Sutton LSCP
Local Safeguarding Children Partnership

SUTTON LSCP PERINATAL MENTAL HEALTH PROTOCOL

Contents

Foreword

This protocol has been created to provide clarity regarding multi-agency roles and responsibilities in respect of perinatal mental health.

It is recognised that there is high importance in raising the profile and supporting the needs of parents and infant's mental health in the perinatal period across the borough, this protocol along with other projects including the perinatal and infant mental health network represents a joint approach to this challenge.

In the first instance, this protocol defines referral pathways and expectations on all professionals and agencies including voluntary services working with mothers, fathers and infants in the perinatal period.

As a partnership working with communities and individual families, we must therefore do all that we can in ensuring that mothers and fathers with mental health illness are identified so that they can be supported to ensure that families can provide safe and nurturing environments for children to reach their optimum outcomes.

1. Introduction

This protocol has been developed following the Child J Learning Review, which involved a mother with mental health issues which were treatable and manageable. It was recognised that multi-agency working would be improved if agencies and professionals were clear about their roles and responsibilities.

The purpose of this protocol is to provide a clear pathway and guidance to professionals across the partnership in Sutton in regards to perinatal mental health, including raising awareness of the issue and the impact of the mother's mental health on her children and wider family.

This protocol will build on the work of the Sutton Perinatal and Infant Mental Health Early Help Network established in summer 2017, by providing sign-posting, greater understanding of roles and responsibilities, developing a common language between all agencies to deliver better outcomes for women, babies, fathers, and families in Sutton.

The protocol aims to give professionals the confidence to enable them to work collaboratively in an open and honest way with women and families and shatter the stigma that surrounds mental health.

2. Perinatal Mental Health definitions

2.1 Definition from NHS England

Perinatal mental health problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 20% of women, and covers a wide range of conditions. If left untreated, it can have significant and long lasting effects on the woman and her family. Perinatal mental health problems can also have long-standing effects on children's emotional, social and cognitive development. [1]

The cost of perinatal mental health problems (2014) reported that perinatal mental health illness affects up to 20% of women and that suicide is reported to be the highest cause of death in the perinatal period.[2]

Conditions include anxiety, panic attacks, depression, and severe mental illness after child birth, such as postpartum psychosis (puerperal psychosis); importantly, all these conditions are treatable or manageable if identified (see appendix 2 for more information about mental health conditions). The impact on women, parents and children can be devastating, however, early identification and intervention can minimise the harm and distress experienced by children and families.

It is vital that the whole children's and adult's workforce understands the complexity and diversity of mental health and its impact on children. Mitigation of the impact of mental health on women and their children will improve the wellbeing and health of children in the long

[1] https://www.england.nhs.uk/mental-health/perinatal/

[2] (Bauer et al., 2014)

term. A multi-agency response is required so that every professional meets their responsibility.

2.2 Mental Capacity Act 2005 and Mental Health Act

The Mental Capacity Act is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. Mental Capacity Act 2005

Mental Health Act- In most cases, when people are treated in hospital or another mental health facility, they have agreed or volunteered to be there. You may be referred to as a "voluntary patient".

However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act (1983) and treated without their agreement. The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.

3. Risk Factors

Some women are at higher risk of experiencing perinatal health problems.[3] Risk Factors include:

- A Previous history of mental illness
- A family history of mental illness
- Psychological disturbance during pregnancy e.g. depression/anxiety
- A single parent/poor couple relationship
- Low levels of social support
- Recent adverse or stressful life events
- Socio-economic disadvantage
- Teenage parenthood.
- Early emotional trauma/childhood abuse
- Unwanted/unplanned pregnancy
- Substance misuse
- Domestic abuse

4. Other Vulnerable Groups

4.1 Paternal and partner mental health

Up to 10% of fathers are reported to suffer from depression during their partner's pregnancy and following birth. [4] Up to 16% may suffer from anxiety in the antenatal period and up to 18% in the postnatal period. [5] Poor mental health in fathers has a negative impact on their own health and can affect the health and well-being of their partner and child. Despite this, fathers' mental health is not routinely assessed by health professionals in the antenatal and

[3] Hogg S (2013) Prevention in mind: all babies count: spotlight on perinatal mental health. NSPCC

[4] Paulson and Bazemore, 2010

[5] (Leach et al., 2016)

postnatal period in the UK and nor is there any national clinical guidance (such as NICE) to support this. [6]

Partners might develop a mental health problem when becoming a parent for similar reasons to mothers, particularly if for those who are:

- A young parent without good support networks in place
- Have experienced abuse in childhood
- Are struggling with stressful life events, like moving house, losing your job or being bereaved
- Have poor living conditions or are living in poverty
- Fathers/partners might also be coping with extra responsibilities around the house
- Financial pressures
- The change in relationship with partner
- Lack of sleep

If a partner is also experiencing a mental health problem, it can be harder to cope with the normal struggles of becoming a parent.[7]

4.2 Teenage parents

Like all parents, teenage mothers and young fathers want to do the best for their children and some manage very well; but for many their health, education and economic outcomes remain disproportionately poor which affects the life chances for them and the next generation of children

Public health England 2016, reports alarming outcomes for young parents including that:

- Teenage mothers are 3 times more likely to experience postnatal depression.
- Teenage mothers have higher rates of poor mental health for up to three years after the birth.
- 2 in 3 teenage mothers experience relationship breakdown in pregnancy or the 3 years after birth. [8]

The Young Mums Together 2018 supports this reporting that teenage parents often experience socioeconomic adversity, facing an even greater risk of parental mental health difficulties and that maternal depression is a particular concern in teenage pregnancy, with heightened rates of the disorder in this population (30–60%). compared to the rate experienced in mums of all ages and their non-pregnant peers.[9] Symptoms of depression among young mums are also more likely to persist well after the birth of their child. Young mums also face an increased risk of post-traumatic stress. Young mums are less likely to

[6] (Baldwin et al., 2018)
[7] (Mind.org.uk, 2019)
[8] (Public Health England, 2016)
[9] Mind.org.uk, 2019

seek support for their mental health for fear of their parenting skills being negatively evaluated. This is a particular concern for women who have histories of abuse, depression and PTSD.

4.3 Children in care and care leavers

Children who experience abuse and neglect, like children who end up in care, are at greater risk of mental health problems and poorer outcomes later in life. Children in care are 4 times more likely than their peers to have a mental health difficulty and 6 to 7 times more likely to have conduct disorders. Children with the poor self-control associated with these disorders are more likely to be involved in crime as adults.

