Multi-Agency Case Audits

Hackney 2019/20

Children and Young People with Mental Health Issues

Case Summaries

Case 1: Young person repeatedly presenting at health services with medically unexplained pain leading to poor school attendance. Referral made to CSC.

Case 2: Young person known to health services following physical injury (no clinical concerns). Subsequent self-harming behaviours and multiple hospital attendances. Referred to CSC and following assessment, support has been provided through the Family Support Service.

Case 3: Young person presented to health services following sexual assault. Young person has suicidal thoughts and has previously self-medicated. Case is managed under a CIN plan with a PLO process underway (at the time of the audit LAC planning was being undertaken).

Effective Practice

Engagement

- (Case 1 and 2) Evidence of professionals working with parents to engage in services resultant in good attendance at appointments.
- (Case 2) Use of family therapist from the same cultural background to engage family and online interpreting service to ensure mother understood conversations.
- (Case 3) When the young person attends the sexual health clinic, their named person is informed to ensure consistency of care. This has avoided the young person having to retell their story (an issue fed back by the young person).

Achieving outcomes

- (Case 1) Professionals ensured the young person had access to home education and they have subsequently exceeded prior expectations by completing a number of GCSEs. The young person now has plans to attend college.
- (Case 1) The young person is achieving outcomes set out in the Child Protection Plan.

Information Sharing

- (Case 1) CAMHS letters copied to the Adult Mental Health Consultant and evidence of good information sharing between CSC and CAMHS.
- (Case 1) Good information sharing between the CIN unit and CAMHS.

Voice of the child

- (Case 1) The young person is able to express insight into their condition, including warning signs and when to call the emergency services. They also express emotions through physical symptoms.

Multi-agency working

- (Case 1) Evidence of multi-agency working and discussion when the case was held in the CIN unit.
- (Case 2) The Home Tuition Service and School worked flexibly to transition learning and support for the young person.
- (Case 3) Confidence that allegations of assaults have been responded to line with standard procedures. Case reviewed at the Extra Familial Risk Panel and MAP meetings. Young person was also seen with a pediatrician (not normal practice for over 13s).
- (Case 3) Good multi-agency working between CSC and Police to locate young person when missing.

Escalation

- (Case 1) The CIN plan has clearly set contingencies for escalating concerns.
- (Case 2) Evidence of challenge and escalation, professionals meetings being convened and CAMHS use of the complex care forum to ensure the service was delivered at the right level of need.
- (Case 3) Effective escalation with professionals recognising the parent's strengths but also identifying the extent to which they could consistently engage with the plan. This case identified the professional challenge where families are not seen to be willfully neglecting their children; positively the professional network kept its focus on the young person's needs.

As per the City of London audit, the positive work undertaken by the partnership across a set of challenging and uncertain circumstances was acknowledged. The cases presented were complex with a wide range of health issues however there was a clear focus on the needs of the young people, good assessments and identification of risk. The high level of risk held by front line professionals on a daily basis was also 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's in the context of self-harming behaviour.

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:

- Health professionals should be aware that they are able to access records outside of their caseload if there is a child protection/safeguarding concern.
- If professionals experience a lack of response from adult mental health professionals (e.g. information requests) this **should be escalated to the ELFT Named Professional for Safeguarding Children.**
- Safety plans should be shared with appropriate professionals (on agreement and as changes are made).
- 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.
- FAST 'no further action' / closure letters to contain enough detail for agencies to understand the rational for closure and clear direction for future re-referrals.

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

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.

Calling Professionals Meetings

Case 2 highlighted that **any professional** in the network who has concerns about a case can call a professionals meeting. A professionals meeting may be important: where there is uncertainty amongst professionals about the necessary steps to safeguard the welfare of a child; where there is concern that the family is undermining attempts to understand potential risks to children; where professional disagreements arise that are impacting on effective work with the family, or where professionals need an opportunity to reflect on the plans for working with a family when progress is not being made.

Have you read the CHSCP guidance on calling a professionals meeting? Find the guidance HERE.

Social Media Footprint

Case 4 highlighted a general reminder, where possible, for professionals to assess young people's social media footprint. This is especially important for young people with increased vulnerabilities.

Are you aware of the CHSCP Online Safety page? It contains a Handbook providing safeguarding professionals with a range of tools that can help identify and mitigate any risks arising from a child or young person's access to technology and/ or use of social media.

The London Child Protection Procedures has recently been updated to include:
When undertaking an assessment (2.5.3) or at a strategy meeting prior to undertaking enquiries under S47 of the Children Act (3.4.2), consideration should be given as to whether checks should be undertaken on social media; More detail (3.8 – 8.5) about the circumstances in which social media searches can be carried out and what practice is not acceptable.

Consideration of Young Carers

Case 2 highlighted that all young carers are entitled to a local authority carer's assessment. This is especially important for care givers who are reaching adulthood and who may not be meet the threshold for support by the community mental health team.

Are you aware of the Hackney Young Carers Project? They work with children aged 8-18 who are caring for a family member who is terminally ill, disabled, has a diagnosed mental health condition or a substance misuse issue. Further information and referrals details can be found HERE.

Wider family

Case 3 highlighted a reminder for professionals to formally include the wider family network in discussions around safety planning and to gain their views on what is happening within the family. This learning was also identified in CHSCB Local Review **Rachel**. This case also highlighted the need for professionals to consider the lived experience of siblings and support from early help services in relation to traumatic experiences they have witnessed.

As part of your assessment, do you identify wider family members who provide care to children or young people in the home? This could be regular care or adhoc e.g. whilst parents are on business trips, holiday or at times of crisis.

Once the wider family network has been identified, do you make efforts to engage formally in assessments or safety planning?

Do you consider the lived experience of siblings and how the current experiences may impact them in later life?