that makes them feel safe and increases the possibility of engagement. As noted in the recommendations from one Case Management Review report this may require reconsideration of agency policies relating to non-attendance.

Thresholds for intervention

There is evidence that in some of the case examples in Northern Ireland agencies did not respond to referrals about an adolescent's needs. In one of the cases reviewed there was a fourteen month delay in responding to a referral by a school about a young person. The referral was deemed to be a low priority based on the information supplied by the school and the thresholds in operation at the time in the HSC Trust. Whilst the review concluded that this delay in itself was not the reason for the young person's death, the lack of response reduced the possibility of intervening to reduce the likelihood of this tragic outcome. This reinforces the importance of services undertaking a holistic assessment of need, and seeing a referral with the wider range of adversities a young person may have experienced.



Often arguments about which agency was responsible for which service and whether thresholds were met delayed the provision of services that the young people needed (OFSTED, 2011). This was an issue across the age range of cases reviewed and a number of English SCRs reflected a preoccupation with boundaries and which professional group was 'responsible' for the child. Neglect posed a particular problem in terms of meeting thresholds for child protection. Previous reviews have observed how the ongoing and chronic nature of many neglect cases sometimes results in professionals becoming immune to deteriorating conditions, basing their decisions on a threshold which 'tolerated a poor level of care of the children' (Rose and Barnes, 2006, p.23). Such cases were especially prone to a divergence of professional opinion, tending to 'drift' within the system with the risks to children not appropriately addressed. Brandon et al., (2008) observed a reluctance to assess these young people as mentally ill and/or with suicidal intent and their older age was sometimes used as a reason for services not being imposed. In some of the Northern Ireland cases it is noted that older young people who had lived with family dysfunction for many years were perceived as 'resilient', rather than their experiences compromising their natural coping abilities over time to the point whereby what might be considered minor triggers provided the tipping point between coping and not coping. OFSTED (2011) also noted a tendency for adolescents to be treated as adults rather than being considered as children, because of confusion about the young person's age and legal status or a lack of age-appropriate facilities. A co-ordinated approach to young people's needs was often found to be lacking and practitioners had not always recognised the important contribution of their agency in making this happen. Reviews highlighted instances where practitioners had incorrectly assumed that other agencies had taken responsibility for addressing their concerns about a young person.

Agency perceptions

Agency perceptions of older adolescent children who were very difficult to help emerged as a key theme from Brandon et al.'s (2008) analysis in England and was evident in further biennial analyses (Brandon et al., 2010 and 2009). A pattern of risky and dangerous behaviour was very common among these older adolescents and harm or suicide often occurred while they were running away or going missing. Often these young people would not stay in foster care or residential care and a number of them were discharged home, where the problems had started in the first place. The 'start again syndrome', where professionals put aside knowledge of the past and focused on the present and on



short term thinking, is identified as a contributory factor to this, as is the overwhelming nature of the needs presented by this very vulnerable group. This was a factor identified within the Regulation, Quality and Improvement Authority's report on pathways to secure care (RQIA, 2011). Overwhelmed practitioners formed a key theme in the 2005-07 biennial review (Brandon et al., 2009) and manifests when the chaos, confusion and low expectations encountered in many families is seen to be mirrored in the organisational response. Practitioners can be overwhelmed not just by the volume of work but also by its nature and it was observed that in some cases involving adolescents, professionals just seemed to give up because the needs of these challenging young people had become too much.

Earlier overview reports (Rose and Barnes, 2005) suggested that professionals made a range of assumptions about adolescents in relation to abuse and neglect which led to different perceptions of them from younger children who were suffering similar significant harm. There was a tendency to think of them as better able to take care of themselves, and to avoid physical harm and ask for help. The potential contribution of unspoken assumptions about the young person bringing the abuse upon themselves, or at least contributing in some way to the situation are also suggested. Brandon et al., (2009 and 2008) indicate that these young people might have been amenable to help if they had been offered the right approach and if, in some instances, they had not been perceived as a nuisance and problematic by the professionals involved.