- Adults who were maltreated as children are at increased risk of physical health problems, including cardiovascular disease, and mental health issues such as substance abuse and suicide.[10]

  Very young children are particularly vulnerable to abuse. Neglect and trauma can have a profoundly negative effect on their development
- The first months and years are critical to a child's development, laying the foundation for future learning, behaviour and health.
- 'Toxic stress' caused by trauma, abuse and neglect disrupt the developing brain's architecture and chemistry, which can lead to severe damage and lifelong consequences for the child.
- Research shows babies as young as 4 months can experience depression as well as serious psychiatric disorders related to attachment and traumatic stress (Luby, 2000).[11]

4.4 Housing and Homelessness

Housing and mental health are often linked. Poor mental health can make it harder to cope with housing problems, while being homeless or having problems in your home can make your mental health worse.

Problems with money, housing and mental health often go together. Money problems might mean parents are struggling to afford rent, mortgage payments or bills.
Parents with mental health illness might also struggle to clean or maintain your living space, for example if experiencing depression, obsessive compulsive disorder (OCD) or hoarding.[12]

Homelessness can cause parents to experience stress, anxiety and exhaustion, as well as feelings of loss of control, loss of self-worth and isolation. These feelings, which can also exacerbate pre-existing mental health difficulties, may impact on a woman's ability to take

[10] Deans et al, 2009; Dube et al, 2001

[11] NSPCC looking after infant mental health: our case for change 2016

[12] Mind.org.uk. (2019). *Housing | Mind, the mental health charity - help for mental health problems*. [online] Available at: https://www.mind.org.uk/information-support/guides-to-support-and-services/housing/#.XTbU_RbYqUk [Accessed 23 Jul. 2019].

care of her physical health in pregnancy. Maternal stress during pregnancy is also associated with poorer physical, emotional and cognitive outcomes for infants.[13]

4.5 Concealed pregnancy

Findings from Serious Case Reviews (SCR) tell us that lack of antenatal engagement can increase risk to babies.

Women choose not to engage with maternity services and conceal their pregnancy for a range of reasons. It is vital that careful consideration is given when assessing the reason for concealment. This could include:

- Previous children removed from the parents' care
- Fear that the baby will be taken away
- Domestic abuse
- Mental Health difficulties
- Learning disabilities
- Chaotic lifestyle
- Substance misuse

Please note this list is not exhaustive.

4.6 Non Engagement

When a woman (or parent) does not engage with primary or secondary services for assessment or ongoing care of a mental health illness identified, the unborn/infant should be discussed in safeguarding supervision and a referral to Children's Social Care made (Children's First Contact Service) if any safeguarding risks or concerns are identified. Other services working with the family e.g. midwifery, health visiting, social care, should be informed.

Please see diagrams below for referral pathways and thresholds into Children's Social Care.

[13] Bergman et al., 2007, as cited in https://www.qni.org.uk/wpcontent/uploads/2016/09/homelessness_babies_families.pdf

Sutton LSCP Perinatal Safeguarding Children Pathway/Guide (professional judgement to be applied)

Risk to consider

- A Previous history of mental illness
- A family history of mental illness
- Psychological disturbance during pregnancy e.g. depression/anxiety
- A single parent/poor couple relationship
- Low levels of social support
- Recent adverse or stressful life events
- Socio-economic disadvantage
- Teenage parenthood.
- Early emotional trauma/childhood abuse
- Unwanted/unplanned pregnancy
- Substance misuse
- Domestic abuse

Vulnerable groups

- Paternal and partner mental health
- Teenage parents
- Children in care
- Housing and Homelessness
- Concealed pregnancy/ Non engagement/ DNA (cancellation of appointments)

Risk Assessment and Safeguarding

Carry out a risk assessment with the woman and, if she agrees, her partner, family or carer. Focus on areas such as self-neglect, self-harm, suicidal ideation/intent, risk to others (including baby), substance misuse and domestic abuse. The safety of the **unborn child/infant remains paramount**, any safeguarding concerns must be referred to MASH.

Was not brought to, or repeated cancellation of appointments with any service must be discussed with your safeguarding supervisor and consideration given to making a MASH referral. Other services involved with the parent should be informed of safeguarding concerns.

Refer to London Safeguarding Board Parenting Capacity and Mental illnessfor more information http://www.londoncp.co.uk/chapters/par_cap_ment_illness.html

