PSAB

Safeguarding Adult Review

YL's story in brief

This is the story of YL, a young adult who lived mostly with her grandparents throughout her life, a home she chose as a child as the place where she preferred to live and where she chose to continue to live as a young adult and as a mother to her own child. YL's family life was complex at times; however YL maintained contact with her mum and her siblings. YL started to present with regular and increasing self-harm behaviours in the summer of 2019, often accompanied by extreme emotional dysregulation, whereby YL was unable to manage her emotional responses typically, including sadness, anger, irritability and frustration. YL regularly self-presented to the Emergency Department (ED) or was conveyed there by ambulance for assessment. At times YL was admitted to hospital. Following assessments, YL was diagnosed with Emotionally Unstable Personality Disorder (EUPD), a mental health condition which is predominantly treated by talking type therapies; for which there is variable success. Hospital admission is only supported when absolutely necessary for people living with EUPD; as hospital environments can increase risk for them in their recovery process. The hospital avoidance approach unless absolutely necessary is recommended in national clinical guidance.

YL was supported by the mental health team in accessing a broad range of talking type therapies and support services and was on the waiting list for others, the mental health team continued to support and review YL both as an inpatient and following discharge, supported by YL's family. YL however continued to self-harm and her emotional dysregulation and self-harm continued to increase in both frequency and intensity, including hearing command voices demanding that she harm herself and eventually demanding that she harm others. YL remained on the waiting list for key therapies in this time. Intermittent alcohol consumption, stress related to relationships, the need for employment and awareness of how YL's behaviour was impacting on her family, especially her own child; were all identified as key triggers for YL's emotional dysregulation.

The risk perceived to YL's child and the need to safeguard them from YL's behaviour became such, that child contact conditions were put in place and legal proceedings commenced. YL's child continued to live with YL's grandmother, with child contact conditions including that YL was no longer allowed to sleep over at her grandmother's house whilst her child was there, effectively resulting in YL becoming homeless. YL was placed in temporary hotel accommodation, which she said that found lonely and isolating and YL's self-harm behaviour began to escalate again from the time she became homeless. Whilst YL recognized that a hospital ward was not the best environment for her recovery, YL maintained that she only ever felt safe when in hospital. Whilst a range of mental health and social care support services were offered and accessed for a period of time by YL, ultimately YL did not find them very effective, a perception also echoed by YL's family. YL tragically took her own life in January 2020 in her hotel room.

What learning did the review identify?

1. ***The multiagency partnership did not always work in partnership effectively. This was underpinned by:***
   - Limited understanding across health and social care practitioners of EUPD and approaches to care and support for this condition.
   - Lack of real time multiagency communication, specifically when supporting people with frequent and dynamic fluctuation of risk.
   - Limited access to meaningful public information to help them understand each service's remit and criteria and practitioner roles and functions.
   - Lack of core multiagency care/safety plan template, used and shared across all health and social care agencies, emergency services and families.
   - Lack of multiagency discharge planning and no family approach to discharging adults who are parents with care and support needs.
   - Limited assessment and sharing of information regarding a person's homelessness, notably when safeguarding referrals are made.
   - Need for clarification regarding responsibility for information sharing and supporting/updating parents subject to child care proceedings.
2. ***Appropriate assessments were not always completed so needs were not always identified or risks mitigated. This was evident because:***
   - It was not possible to confirm that evidence based tools were routinely used to assess individuals in ED with acute Mental Health crisis.
   - There was not always ready access to urgent mental health assessments in ED or beds in the mental health unit at the point of presentation.
   - There was variation in the undertaking and rating of risk assessments, which seemed fragmented at times and lacked meaningful assimilation.
3. ***Support was not always provided to meet identified need. This was evident by:***
   - Health and social care did not support families enough in their need for understanding YL's needs and how they could be met.
   - Wait times for key psychological therapies result in people not being able to access them when they are identified as needing them.
   - There were reports of calls not being answered or returned, which included calls made at a time of crisis.
   - The allocation of a care coordinator as a lead professional within mental health was later than would have been helpful for YL.
4. ***The voice of the adult was not always heard***
   - The need to safeguard YL's child overshadowed the need to safeguard adults too.
   - There was no evidence of joint adult and children's services family assessments, where both adult and child voices could have been heard.
   - Re-referral to the Job Retention Specialist did not take place when YL shared that her new career choice was mental health care on night duty.
   - There was no evidence of time taken to listen to and respond to carers in their own right or of advice to carers of how to access this support.
   - There was little evidence of risk assessment of how YL would live in a hotel and cope in an environment that lacks facilities for daily living.
5. ***Safeguarding practice was not always optimal***
   - Agencies did not seem to recognize and respond to the risk associated with YL no longer perceiving that her child was a protective factor.
   - There was no evidence of a joint adult and child integrated Family Approach to safeguarding with this complex family.
   - Public and professionals did not always understand agency roles, functions, scope and limitations to respond in crisis or to safeguarding risk.
6. ***Other learning identified***
   - The local housing market for temporary accommodation is not always fit for purpose, especially for people living with mental health conditions.
   - The governance, support, supervision and information sharing with hotel providers needs to be reviewed and improved.
   - Families and carers who support people living with EUPD are not always offered carers assessments aligned with the Care Act (2014).
   - Families are not always offered bereavement counselling
   - YL did not always collect her medication and services were not aware of this.
   - There is a need for assurance regarding the quality of contract monitoring in relation to safeguarding.

Overarching areas for improvement and action required as a result of the learning identified

Improved understanding is needed of/for:

- EUPD and approaches to care and treatment
- How EUPD differs from acute psychosis
- Multiagency Services criteria, remit and practitioner roles
- Discharge planning for parents with care and support needs
- How risk assessments are/can be assimilated across teams
- The safety and monitoring of processes for the collection of prescribed medicines
- Missed and/or abandoned calls to crisis intervention services
- The criteria for allocation of a CCO
- Role, function and referral criteria for Job Retention Specialist
- How Carers' experiences are considered and listened to
- How daily living needs are met in temporary hotel accommodation
- How agencies understand the concept of children as a protective factor
- Adult and child Family Approach to safeguarding complex families
- Understanding roles, scope and limitations to respond in a crisis
- Temporary housing market and meeting needs of mental health

Assurance is needed for/regarding:

- Real time multiagency communication regarding fluctuating risk.
- Sharing of information regarding a person's homelessness status
- Use of evidence based tools to assess acute Mental Health crisis in ED
- Urgent mental health assessments in ED is readily accessible
- Safeguarding of children doesn't overshadow need to safeguard adults
- Local model for joint adult and children's services Family assessments

Development is needed of:

- A core multiagency care/safety plan template

The following needs further consideration/examination:

- Responsibility for information sharing and supporting of parents subject to child care proceedings
- The governance, support, supervision and information sharing arrangements for hotel providers
- How to value families and carers by investing more in education and support specific to their needs
- Care Act assessment of carers of people living with EUPD
- Audit wait times for key psychological therapies
- Commissioning and contract monitoring in relation to safeguarding and the quality assurance process for this