Access to mental health services for adolescents

A number of SCRs and CMRs involving older adolescents demonstrated the need for help from CAMHS (Brandon et al., 2009). At times young people's mental health symptoms were not appropriately diagnosed or treated because of non-attendance at appointments. The 2005-2007 English biennial analysis notes that contact with CAMHS is often made through parents and even older young people may find it difficult to keep appointments without their parents help and co-operation. The key role of GPs in following up children and young people with depression who do not attend CAMHS appointments is highlighted. In some of the Northern Ireland cases it was apparent that young people had been referred to the appropriate service, but that once they did not engage they were referred to an alternative service without due consideration to what supports they might need to help them engage with whatever service was on offer.



When professionals did identify that a young person was in need of specialist mental health assessment the service required was not always available. In one CMR it became clear that at the time in Northern Ireland there was a gap in the availability of emergency psychiatric services out of hours for young people aged 13 years to 15 years.

Additionally, some young people were caught in the transition to adult services, often experiencing long delays before help was offered. Adult mental health services often place the onus on the patient to follow up missed appointments and there was a lack of recognition that some young people may need help to attend, especially in the period of transition between children's and adult services.

The voice of the child

In considering practitioners' understanding of child development, Brandon et al. (2011) identify a variety of issues which prevented practitioners from paying sufficient attention to the impact of maltreatment on adolescent development. Key amongst these were not developing a relationship or getting to know the young person or making sense of the impact that their experiences had on their sense of themselves and on how they behaved. In one CMR report it was noted that the young person had a good relationship with their social worker, and that rather than the social worker acting as a conduit to other specialist services it might have been more useful for the young person to have had more time with this social worker to explore the issues of concern.

Not speaking to the child and allowing the parents' voice to dominate were also common. Indeed, this is a recurring theme across all age groups and overview reports with the voice of children missing or invisible to professionals in a number of ways, including: young people who were hardly consulted or spoken with; siblings who were similarly not engaged; young people who were not seen because they were regularly out of the home or were kept out of sight; non-attendance at school; young people who ran away or went missing and children who chose not to or were unable to speak because of disability, trauma or fear.

In contrast, in some of the Northern Ireland cases there were high levels of contact between the young person and professionals. However, in one instance the contact was mostly by mobile phone due to the chaotic lifestyle of the young person. This reduced the opportunity to have more meaningful discussions of the



issues in the young person's life. In another case the contact focused solely on discussions of presenting issues, and opportunities to explore underlying issues, such as whether the young person had been sexually abused, were not taken.

Similarly, acceding to the child's wishes also can be problematic. In one local example the HSC Trust gave too much weight to the young person's wishes to have no further social work involvement, whilst in another instance the young person's request for confidentiality resulted in some professionals not being notified about instances of self-cutting behaviour.

This theme highlights the importance of agencies and professionals in considering how young people can be supported to have a voice and for managers and policy makers to consider how processes routinely expect and facilitate this. As noted by one senior manager, the child's best interests must prevail, but establishing and maintaining the trust of young people is at the heart of pulling some young people back from the edge of the abyss.

Summary

In reviewing the eight cases from Northern Ireland we are reminded that some young people have led difficult lives, and that this can manifest itself in poor mental health, challenging behaviours, and a difficulty in accepting support and help from concerned others. The reviews of such cases in both Northern Ireland and England confirms that there are a range of adversities which impact on an adolescent's sense of wellbeing in both the immediate and longer term, and that professionals and their employing agencies must be mindful of what services they provide as well as how they are provided.

By looking at these cases through the lens of the literature on adversity and the impact of multiple adversities over time, we are better able to see why some young people place themselves at risk and end up dying by suicide. Their natural resilience and ability to cope with life's ups and downs has been compromised, and in the absence of alternative supports, it is unsurprising that some young people feel overwhelmed by the challenges of their particular situations. This review has helped to draw together a body of knowledge that informs our understanding of why young people may feel overwhelmed, and why professionals need to conceptualise young people's needs differently.



CHAPTER 7: Conclusion

As John Coleman (2010) notes, adolescence is both a challenge and a delight. It is a time when new opportunities present that allow the development of new relationships, new skills and a growing sense of independence and self. However, it can also be a time of challenge as individuals need to negotiate more complex and differentiated social and family relationships, issues of values and attitudes come to the fore, and questions about identity and the future become more apparent. On the whole research has concluded that most adolescents navigate this stage of life with few difficulties (Coleman and Hagell, 2007), but a minority do find this stage of life challenging, and their ways of coping may have negative consequences for both themselves and others.