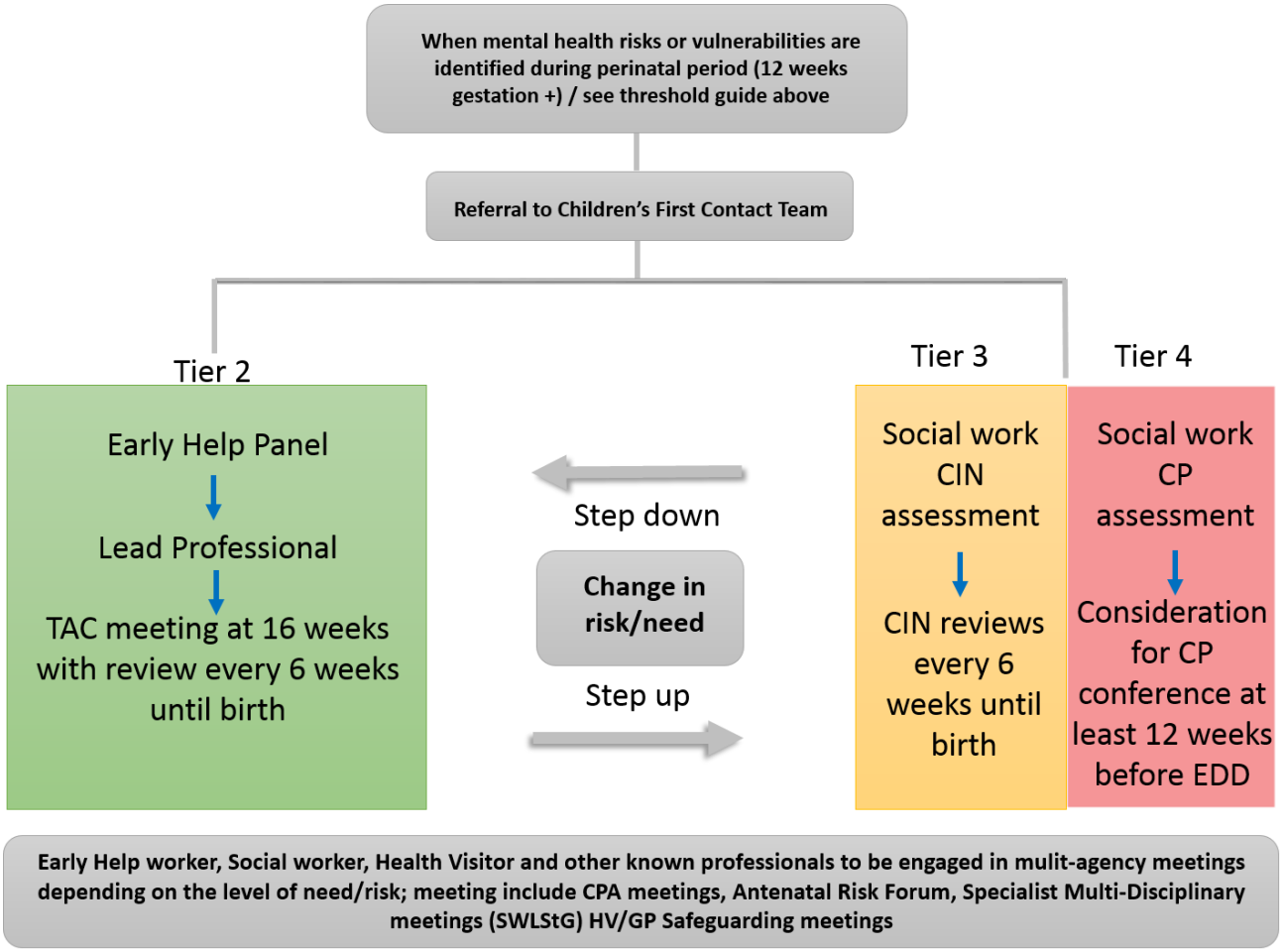
Thresholds/ Identified Need

Tier 1: Universal (consent required)	Tier 2: Early Support (consent required)	Tier 3: Complex Multiple Needs (consent required)	Tier 4: Children in Acute Need (consent not required)
• No history of previous or current mental health illness	• Stable emotional wellbeing/mental health with mild to moderate depression/anxiety • Previous history of mental health illness identified. • Disclosure of adverse childhood experiences (ACE) • Current medication for mental health • Risk factors (see above) • Risk factors that may affect bonding and attachment i.e. traumatic birth, Infant medical need, breast feeding difficulties	• Moderate to severe non psychotic depression and/or anxiety • Existing mental health illness managed by Recovery and Support team • Risk factors above are present • Mental health illness causing some limitation of function • Intrusive thoughts • Thought of self harm/suicide with no plans • Expressed or observed difficulties with bonding with baby	• Evidence of mental health illness that is likely to impact on safety of mother and/or baby. • Acute episode/crisis of Mental health illness / rapidly changing mental state • Mental health causing significant limitation of function. • Intrusive thoughts with intent to harm others and self • Risk to self or others • Estrangement from infant • Evidence of psychosis

Available Services

• Liaison between all services and development of an integrated care plan. • Boots Trust wellbeing plan • UNICEF building a happy baby • *HV Well baby Clinic • Baby and Me • Children's Centre Activities • 21 and under at time of conception will be offered enhanced parent pathway	• Liaison between all relevant services and development of an integrated care plan. • Referral to Children's First Contact Service (which includes Early Help) • GP services • Secondary care mental health • Health visitor listening visits • Self-referral to Sutton uplift • Wellbeing SPACE group • Home-start Peer Support • Sutton Mental Health Foundation • Signposting to self help • GP lead professional Liaison between professionals as required • Parents under 18 – consider ref to CAMHS, liaise with Perinatal Mental health service for advice • Parents under 18 – referral to CAMHS Tier 2	• Liaison between all relevant services and development of an integrated care plan. • Perinatal Mental Health Service (PMHS), • Community Mental Health Services / lead professional • Social Work CIN Services and CIN meetings • Parents under 18 – referral to CAMHS Tier 3/4	• Liaison between all relevant services and development of an integrated care plan • A+E / 999 SWLStG Crisis Line • Secondary Care Mental Health Services and lead professional • Child Protection Services • Care Programme Approach (CPA) • Parents under 18 – referral to CAMHS Tier 4

Pathway Following Referral to Children's First Contact Team



5. ROLES AND RESPONSIBILITIES

Coordinated Care

Sutton's safeguarding children partnership advocates the practice of working within the NICE guidance CG 192: Antenatal and postnatal mental health: clinical management and service guidance, as this guidance fosters a joined up working approach across all agencies working with infants with parents with mental health illness. To include as follows:

To develop an integrated care plan for a woman with a mental health problems in pregnancy and the postnatal period that sets out:

- The care and treatment for the mental health problem; and
- The roles of all healthcare professionals, including who is responsible for:
  - coordinating the integrated care plan
  - schedule of monitoring
- Providing the interventions and agreeing to core outcomes with the woman.

The healthcare professional responsible for coordinating the integrated care plan should ensure that:

- Everyone involved in a woman's care is aware of their responsibilities;
- There is effective sharing of information with all services involved and with the woman herself;
- Mental health (including mental wellbeing) is considered as part of all care plans; and
- All interventions for mental health problems are delivered in a timely manner, taking into account the stage of the pregnancy or age of the infant.[14]

When adult mental health services and Sutton Children's Social Care are both involved with a family, joint assessments should be carried out to assess the support parents needs and the risk of harm to the infant, in line with the referral and assessment procedure.[15]

5.1 GPs

A GP may have an established relationship with a woman before she conceives and often hold detailed information within their patient's care record. Partners, other children and members of the wider family may also be known to the practice and be aware of a relevant family history of mental health. Practices can offer continuity of care over many years and are often well placed to identify perinatal mental health problems early and offer treatment,

[14] Antenatal and postnatal mental health: clinical management and service guidance file:///C:/Users/sgalvin/Downloads/antenatal-and-postnatal-mental-health-clinical-management-and-service-guidance-pdf-35109869806789.pdf

[15] London Child Protection Procedures http://www.londoncp.co.uk/chapters/referral_assess.html#assess

sign-posting and referral to other agencies. GPs are also in communication with other community teams including Health Visitors, midwives and the mental health services who may hold information.

When any pregnant woman first presents to their GP they should be asked about previous or present mental ill health, including details of any care provided by mental health services. They should also be asked if they have any close family with a history of perinatal/ mental ill health. This information should be clearly identified in the referral information from GPs to antenatal services. All other members of the primary care team, for example, nurse practitioners, should be aware of the importance of including this information in antenatal referrals.

For any woman taking psychotropic medication while planning pregnancy or in the antenatal period or postnatal period, consideration should be given to the risks and benefits of their individual circumstances regarding starting, using or stopping treatment.[16] The GP will need to consider referral or liaison with the specialist perinatal mental health team and refer to Nice Guidance 192.

GPs, like midwives should ask women the 'Whooley Questions' during any attendance in pregnancy and the postnatal period. Any positive response to these questions should be followed up in line with the LSCP threshold.

