Durham Safeguarding Children Partnership

Priority Four
Mental Health and Wellbeing

How do we identify families at the earliest opportunity for support? We look at the journey of families that have gone into crisis and whether there was an opportunity to offer any intervention or support at an earlier opportunity to prevent families reaching crisis point.

This learning briefing has been developed following the DSCP completing work under Priority four, Mental Health and Wellbeing which forms part of the DSCP Priority Plan 2023-2026. This briefing highlights the key learning, shares strengths in practice and identifies areas for learning in safeguarding practice, together with details on the steps you can take to find out more and access further training and resources.

Methodology:

1. A practitioner led, multi-agency deep dive was arranged by the DSCP Business Team.
2. Two surveys were shared, one with children and young people and one with their parents and carers.

Scope:

1. There were 3 young people (YP) identified to take part in the deep dive, all of the young people.
   - Were open or previously open to Rapid Response Service (Tier 4 support)
   - Were currently assessed as being stable in their mental health.
   - Wanted to be involved in the process and offer a voice and understanding of their experience.
2. A survey was shared with children and young people and one with their parents and carers. The YP are open to tier three and tier 4 support and currently have an allocated worker to support.
   - 120 surveys were shared with children, young people and their parent's/carers.
   - 38% children responded.
   - 34% parents 'and carers responded.

Strengths

1. Throughout all of the deep dives/surveys, it was consistently seen that the Rapid Response Team are very supportive and adapt the support to each child and the uniqueness of the family.
2. Empowering children, young people and families by listening to them, not judging, understanding them and getting to know them. Young people and families felt empowered to ask questions when this approach was taken.
3. There was evidence that the voice of the child was gathered and recorded on multi agency records.
Resource: Voice of the Child and Lived Experience

Voice of the Children

"Always tell the truth to young people, what you tell the parent you tell the young person. Let people take it at their own pace to talk and get better. Being consistent with young people, making them feel comforted and listened too" (YP Deep Dive)

"Professionals to be open minded, you don't know everything straight away, take time to learn this. We don't need someone to fix everything, but we do need them to listen and to help. Look underneath what is happening on the surface and treat everyone with kindness" (YP Deep Dive).
Resource: CYP MH Rainbow Resource Dec 23

Voice of the family

"There should be more awareness and knowledge about receiving help. …….. I went into it blind not knowing at all how the processed worked. It was very daunting". (Parent Survey)

"Listen to them (children), listen to what parents are actually saying, see every young person as unique, everyone is different. (Parent Deep Dive)
Resource: Mental health and emotional support for adults in County Durham.pdf

Learning

1. **Recording:**
   a. There were discrepancies on different partner agencies recording systems. Children were inaccurately recorded as having communication and neurodiverse diagnosis. Mothers' partners were recorded as fathers to the children. Information was limited on non-resident parents.
   b. None of the three deep dive cases had a multi-agency chronology, non-had an easily accessible full history of the Childs journey.
2. **Information Sharing:**
   a. Limited information sharing was seen, different partners held different information, but this was not shared both within and outside of their organisation.
   b. When children moved from other local authorities into the Durham area information was not transferred, and assessment were not completed with a full history.

Learning

3. Multi agency approach/response:
a) Team Around the Family (TAF) attendance was low on each of the cases, this led to closure of TAF plans or an uncoordinated approach to the care of the children.
b) Some agencies struggled with the complexity of the child's health needs, they were coping with situations they were not able or trained to support.

Parents felt that their parenting was being questioned, and that discussion around safeguarding concerns was seen as a threat, rather than enable discussion to support and include parents.

Resources:.
Clarify, Verify and Reflect: Professional Curiosity.pdf
Information Sharing – How we share information in Durham

Next Steps/Tools

Resources
Self-harm Guidance for school based staff
Mental-health-and-emotional-support-for-adults-in-County-Durham
DSCP Training course: Training Information (durham-scp.org.uk)

- Being Part of a Team Around the Family (TAF)
- Impact of Parental/Carer Mental Ill Health on Children (PAMIC)
- The Multi-Agency Chronology of the Childs Significant Events

Priority Work