The UNCRC places a duty on States parties to ensure that children and young people are supported during childhood in order to attain the highest standard of health and wellbeing, and to respond robustly where factors may be impacting on children's welfare. In the most recent General Comment (CRC, 2011) the Committee on the Rights of the Child recognises the multiplicity of ways in which children's needs may not be met by both parents and State bodies.

In this report we have sought to highlight the risks to one particular group of young people – those who die by accident or suicide. Regrettably death by suicide in adolescence is a common enough occurrence for a substantial body of research literature to have been compiled. This points to the need to locate suicide as being part of a range of behaviours linked by the emotional sequelae of the experiences of adversity in childhood. Whilst we must recognise that adversity in childhood is not in itself deterministic of a poor outcome in later life, there is substantial evidence that it does increase the probability of compromised outcomes (Davison et al., 2010). For example, in a recent report exploring the potential benefits of early intervention on diverting some young people from the youth justice system, the Criminal Justice Inspectorate in Northern Ireland (2012, p.v) has found that:

'A snap-shot study on the backgrounds of young people detained in the Woodlands Juvenile Justice Centre in November 2011 shows over a third were 'looked-after' or voluntary accommodated children within the care system; 82% were identified as coming from a single parent family and 34% had experienced domestic violence in the home environment. In



relation to educational attainment, 38% of the sample had a statement of learning needs whilst 14% had a recognised learning disability; 80% of the sample had issues relating to school exclusion or absconding from school. The vast majority of young people (92%) had misused drugs or alcohol, while 32% had self-harmed.'

In reflecting on why some young people appear to cope better with adversity than others Coleman and Hagell (2007, p.14) have noted that:

- There is strong evidence from longitudinal studies that, where protective factors are present, most children and young people do recover from short term adversity. In this sense we can say that the majority of children and young people have the capacity for resilience so long as the risk factors are limited, and protective factors are in place.
- Where risk factors are continuous and severe, only a minority manage to cope. The more serious the adversity, the stronger the protective factors need to be. Thus, under conditions of major risk, resilience is only apparent among a minority who can draw on the strengths gained from protective factors.
- The major risk factors for children tend to lie within chronic and transitional events, rather than in acute risks. Therefore children show greater resilience when faced with acute adversities such as bereavement, or short term illness, and less resilience when exposed to chronic risks such as continuing family conflict, long term poverty, and multiple changes of home and school. The research highlighted in this report also confirms that it is the *multiplicity* of chronic adversities which are the most dangerous for children and young people.
- Resilience can only develop through exposure to risk or to stress. Resilience develops through gradual exposure to difficulties at a manageable level of intensity, and at points in the lifecycle where protective factors can operate. This requires the support of others, typically family and peers. However, for some young people it may be that family and peers are the source of their stress, and that the stress is overwhelming and persistent.

Newman (2004) suggests a number of strategies for promoting resilience in childhood based on our current understanding of resilience and how children and



young people cope with adversity (Box 6). This is supported by the most recent General Comment from the Committee on the Rights of the Child (2011, p.26) which states that:

‘It is of critical importance to understand resilience and protective factors, i.e. internal and external strengths and supports which promote personal security and reduce abuse and neglect and their negative impact.’

This raises a question as to how visible children who are experiencing adversity are within society and to professionals with responsibility for supporting families and promoting children’s wellbeing. On the one hand there is substantial evidence that large numbers of children experience adversity, such as living in poverty (MacInnes et al., 2012) or experiencing abuse and neglect (Radford et al., 2011). Yet, for the majority of these children and their families, the interventions aimed at meeting their needs are at a societal or community level, in the form of the tax and welfare benefit regime, or universal targeted interventions such as Sure Start and Head Start, which may not actually reach the families and children most in need of the service (Winkworth et al., 2010).

Box 6: Strategies for promoting resilience in childhood

A tiered approach to promoting resilience in children and young people:

Tier 1 Preventative

To reduce the child’s exposure to risk – whilst this sounds simple it is more difficult to achieve, although approaches such as parenting classes, Sure Start and homework clubs can all contribute.