Most practices offer a routine 6 week check for babies and mothers (and their partners) which is an important opportunity to assess maternal (and paternal) wellbeing. Practices can code concerns on their clinical system (EMIS) and this information is transferred to the new practice when patients move.

GPs can support women who have been identified by the Midwife or Health Visitor as needing additional support. Women can also self-refer to their GP for support. GPs can treat uncomplicated non-psychotic depression and anxiety; this may include prescribing medication or signposting to more specialist services. It is important for GPs and mental health workers to be aware of the potential risks associated with mental health needs versus the benefits and potential harm of prescribed medication in pregnancy and postnatally, including whilst breastfeeding.

If more specialist support and advice is required, then GPs should refer to secondary mental health services for more complex or significant disorders. This specialist support can take three forms:

1. The Specialist Perinatal Mental Health service can provide advice to the GP and or Midwifery service/Health visiting service, with the GP or midwife/health visitor remaining the lead professionals.

2. Should the individual already be under secondary mental health services then the Secondary Mental Health team continues leading on the mental health care provision whilst being supported by the specialist Perinatal Mental Health Team, as an

[16] (Nice.org.uk, 2019)

adjunctive service, on areas where perinatal expertise are required to manage the individual's care

3. Should the individual already be under secondary mental health services then the Secondary Mental Health team continues leading on the mental health care provision whilst being supported by the specialist Perinatal Mental Health Team, as an adjunctive service, on areas where perinatal expertise are required to manage the individual's care.

5.2 SWLStG Specialist Perinatal Mental Health Services

This service works with women who are either pregnant or in the first year following the birth of their baby and present with moderate to severe mental health problems or with high risk factors for perinatal mental health problems due to history or family history. The service is also available for advice and input where necessary for GP's and other professionals in prescribing medication for mental health reasons during pregnancy and breast feeding e.g. antidepressants.

Women with known history of mental illness on psychotropic medication are eligible for pre-conception counselling and advice.

The service takes referrals directly from primary care and midwives as well as co-working with community mental health teams (CMHTs). The Service can give advice and support to other mental health services, primary care, midwifery and social care. The service works closely with the Children's Social Care when there are issues of child protection providing advice and support across health and social care.

More information on the service can be accessed here: https://www.swlstg.nhs.uk/our-services/find-a-service/service/perinatal-mental-health-service

5.3 Adult Mental Health Teams including recovery team/home treatment team/ IAPTs

When treating mothers and fathers in the perinatal period adult mental health teams play a crucial role in identifying infants that may be at risk due to parental mental health illness, which may impact on parenting capacity and have an adverse effect on a child's development needs and safety.[17] It is essential that adult mental health teams seek advice from the specialist perinatal mental health team and access child protection supervision with designated safeguarding leads. Information sharing related to a parent's mental health is essential with GP's, midwives, health visitors and social workers as this leads to coordinated care (see section 7.1)

If there are mental health concerns and missed appointments, you must inform the GP and the Health Visitor and consider a safeguarding referral.

[17] (Londoncp.co.uk, 2019)

5.4 Midwives

Midwives play a central role alongside the GP in ensuring that pregnant women with mental health illness achieve the best possible outcomes for themselves and their babies. Midwives work collaboratively with obstetricians GP's, Health visitors, social workers and mental health professionals when appropriate, and midwives should refer to their own organisational policies for in-depth guidance. (See appendix 3 for midwives perinatal mental health flowchart).

Midwives should coordinate maternity care by ensuring that all women are asked about their mental health when they book for antenatal care, using the Whooley questions for prediction and detection of mental ill health. Assessment at booking should also include a holistic family health needs assessment to identify risk factors for perinatal mental health. Mental health should be assessed and recorded at every contact.

Midwives provide support for mild to severe perinatal mental health which includes:

- Information liaison between, GP's, St Helier Psychiatry registrar, specialist perinatal mental health services and health visitors.
- Making referrals as appropriate to the Children's First Contact Service (CFCS), Sutton Uplift and other services.
- Referrals for 1:1 support at the Maple Clinic

The Maple Clinic is run by a Specialist Midwife for Perinatal Mental Health and a Specialist Obstetrician. It caters for all women with pre-existing mild to severe Mental Illness and those who develop symptoms during pregnancy. Appointment times are double that offered in regular antenatal clinics, allowing mental health support to be delivered alongside routine midwifery care. Counselling is offered either by our Midwifery Counsellor, or by referral to external IAPT agencies such as UPLIFT. Women requiring the support of a psychiatrist, or for who ongoing care plans are required, referral is made to the South West London Perinatal Mental Health Service. This service offers women appointments at St Helier hospital, as well as home visits as required and runs closely alongside the Maple Clinic, ensuring a consistent approach to support with joint care planning. Emergency out of hours care for women suffering a mental health crisis is provided by the Psychiatric Liaison Service who cover Accident and Emergency.

5.5 Health Visitors

Health Visitors provide a universal service to all families, and an enhanced service to support families with additional needs, including women and families suffering from Perinatal Mental Health difficulties. There is a specialist health visitor for perinatal mental and infant mental health available for support, advice, liaison and input.

Perinatal Mental Health support includes;

- Detection and assessment in line with NICE 192 guidelines using the Whooley Questions and GAD-2 at all universal contacts and other times as appropriate in pregnancy and infant's first year of life.
- Further assessments as indicated using Edinburgh Post-natal scale GAD7 and family health needs assessment.

- In the home listening visits.
- Universal Plus baby massage**.**
- Referral to a Group called Wellbeing SPACE, run in conjunction with Sutton Uplift
- Information Liaison with GP's, Midwives and other appropriate services with consent.
- Signposting/referral to other appropriate services e.g. Sutton Uplift, SWLstG
- Perinatal mental health services, Homestart, Sutton mental health foundation. Online support and useful website.
- Making the appropriate referrals such as Children's First Contact Service (CFCS), Sutton Uplift, Home Start and Early Help Assessment Tool (EHAT).

5.6 Police

The Police will use referral pathways if they have concerns for a person or child, for example a pregnant woman/parent suffering from a mental health crisis. The Police also have legal powers to use if necessary.

Police officers have legal powers under Section 136 of the Mental Health Act to detain people who appear to them to be "mentally disordered" and who are "in immediate need of care and control". Officers typically transport detained people to safe places, for example Emergency Departments where their mental health can be assessed by appropriately trained and experienced health and social care professionals. Where there is an unborn child and/or children, a Children's First Contact Service (CFCS) referral needs to be made.

Police Officers are unable to use a Police station as a place of safety for under-18s and will only be permitted to use such a place for over-18s "in exceptional circumstances".

