Multi-Agency Case Audits

City of London 2019/20

Children and Young People with Mental Health Issues

Case Summary

Case 1
Young person admitted to adolescent mental health unit. Assessment undertaken by Children and Families Services (no further action to be taken). The professional network is coordinated by the CAMHS Care Coordinator. Young person has a recent diagnosis of Autistic Spectrum Disorder and has made a disclosure of historic sexual abuse.

Effective Practice

- Education Services were involved in the case even though there was no statutory requirement (young person was not missing in education).
- There was a good level of professional attendance at CIN and Care Programme Approach (CPA) meetings.
- The Children and Families Team reflected on the young person's social media usage (a component of the local assessment framework), suicide contagion and learning from recently published CHSCP **Local Reviews** to help assess risk and inform their approach to working with this family.
- The voice of the child was confidently relayed by the CAMHS Care Coordinator and seen to help assess risk and support safety planning.
- Evidence of timely interventions (strategy discussion with key partners, CAMHS intervention and a face to face discussion following disclosure of abuse). Ongoing thought is given to the most appropriate professional to engage the young person.
- Sensitive decision making by the social worker on whether it would be helpful to speak to the young person at the point of their being critically unwell.
- **Overall, the positive work undertaken by CAMHS in a challenging and uncertain set of circumstances was acknowledged.**

Improving Practice – Key Messages:

Understanding of Autism Spectrum Disorder (ASD)

The cases audited (in both City of London and Hackney) presented a common factor in the late identification of ASD. As a partnership, there are opportunities to explore how professionals can be supported in early identification, communicating with ASD young people, working with parents (who may themselves have witnessed traumatic events) and understanding the impact ASD may have on a young person in the context of self-harmning behavior.

Are you signed up to our monthly 'Things You Should Know' briefings? Updates on partnership activity in this area will be communicated via this briefing – sign up HERE!

Information Sharing

This case highlighted areas for continued improvement in information sharing:

- Sharing of safety plans with appropriate professionals (on agreement and as changes are made).
- Ensuring that a core list of key professionals are invited to planned and emergency meetings.
- Outcomes of meeting being consistently communicated to key professionals.
- Need for increased awareness of the School Nursing Teams to ensure that the right professionals are informed of CIN meetings, sent relevant correspondence, and involved in discharge planning for school aged children.

Do you ensure that all identified professionals are aware of safety plans when issued and as updates are made?

Do you / your agency have a list of the core professionals to be invited to meetings? This is especially important for emergency meetings convened when young people are in crisis?
Do your / your agency systematically disseminate the outcomes of meetings to identified professionals in the network? Conversely, do you take personal responsibility to be sufficiently informed if you do not hear about the outcome of a meeting?

Are you aware of the School Nursing Service? It provides school-based health services for children and young people attending state-maintained schools. The service also includes a prioritised, safeguarding school health offer to Children in Need, children on Child Protection Plans, and any children identified as 'vulnerable' who are of school age and living in City and Hackney. Find out more including how to contact the service HERE.

Absent Fathers

This case highlighted the need for professionals to seek clarity on the identity of absent fathers or other male figures who play/have played a role in the family. This is especially important for young people who struggle with, or display self-harming behaviours linked to their identity.

Continued professional curiosity around absent fathers / paternal extended families can help professionals identify the wider support network, fully assess risks and increase the young person's understanding of themselves and their emotional wellbeing.

In conversation with mothers, are you explicit around the importance of identifying and speaking to fathers / male figures as part of your engagement with the family?

Where the information is not forthcoming, do you think about who else may hold this information in the network, e.g. birth information held by GPs?

The NSPCC briefing 'Hidden Men: Learning from case reviews' identifies further good practice in identifying fathers/males figures:

- During pregnancy and after birth, make active enquiries about the child's father, the mother's relationships and any adults in contact with the child. Record these details.
- Identify and carry out checks on any new adults who have significant contact with vulnerable children. Always clarify who the members of a household are each time you visit a family.
- Be aware that some individuals will have a number of aliases. You might also receive names which are incorrectly spelt. Make sure you carry out checks which allow for different spellings of a surname.
- It can be difficult to get mothers to open up and discuss their partners' involvement in their children's lives. Supervisors should support practitioners to find ways to engage with mothers and build trust.