Tier 2 Responsive

To find ways of interrupting the chain reaction of negative events – as noted, the presence of one risk factor increases the likelihood that others will be present. As a result, if one risk factor can be diminished or reduced, then it may follow that other positive consequences will occur. For example, addressing issues related to domestic violence may improve a parent’s mental health and result in lesser use of substances.

Tier 3 Compensatory

In order to enhance the potential strength of protective factors provide the child or young person with positive experiences, to enhance self esteem and to develop positive relationships. For example, peer mentoring, opportunities to engage in youth work activities and involvement of wider family members.



However, there is evidence that some young people with additional needs are known to child welfare, health and education professionals, and that at least some of their needs have been identified. This study supports a growing body of evidence which highlights what could usefully be done to better meet the needs of these young people based on examples of practice that have been shown to be effective:

- These very vulnerable young people need more creative, more responsive, individually tailored services that extend into their adulthood.
- As these young people are often known to multiple services, there is a need for greater co-ordination between service providers.
- Services should be sustained and planned on a long term basis so that they can address root causes and not just respond (or fail to respond) to young people's current distress or challenging behaviours.
- Staff need to have a skill set which involves the ability to engage with young people who do not necessarily want to engage, and to be able to motivate the young person to make positive choices in their life.
- There is a need for services in children's social care, health, education and criminal justice to develop better ways of identifying children suffering from depression and being more responsive in addressing any assessed need.
- There needs to be a clear transition from children's services to effective and responsive adult services.
- Whilst some young people may present with troublesome behaviour, this should not stop them being seen as troubled. Therefore providing compensatory experiences in order to promote greater resilience must be seen as part of the therapeutic intervention, rather than a reward for inappropriate behaviour.
- Since these young people are often extremely challenging to help, excellent training, support and supervision is needed for those providing their care.

Given that there are likely to be a significant number of young people already known to child welfare services there is a need to support staff to better see and understand the range and depth of adversities that children will have experienced, and the longer term impact of same. Building on our growing



understanding of resilience, it is useful to consider how we provide greater support to more vulnerable young people around natural transition points (such as the move from primary to post primary education) rather than focusing solely on stress points (such as a crisis) which by definition cannot be predicted. This requires a refocusing of our conceptualisation of interventions – rather than being solely remedial, they should be designed to promote current coping and longer term positive outcomes. This orientation assimilates the notions of vertical and horizontal stressors with a life-course perspective.

It is encouraging to note that agencies such as the Department of Health, Social Services and Public Safety (2011), the Health and Social Care Board (2012), the Public Health Agency (2012) and the Criminal Justice Inspectorate Northern Ireland (2012) recognise that earlier, co-ordinated and more sustained interventions are both a socially responsible and an economically sound way to meet the needs of the Northern Ireland population.

In conclusion, there are a number of specific recommendations arising from this review which we think are worthy of further consideration. In making these recommendations we have sought to ensure that they are realistic, achievable and directed to the body or organisation with primary responsibility for the particular issue. We are mindful though that rarely is one organisation solely responsible for supporting young people.



CHAPTER 8: Recommendations

Recommendation 1: Assessment

There is a need to support staff to see and understand that there are a range of both presenting and underlying factors which may be impacting on a young person's developmental and coping abilities. Building upon the successful roll out of the Understanding the Needs of Children in Northern Ireland (UNOCINI) assessment framework in Northern Ireland we would recommend that a structured decision making tool is introduced to support staff in any service to identify the key childhood adversities known to lead to poorer outcomes in later life. This should lead to the aims of UNOCINI as a holistic assessment to be more fully realised. This tool could be piloted and evaluated in one area as a means of assessing its utility. This issue should be considered by the Department of Health, Social Services and Public Safety and the Health and Social Care Board as the lead agencies with regards UNOCINI.

Recommendation 2: Case planning

It was an unsurprising finding that the majority of the young people in the Northern Ireland sample were not subject to either a child protection plan nor were they looked after. Children in such circumstances benefit greatly from the multi-agency co-ordination of interventions and services that result from being on the child protection register or being looked after. However, the majority of the young people were known to a range of services, and professionals did have concerns about the needs and wellbeing of the young people. There is a need therefore to ensure greater co-ordination in the response of professionals and provision of services. This is most likely to be achieved by the appointment of a lead professional, identified at a case planning meeting, and supported by an agreed and written intervention plan. The lead professional should ordinarily be from the agency with greatest contact with the young person, as the role is both about co-ordinating services alongside developing a therapeutic relationship with the young person. This issue should be considered by the Health and Social Care Board through the Children and Young People's Strategic Partnership, and the Safeguarding Board for Northern Ireland.