5.7 Children's Social Care

The perinatal mental health service has a lower threshold for accepting a mother with mental health illness versus ordinary mental health thresholds. Where there are mental health concerns Children's Social Care need to engage with the appropriate adult mental health services, including perinatal services.

The majority of parents with perinatal mental health illness do not pose a risk to their children and are able to provide safe and effective care. However an infant, or unborn, who is likely to suffer significant harm, or whose well-being is affected, may be one:

- Who features within parental delusions;
- Who is involved in his / her parent's obsessional compulsive behaviours;
- Who becomes a target for parental aggression or rejection;
- Who may witness disturbing behaviour arising from the mental illness (e.g. self-harm, suicide, uninhibited behaviour, violence, homicide);
- Who is neglected physically and / or emotionally by an unwell parent;
- Who does not live with the unwell parent, but has contact (e.g. formal unsupervised contact sessions or the parent sees the infant in visits to the home or on overnight stays);

- Who is at risk of severe injury, profound neglect or death;

Or s/he could be an unborn child of:

- A pregnant woman with any previous major mental disorder, including disorders of schizophrenia, any affective or schizo-affective type; also, severe personality disorders involving known risk of harm to self and/or others. (For further information see London Child Protection Procedures).[18]

There should be joint-working and care planning at an early stage when cases are known to perinatal mental health teams and social care, or if there are any professional concerns regarding an unborn child or infant. This should include regular multi-professional meetings, information sharing and all agencies contributing to a streamlined plan where appropriate.

Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm Children's Social Care should consider the need for a strategy discussion with other agencies including health agencies, the police, education, social care and any other appropriate agency. The strategy discussion should be convened by Children's Social Care.

A strategy discussion may take place following a referral, or at any other time. The discussion should be used to:

- Share available information.
- Agree the conduct and timing of any criminal investigation.
- Decide whether an assessment under s47 of the Children Act 1989 (s47 enquiries) should be initiated, or continued if it has already begun.
- Plan how the s47 enquiry should be undertaken (if one is to be initiated), including the need for medical treatment, who will carry out each action, by when and for what purpose.
- Agree what action is required immediately to safeguard and promote the welfare of the child, and/or provide interim services and support.
- Determine what information from the strategy discussion will be shared with the family, unless such information sharing may place a child at increased risk of significant harm or jeopardise police investigations into any alleged offence(s); and
- Determine if legal action or advice is required.

Where there are perinatal mental health issues that may impact on parental capacity that could lead to the unborn/child having additional needs or being at risk, agencies need to refer the parent to social care (number and team to be entered) at 12 weeks. This will provide an opportunity for social care to undertake an early help assessment in partnership with other agencies.

If the family requires a lead professional for a co-ordinated approach to the provision of additional services such as family support services, parenting programmes, and children's centres. These will be provided within universal or targeted services provision, either outside of or in partnership with Children's Services.

[18] (Londoncp.co.uk, 2019)

If safeguarding concerns are identified during the pregnancy, or following the birth, the case must be escalated to statutory social work level. For an unborn, statutory social work assessment will begin at 20 weeks and if significant harm is a feature, a pre-birth conference to be convened at 24 weeks or as close to that date as possible.

5.8 Adult Social Care

Adult social care in Sutton has the following responsibilities which may be relevant in relation to perinatal mental health:

1. Adult safeguarding: Adult social care has a responsibility to safeguard adults with care and support needs who may be experiencing, or at risk of, abuse or neglect. This duty might apply to expectant mothers or to adult siblings of the unborn child. If this is thought to be the case, a safeguarding concern must be raised with the relevant adult social care team.

2. Care and support: Where it appears to a local authority that an adult may have needs for care and support, the authority must carry out an assessment to establish whether the person is eligible for care and support. The same duty applies to carers of that adult. There may be situations when an assessment of needs should be carried out in relation to an expectant mother and her carer(s). In this situation, the assessment must include information from maternity services and children's services.

If the expectant mother is already receiving care and support through adult social care, a social worker from the relevant adult social care team and a representative of the care provider must be included in planning meetings which take place before and after the child's birth.

There may also be situations where the expectant mother's household includes other adults with care and support needs, or there may be carers for the expectant mother. If this is the case, the expectant mother's consent to include a representative from the relevant adult social care team in planning meetings should be sought.

3. Deprivation of Liberty Safeguards: There may be situations where the expectant mother needs to remain in hospital for a not negligible period of time prior to the birth of her child and is unable to consent to this. This is likely to amount to a deprivation of liberty and, if justified, will need to be authorised. A referral to Adult social care must be made so that an assessments for Deprivation of Liberty Safeguard (DOLS) can be carried out.

4. Assessments under the Mental Health Act: There may be situations where the woman, either before or after the birth of their baby, becomes mentally unwell and refuses treatment necessary for her own health and safety and the safety of others. If this is the case, an assessment under the Mental Health Act may be needed. Perinatal mental health services will need to make a referral to the Sutton Approved Mental Health Professional (AMHP) service. The AMHP will contact maternity and children's services to ensure that the outcome of the assessment is fully informed by any concerns that there may be for her or for the unborn or newly born child.

5. Aftercare under s.117 of the Mental Health Act: The local authority and CCQ have a duty to provide aftercare to people who have been detained in hospital under certain sections of the Mental Health Act. The purpose of aftercare is to prevent relapse and a future admission to psychiatric hospital. Given the risk to the expectant mother's mental health after childbirth, if s.117 applies due to previous admissions to a psychiatric hospital, the aftercare plan should be reviewed to ensure that all reasonable measures are being taken to prevent a relapse in the person's mental health at this time.

If the woman is admitted to hospital under s.3 of the Mental Health Act following birth, s.117 will apply when she is discharged.

5.9 Voluntary Sector

Voluntary agencies, including charitable organisations, provide an important role by supporting families in the community and working in partnership with health, education and children's and adult's services.

Awareness of the mental health needs of a mother, father and infant in the perinatal periods is paramount, but voluntary professionals should consider the infants needs first and foremost. If an infant is seen as being at risk, this should immediately be reported to Sutton's Children's First Contact Service (CFCS) if the child is not open to statutory services.

It is recognised that the voluntary sector play a pivotal role in supporting young families in the community. Colleagues in this area of work are therefore likely to be engaged with families who may avoid other interventions.

Support provided by voluntary sector can be found here on Sutton Council's website.

5.91 CAMHS (Child and Adolescent Mental and Health Services)

As documented in section 5.2 young parents have a greater vulnerability to perinatal mental healt*h illness.*

Any mother under the age of 18 with current, or historical mental health difficulties or illness will remain under the care of CAMHS as the Perinatal mental health service does not work with young people under the age of 18. CAMHS should liaise closely with the perinatal mental health service for advice regarding medication and the specialist care required at this time.

