Mental Health Audit. February 2020

This audit topic was selected by PAQA to evaluate the experience of children identified as a 'child in need' or subject child protection planning, and children in care who have mental ill health. It focused on children aged 10–15 years.

About the Audit

This audit was in line with the current theme for the Joint Targeted Area Inspections. The purpose was to identify:

1. Key learning points regarding working with children with mental health needs
2. Good practice
3. Any areas of concern

Audit Methodology

A joint-agency methodology was used to understand how agencies work together to identify children experiencing mental ill health and how they intervene early to support these children when problems arise.

Partners may be working with children who are awaiting a service or having difficulty accessing the right support. The audit was interested in how they provide ongoing support to these children and their families, and the impact on children of delays in accessing services.

The auditors looked for examples of good practice as to how partners work collectively to provide support to prevent deterioration in mental health and promote good mental well-being and resilience.

A small number of cases were audited in detail.

The audit was conducted by each agency first reviewing their own records and then meeting with partners to share their findings and identify common themes.

Key Messages / Findings

1. **Timeliness of mental health intervention:** this was regarded as being appropriate in most cases.

2. **Domestic abuse** is a prevalent feature in the family environment of vulnerable children. It was not possible to assess whether this factor had directly impacted on the child's mental health.

3. **Parental mental health:** some of the children were impacted by mental health issues faced by their parents and it wasn't always clear how this was managed.

4. **School attendance:** poor school attendance was a feature throughout. This meant that the children, who had multiple vulnerability factors, didn't have the support network of school available to them.

5. **Lived experience of individual siblings within large family groups:** there was good evidence of a Think family approach by practitioners. However, it was also apparent that sometimes the needs of an individual child were overshadowed by the needs of their siblings.

6. **Relevant professionals linked to strategy meetings:** health information was not consistently included in strategy discussions, so it was known in all cases at an early stage, if mental health services were involved with a child. New 'MASH' processes mean that health information is now included in strategy discussions.

Examples of good practice

The following are examples where partners recognised safeguarding concerns, acted and/or shared information appropriately:

- In most cases children had not had to wait to receive help with their mental health
- There was good evidence of the child's wishes and feelings in the records in particular through the mental health records. For example, one case recorded that the young person "wants to be like everyone else" and wants to have "a proper family". This led to a helpful piece of work with them about how families can look different and how belonging can come through connections between people, even if not related by blood.
- There was good evidence of practitioners from different agencies communicating well with one-another.

Identified areas for improvement:

The following were noted:

- **School attendance**: in almost all cases of children with mental health problems had poor school attendance and the auditors could not identify clear plans to help them engage in to school life or alternative provision.
- **The importance for practitioners of separating out the needs of individual children within the family**. These children had mental health problems and were generally living in families where life was not straightforward and other family members had their own set of needs. It was not always clear to the auditors how their needs had been separated out from other family members.
- **Signposting to other services:** in a number of cases the children with mental health problems had other risk factors in their life that affected their well-being e.g. young carers, child of an offender. It was not clear to the auditors that these children had been directed to support to assist with these additional challenges.

Summary

A small sample of cases were audited and findings are presented with that caveat. However, the findings did reflect themes from recent reviews and other audits e.g. (1) adverse family circumstances such as domestic abuse and poor parental mental health impacting on children's wellbeing and (2) that children are safer when in school and there is more opportunity to support their wellbeing.

Audit Recommendations

It is recommended that the learning from this review is shared with the following sub-groups in order that it can be considered within their ongoing work:

1. **Safeguarding in Education**: for reinforcing the message that clear planning is needed to get children back in to school when they are not attending. Schools are key to noticing and alerting others to the potential concern.
2. **Domestic abuse operational group**: for awareness that the audit highlighted the potential impact on children's mental health of living in a home where domestic abuse is feature.
3. **The OSCB Business Group**: for awareness that parental mental ill health can also impact on children's wellbeing. Work is underway to develop joint assessments between adult mental health and children's social care (a recommendation from the serious case review for Child M).
4. **The OSCB Neglect strategy group**: for awareness