Recommendation 3: Identification of depression

The research is clear that earlier identification and response to a young person's poor mental health, and in particular depression, will reduce substance misuse, self-harm, and suicide attempts. There is a need to ensure that professionals having greatest contact with young people in education, social care, health care and criminal justice have greater understanding of what depression is, how to identify it and how to respond. This is particularly the case for young people in various forms of residential care, or where family relationships have broken down. Recently there has been a notable roll out of training about suicide, and this should be reviewed to ensure the target groups for this training are receiving it and that the broader issue of adolescent depression is also addressed. This issue should be considered by the Department of Health, Social Services and Public Safety and the Public Health Agency in the development of a new service model for the delivery of CAMHS services, and the refreshed *Protect Life* strategy.

Recommendation 4: Reducing the impact of adversity

In an ideal world professionals would rather prevent children from experiencing adversity in the first instance. Whilst this is possible, and interventions such as Sure Start and positive parenting interventions do make a difference, most child welfare professionals will continue to need to respond once a crisis or problem arises. In doing so there is a clear need to manage the twin objectives of reducing any immediate risk a child may be exposed to, alongside providing evidence based therapeutic interventions to attend to the psychosocial impact of the adversity on the child or young person. Professionals need to be mindful of the possibility of the young person having experienced multiple adversities and to see their role as being broader than responding just to the immediate or current issue. There is clear evidence that many therapists continue to deal with the presenting issue, without due consideration of the wider array of adversities the young person may have experienced. This issue should be considered by the Health and Social Care Board through the Children and Young People's Strategic Partnership, and the Safeguarding Board for Northern Ireland.

Recommendation 5: Pathways to impact

There is a strong evidence base to inform our understanding that a range of experiences in childhood have a negative impact in adolescence and adulthood.



We also know that some types of intervention are protective, such as screening for depression and mentoring schemes. We need though to more fully appreciate the trajectories over time for young people who do receive interventions to better understand what works and in what circumstances for whom. For example, it would be useful to compare groups of young people with similar profiles but who are known in the main to different services such as youth justice, CAMHS, substance misuse services and services for looked after children – to identify whether young people with similar needs end up in different service systems by chance, and whether different service systems produce better outcomes for young people with similar needs. This requires a refocusing on the outcomes to be achieved for young people, rather than the outputs of different services and systems. This issue should be considered by the Office of the First Minister and Deputy First Minister in relation to their lead responsibility for addressing social exclusion and the ten year strategy for children and young people in Northern Ireland.



APPENDIX 1

Adversity Questions – Prior to their 18 th birthday are there indications that....	Yes?	No?	Details
A parent or other adult in the household often or very often ...Swore at them, insulted them, put them down, or humiliated them? or Acted in a way that made them afraid that they might be physically hurt?			
A parent or other adult in the household often or very often ...Pushed, grabbed, slapped, or threw something at them? or Ever hit them so hard that they had marks or were injured?			
An adult or person at least 5 years older than them ever ... Touched or fondled them or had them touch their body in a sexual way? or Attempted or actually had oral, anal, or vaginal intercourse with them?			
Did they often or very often feel that ...No one in their family loved them or thought they were important or special? or Their family didn't look out for each other, feel close to each other, or support each other?			
Did they often or very often feel that ...They didn't have enough to eat, had to wear dirty clothes, and had no one to protect them? or Their parents were too drunk or high to take care of them or take them to the doctor if they needed it?			
Was a biological parent ever lost to them through divorce, abandonment, or other reason?			
Was their mother or stepmother often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?			
Did they live with anyone who was a problem drinker or alcoholic or who used street drugs?			
Was a household member depressed or mentally ill or did a household member attempt suicide?			
Did a household member go to prison?			
Are there any reports of victimization by peers?			



Are there indications that they came from a neighbourhood characterized by high levels of economic and social deprivation?			
Are there indications that they came from a family experiencing high levels of economic and social deprivation?			



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