There should be transitions to adult's social care with perinatal support if there is overlap with Adult's services in line with SWLStG local policies.

6. Multi-agency responsibility and the importance of working in partnership

6.1 Early Help & Prevention Panel

The Early Help and Prevention Panel (EHPP) is a problem solving, decision making and allocation forum. The objective of the EHPP is to ensure "All services work together to provide

a seamless offer to children and their families, preventing the escalation of need and ensuring targeted, timely interventions that are supported by effective multi agency practices".

The purpose of the EHPP is to promote better outcomes for vulnerable children, young people and their families in Sutton, by providing a coordinated response to need, that swiftly identifies appropriate multi-agency packages of support.

6.2 Care Programme Approach (CPA)

The Care Programme Approach is for people with mental health problems who have complex needs. Your CPA describes how your care will be assessed, planned and delivered to provide you with the extra to support your need to overcome the difficulties you are facing. For more information click here

6.3 Child In Need meetings (CIN)

Child in Need Meetings will follow an assessment where the assessment has concluded that a package of family support is required to meet the child's needs under Section 17 of the Children Act 1989. For more information click here

6.4 Team around the Family (TAF) / Team around the Child (TAC) meetings

The Team around the Family/Child meetings will include the services which are invited to work together to support the family. During this meeting a support plan will be created and a lead professional will be agreed amongst the professionals involved.

For more information please refer to the EHAT Guidance Notes

6.5 Child Protection meetings

A child protection conference brings together family members (and the child/ren where appropriate), supporters / advocates and those professionals most involved with the child and family to make decisions about the child's future safety, health and development. If concerns relate to an unborn child, consideration should be given as to whether to hold an initial child protection conference prior to the child's birth.

For more information click here

6.6 Antenatal Safeguarding Forum

The antenatal safeguarding forum is to promote partnership between maternity services, Children's Social Care and other relevant agencies in reviewing all families identified as expecting a child that may be vulnerable. The purpose is to ensure roles and responsibilities of all involved in the pre and post-birth care are identified. The sharing of the outcomes of all Child Protection Conferences and Child In Need plans with relevant agencies. Membership

includes midwives, safeguarding midwives, neonatal team, liaison health visitor, specialist midwives, early help team (LBS) and social worker (LBS).

6.7 GP and Health Visitor

The quarterly meeting at the GP Surgery will consider issues which may need to be discussed and information shared but are not urgent in nature. The purpose is to promote the welfare of children and young people, protecting them from significant harm depends crucially upon effective information sharing, collaboration and understanding. The membership is the safeguarding lead in each GP practice the allocated health visitor, a representative from Midwifery and any other relevant professionals are able to meet in a multi-professional forum in order to discuss antenatal, babies, children, young people and families who are identified as being vulnerable. The aim is that they receive the support that is required in order to promote their welfare and safeguard them from harm by means of a co-ordinated plan of action and liaison with appropriate services.

7. Information Sharing

Sharing the right information, at the right time, with the right people, is fundamental to good practice in safeguarding children and adults.

When working with children and young people, it's important to keep in mind two essential factors:

- Timely information sharing is key to safeguarding and promoting the welfare of children. It enables intervention that crucially tackles problems at an early stage
- If a child is at risk or suffering significant harm, the law supports you to share information without consent.

This must be balanced with ensuring that personal information will be treated respectfully and confidentially. Sharing information appropriately is key to putting in place the right support. When making these decisions, the safety and welfare of the child must be the key consideration. Refer to guidance: Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers (July 2018)

For Adults at Risk given the duty to cooperate in the Care Act 2014, there are only a limited number of circumstances in which it would be acceptable not to share information pertinent to safeguarding with relevant multi-agency safeguarding partners. These would be where the person involved has the mental capacity to make the decision in question and does not want their information shared, and:

- their 'vital interests' do not need to be protected
- nobody else is at risk
- there is no wider public interest
- no serious crime has been or may be committed
- the alleged abuser has no care and support needs
- no staff are implicated
- no coercion or duress is suspected
- the risk is not high enough to warrant a referral to a Multi-Agency Risk Assessment Conference (MARAC)
- No other legal authority has requested the information

8. Record keeping

All records must be written clearly, and in a manner that can be easily understood by others. Case notes should always be written in a way that respects the person's dignity.
Practitioners caring for adults need to be aware of their responsibilities to children and unborn babies when making assessments. Clearly document that they have considered any potential risks and how they are to be managed. Any decisions to share or not to share information need to be clearly recorded in the client notes.

Good record-keeping is central to effective safeguarding, even if 'safeguarding' is not required and it particularly important when you are assessing a person's capacity to make their own decisions. People benefit from records that promote good communication and high-quality care. Failing to keep accurate records of decisions you have made and actions you have taken can put people at risk.

Please refer to your local record keeping policy.

9. Supervision

Safe and effective practice is supported by good quality supervision of staff when working with children, young people, families and Adults at Risk. Effective judgements in relation to outcomes for children and adults who are in need of additional support and care is essential for professional development and supports practitioners.

This in turn enhances decision making. Supervision provides a supportive learning environment, an opportunity to reflect on practice, assess risks and make decisions. It will support members of staff to be confident in providing services for children and young people, develop integrated working, improve their own performance and learn from practice.

10. Support Groups/ Services

The Sutton Perinatal and Infant Mental Health Network Mapping Tool provides up-to-date information about the Services and support for Perinatal Mental health in Sutton

All professionals working with young families are advised to access this

https://sites.google.com/sutton.gov.uk/perinatalandinfantmentalhealth/home?authuser=0

Appendix 1: Learning from Child J Learning Review

Child J Learning Review five key issues are:

Issue One **There is no formal multidisciplinary pregnancy / perinatal pathway or provision for a lead practitioner across health services that work with vulnerable adults and who are pregnant**.

This means that no one professional has the whole picture or oversees case management for service users with complex needs. This can result in practitioners not having correct or full information and delivery of services that lacks co-ordination.

Professionals (and family members) meeting in non-statutory fora to share information and make interagency plans would provide co-ordinated support to the parent and (unborn) child and also help determine when threshold was met for other services such as Children's Social Care.

Questions for the board and organisations

· How does the Board ensure that the relevant adult and children's health professionals are involved in such complex cases with full engagement across these agencies?

· Is the Board assured that the principles underpinning the Care Act 2014 are being consistently and effectively applied in Sutton to women who are pregnant or a parent?

Issue Two

There is no formal multidisciplinary pathway that ensures Children's Social Care services and adult mental health services work together in relation to (unborn) children in need.

This means that practitioners are dependent on informal communication and are without a mandate or a forum to hold joint discussions with or without service users.

Questions for the Board

· How can a culture of multi-agency working between CSC child in need workers and adult services EIS workers including multi-agency professionals meetings, be established in Sutton?

· How can awareness of each other's roles be raised amongst adult's and children's workers?

Issue Three

Prior to instigation of child protection procedures, the service user was often the key means by which information was relayed between professionals. This situation brought accompanying risks of misinterpretation and misunderstanding and increasing opportunity to divide professional opinion.

Professional relationships with users of adult mental health services are usually long term. Information sharing with other professionals is an important part of service user recovery and maintenance. However, this can lead to increased risks to any (unborn) child involved.

Until child protection procedures were invoked, Ms M was often the key means by which adult and children's health practitioners received information about each other's involvement with her. While both adult mental health and maternity nursing services held their own multi - disciplinary meetings/reviews to discuss concerns and case management, these did not include practitioners from both adult and children's services. Multidisciplinary meetings held by adult services after a child protection plan and later ICO were in place did not always benefit from participation

by children's social workers or a generic social work perspective as the Sutton EIS team does not include a social worker.

Questions for the Board

· How can the Board be assured that the correct balance is established between EIS service user independence, with the needs of the (unborn) child remaining paramount?

· How can multidisciplinary participation in existing statutory processes such as CPA review and non-statutory discussion such as the vulnerable women's meeting be used better to optimise their value in achieving a balance to address the needs of the adult and also ensure the paramountcy of the child?

Issue Four

While child protection procedures were correctly applied, opportunity was not always taken to ensure best practice within this framework.

Opportunities were not taken to use existing escalation procedures to help address emerging professional differences in relation to the protection plan when informal discussion had not brought resolution.

Question for the Board.

· How can the Board make sure that conference chairs and practitioners know how to use escalation processes to resolve professional differences in relation to partnership working under child protection protocols?

Issue Five

The legal basis on which Ms M and child J went to be at a relative's house and subsequently returned home remains unclear.

The risk 'home conditions' posed to child J was a matter about which perspectives of adult and children's services practitioners differed. However at one point children's practitioners considered it was no longer safe for child J to remain looked after by Ms M in that environment, at least in the short term.

Question for the Board.

· How can the Board be assured that Children's Social Care services are correctly implementing legislation under S20 of the Children Act 1989?

Appendix 2: Perinatal mental health conditions

Perinatal Mental Health Conditions Stress

Adapted from : Sandman et al (2001, Prenatal Programming of Human Neurological Function.

Stress in pregnancy is thought to relate to Corticotrophin Releasing Hormone (CRH) released by the Hypothalamus, this can have profound effects on the mother and foetus stress response.

Natural increases in the hormone are important for foetal maturation – but if levels are altered in response to stress they can programme the foetal nervous system with long term consequences.

Foetal exposure to high levels of stress can result in:

- Delayed foetal nervous system maturation
- Restricted neuromuscular development and altered stress response of the neonate
- Impaired mental development and increased fearful behaviour in f infant
- Potential reduced grey matter in children
- Increased risk for emotional and cognitive impairment Link Vivette Glover

Anxiety

Many women suffer from either new onset of exacerbation of existing anxiety disorders during the perinatal period. Studies of pregnant women have identified that 21% had clinically significant anxiety symptoms and of these 64% continued to have postnatally. Prospective studies have demonstrated that anxiety disorder antenatally is one of the strongest risk factors for developing postnatal depression [19] Risk factors for Anxiety include:

- Family history of anxiety disorders
- Personal history of anxiety or depression
- Thyroid imbalance
- Low socioeconomic status
- Unplanned or unwanted pregnancy
- Child care stress
- Personal characteristics like guilt-prone, perfectionism, feeling unable to achieve, and low self-esteem.

Poor outcomes associated with anxiety in pregnancy include:

- Pre-eclampsia
- Increased nausea and vomiting
- Longer sick leave during pregnancy
- Increased visits to obstetrician
- Spontaneous preterm labour and preterm delivery
- More difficult labour and delivery with increase of PTSD symptoms related to birth
- Elective caesarean section
- Low birth weight and low Apgar scores
- Admission of infant to neonatal care
- Breastfeeding difficulties

[19] Anniverno et al (2013) Anxiety Disorders in Pregnancy and the Postpartum Period.

Intense anxiety can impair maternal functioning, cause significant distress and may seriously disturb mother-infant interaction.

Generalised Anxiety disorder (GAD)
Pregnant women with GAD experience excessive worries. GAD main symptoms are:

- Anxiety
- Apprehensive expectation
- Nervousness
- Fatigue
- Excessive, intrusive and persistent worries
- A pervasive feeling of apprehension or dread
- Inability to tolerate uncertainty
- Difficulty concentrating or focusing on things
- Muscle tension
- Sleep disturbance
- Feeling edgy, restless or jumpy
- Stomach problems, nausea, diarrhoea

Tokophobia
Extreme fear of childbirth **Panic disorder.**
Symptoms of panic disorder in the perinatal period may worsen with some women becoming agoraphobic and socially isolated.
Obsessive-compulsive disorder (OCD)
Symptoms of perinatal OCD can impair a mother's ability to care for their infant and can include:

- Obsession, also called intrusive thoughts which are persistent, repetitive thoughts or mental images related to the baby
- Compulsions where the woman may do certain things over and over again to reduce her fears and obsessions'' these relate to cleaning, washing and checking.
- Fear of being left alone with the infant
- Hypervigilance in protecting the infant
- Loss of appetite
- Feelings of guilt and shame

Post-traumatic stress disorder
Risk factors for postpartum PTSD include:

- Domestic abuse
- History of sex trauma
- Previous adverse reproductive events e.g. ectopic pregnancy, miscarriage, stillbirth.

Symptoms may include:

- Anxiety and panic attack
- Recurrent intrusive memories
- Flashbacks or nightmares
- Avoidance of stimuli associated with the event
- Depressive symptoms
- Fear of sexual intimacy

Perinatal Mood disorders the blues
At least half of women who have a baby experience low mood, either at some point during their pregnancy or in the initial days or weeks following birth. Symptoms include feeling tearful, overwhelmed and irritable, but these usually pass with rest, support and reassurance.

Antenatal depression
Antenatal depression is experienced as persistent low mood in pregnancy and is thought to affect around 12% of women.

Postnatal depression
Postnatal depression is experience where low mood persists from pregnancy or occurs for the first time postnatally. Symptoms of Perinatal Mood disorders include:

- Irritability
- Difficulty sleeping even when the baby is sleeping
- Tiredness/lack of energy
- Change in Appetite
- Tearfulness/crying/ feeling sad
- Anxiety
- Lack of motivation or enjoyment
- Panic attacks
- A sense of being overwhelmed
- Personal neglect
- Impaired concentration
- Feeling hopeless
- Withdrawal from family and friends/ Feelings of isolation
- Poor mother-infant interaction (e.g. lack of interest in the child or lack of sensitivity to the infant's needs)
- Physical signs of tension such as headaches or gastrointestinal symptoms
- Thoughts of self-harm and suicide
- Thoughts of harming the child

DSM-5 Criteria for a major depressive episode
Five or more symptoms in the same two week period. Each of the symptoms represents a change from previous functioning and needs to be present nearly every day. At least one of the symptoms is a depressed mood or loss of interest or pleasure:

- Depressed mood
- Loss of interest
- Insomnia or hypersomnia

- Psychomotor retardation or agitation
- Loss of energy or fatigue
- Worthlessness or guilt
- Change in appetite
- Impaired concentration or indecisiveness
- Recurrent thoughts of death or suicidal ideation or attempt

Postpartum Psychosis or Puerperal psychosis is a severe illness with an acute and rapid onset. It affects between one to two women in every 1000 births and manifests within days to several weeks after childbirth.

Risk factors for postpartum Psychosis:

- Bi-polar disorder
- For women with bi-polar disorder and a family history of postpartum

Psychosis in a first degree relative the occurrence is almost double of that of women with bipolar without a family history.

- Postpartum psychosis can occur in women with no previous psychiatric or family history.

Symptoms of Postpartum psychosis[20]

- Rapidly changing mood
- Racing thoughts
- Bizarre behaviour
- Lack of inhibition
- Hallucinations – distortion of the 5 senses
- Delusions – thought disorder
- Confusion
- Agitation
- Flight of ideas
- Lack of insight

Other mental health Conditions:

Bipolar Disorder

Episodes of mania or depression are experienced either alternately or together.
During periods of mania symptoms may include:

- Increased energy
- Loss of inhibitions
- Delusions of grandeur

[20] iHV Perinatal and Infant Mental Health. Multi-agency Champion training program (2017)

- Euphoric mood
- Irritability
- Rapid speech
- Symptoms of depression as described earlier

Schizophrenia

Positive symptoms of schizophrenia:

- Hallucinations
- Delusions: A false belief that is resistant to reason/logic. Delusions vary in content and include paranoid/persecutory delusions e.g. the belief that neighbours are spying on them
- Thought interference
- Made act: an individual may believe that their body or parts of body are controlled by an external force

Delusions involving the foetus or infant/child are extremely concerning and should always trigger an immediate and thorough risk assessment by specialist services.[21]

Negative symptoms of Schizophrenia
As well as positive symptoms, individuals with schizophrenia may experience negative symptoms. These include:

- Losing interest and motivation in life and activities, including relationships
- Fewer spontaneous movements and spend time doing nothing
- Facial expressions do not change much and the voice may sound Monotonous
- Emotions may become flat and an individual appears to be disinterested or disengaged

Negative symptoms of schizophrenia can have a significant impact on the parent/infant relationship and infant development.

Cognitive symptoms of schizophrenia
As well as positive and negative symptoms, individuals with schizophrenia may have varying degrees of cognitive impairment:

- Difficulties understanding information
- Memory problems
- Reduced concentration
- Unable to organise time effectively
- Difficulties in prioritising and planning tasks

Schizoaffective disorder

[21] iHV Perinatal and Infant Mental Health. Multi-agency Champion training program (2017)

Schizoaffective disorder is a severe mental health illness including both symptoms of Schizophrenia e.g. delusions and hallucinations and mood disturbance e.g. depression or mania.

Mothers with schizoaffective disorder have an increased risk of relapse and higher rates of postpartum psychosis.

Personality disorder

Personality refers to the collection of characteristics or traits we develop. The Nice CG (2014) states that 3% of women in the UK are thought to have a personality disorder. Symptoms are seen in at least two of the following areas which can all impact on parenting.

- Thoughts- ways of looking at the world, thinking about self or others and interacting
- Emotions – appropriateness, intensity and range of emotional functioning
- Interpersonal functioning – relationships and interpersonal skills
- Impulse control- considering the outcomes of actions
- Pregnancy and childbirth in women with personality disorders (particularly borderline personality disorder) can evoke many issues relating to trauma in their past, which in turn can affect their ability to cope with becoming a mother and caring for their baby.

Personality disorders are associated with higher rates of substance misuse, deliberate self-harm, suicidality, increased risk of social care and poor engagement with antenatal and postnatal care which can lead to poor outcomes for the individual and the infant.[22]

Eating disorders

Eating disorders e.g. Anorexia Nervosa, Bulimia, Binge eating Disorder are characterised by significant disturbances in normal eating patterns and behaviours, body image and normal weight gain. NICE CG 192 (2014) states that changes to body shape, including weight gain in pregnancy and childbirth may be a concern for a woman with an eating disorder.

- Eating disorder are not uncommon during the perinatal period, with recent studies estimating the prevalence in pregnancy to be 5-7% [23]
- Eating disorder symptoms tend to improve during pregnancy, however they do not completely disappear, and recurrence and new onset eating disorders may occur in the postpartum period.[24]

[22] iHV Perinatal and Infant Mental Health. Multi-agency Champion training program (2017)

[23] Easter et al Recognising the Symptoms: How Common Are Eating Disorders in Pregnancy? 2013

[24] Eater et al Antenatal and Postnatal Psychopathology Among Women with Current and Past Eating Disorders: Longitudinal Patterns 2015

- Women with eating disorders often experience higher levels of depression and anxiety during the perinatal period and are at a higher risk of experiencing postnatal depression.[25]

Appendix 3

Assessing severity of common mental health disorders: definitions

Assessing the severity of common mental health disorders is determined by three factors: symptom severity, duration of symptoms and associated functional impairment (for example, impairment of vocational, educational, social or other functioning).

Mild generally refers to relatively few core symptoms (although sufficient to achieve a diagnosis), a limited duration and little impact on day-to-day functioning.

Moderate refers to the presence of all core symptoms of the disorder plus several other related symptoms, duration beyond that required by minimum diagnostic criteria, and a clear impact on functioning.

Severe refers to the presence of most or all symptoms of the disorder, often of long duration and with very marked impact on functioning (for example, an inability to participate in work-related activities and withdrawal from interpersonal activities).

Persistent subthreshold refers to symptoms and associated functional impairment that do not meet full diagnostic criteria but have a substantial impact on a person's life, and which are present for a significant period of time (usually no less than 6 months and up to several years).

www.nice.org.uk/guidance/cg123/chapter/Appendix-E-Glossary

[25] Eater et al Antenatal and Postnatal Psychopathology Among Women with Current and Past Eating Disorders: Longitudinal Patterns 2015

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