ADULT D – Learning Review

The review

The purpose of this report is to identify learning as a result of the experiences of Adult D when receiving services from professionals.

The brief overview report provides partners with an understanding of Adult D, her circumstances, service involvement and learning.

How you can make a difference

- Consider the impact of Post-natal Depression (PND) during assessments

The review considered that the issue and impact of PND had not been considered by the professionals during their assessments and as a result there were missed opportunities. Too much emphasis was placed on the marital breakdown as the cause of Adult D's depression.

NICE Guidance 'Ante Natal and Post Natal Mental Health: MH problems in Pregnancy and the Post Natal Period' advises that women who have a mental health problem may be unwilling to disclose or discuss it because of fear of stigma, negative perceptions of them as a mother or fear that their baby may be taken into care. To counteract this health professionals, need to nurture relationships with new mothers which will enable more transparent discussions and increased trust.

- Children should not be seen as a protective factor

The Children were seen as protective factors however children cannot be held to account to risk manage the adult in their life; by treating children as a protective factor significantly increases the risk to them.

- Communication between multi-agency colleagues

Key information was not shared with multi-agency colleagues, it appears that the impact of Adult D's mental health and suicidal feelings were not fully considered.

Background summary

Adult D was a young mother who was experiencing marital difficulties. Prior to this Adult D presented as content with her home life and well supported by her family.

In March 2017 Adult D was found in her home unresponsive, she died 3 days later and the coroner recorded a verdict of suicide.

In February 2017 Adult D attended her GP surgery reporting low mood, irritability, feelings of helplessness and hopelessness. The GP referred Adult D to Healthy minds for further support, where she reported ongoing marital difficulties since and suggested she may have

had depression and suicidal thoughts, of which were indicated as low risk at the time. Shortly after this anti-depressant medication was prescribed.

Early March 2017 Adult D was admitted to hospital following an overdose of medication and alcohol. Adult D was referred to the Mental health liaison. Adult D shared that her marriage had recently broken down. Adult D was supported by her family and the family also had contact with the mental health liaison service regarding management of her medication.

Following this admission Adult D was referred to the home treatment team. Adult D continued to express suicidal thoughts and very low mood. Over subsequent days Adult D's suicide risk increased, and a plan was put in place to reduce this. Due to this a safeguarding children's referral to Local Authority was made. No further action was taken as it was considered that appropriate mental health and family support was in place. The children at this time were identified as protective factors.

Adult D was known to the Health visiting services since 2013 and was categorised as a 'Universal family' with no concerns. In 2015 the family were escalated to 'Universal Plus' due to child development concerns.

Key learning and themes

Mental Health

Adult D presented with indicators of depression, over a number of years; the cause of which could have been threefold, PND, relationship breakdown or endogenous depression[1] It would appear that significant emphasis was given to the relationship breakdown by ADULT D and the professionals around her which resulted in a treatment and management plan being tailored to this specific area.

There is a suggestion from disclosures by Adult D and her partner that she experienced post-natal depression following the birth of her daughter; in 2017 Adult D advised that she had Health visitor support but there is no evidence that she was in contact with the HV at this time. The family had not sought support from health professionals as they believed they were able to manage the situation themselves. Latterly Adult D's husband suggested there had been a re-emergence of PND symptoms after the birth of their son but once again no support was sought.

The Panel reviewed the heath records and noted the GP comments at the maternal post 6-week examination (OS) 'mood okay'. Furthermore, a review of the available Health Visitor records shows no evidence of a PND assessment or any questions being raised.

Research shows PND is often more prevalent post a caesarean birth and where there are marital difficulties; in this instance ADULT D experienced both and therefore PND should have been given greater consideration by those involved. Alongside this, ADULT D had a family history of suicide and suffered a chronic health condition; which are also indicators for an increased risk of depression.

Learning

[1] Persistent, intense periods of sadness for extended periods of time- no apparent cause

There is a need to identify PND identification and management across the City.

There is a need to strengthen Health Visiting (HV) documentation taking into account PND and the HV Practice Handbook.

Protective Factors

ADULT D reported that she had suicidal feelings and was unhappy that her suicide attempts had been unsuccessful. She reported that her family were protective factors but recognised this did not stop her attempting to take her life the first time. She did share that if her children were in the care of her family and she could guarantee a successful method of ending her life then she would. The Panel noted that risk assessments continued to see family members as protective factors and therefore the risk of self-harm was perceived to be reduced.

NSPCC ***'Parental Mental Health: Learning from case Reviews, 2015'*** advises that when a parent discloses suicidal feelings that 'as well as leading to a referral to mental health services, disclosure of suicidal feelings should lead to full consideration of child protection issues in relation to a suicidal parent. Children should never be considered a protective factor for parents who feel suicidal. In some cases, professionals inappropriately viewed the child as a protective element who could help to reduce the parent's risk of self -harm. This belief significantly increases the risk to the child.'

In short, Children can't be held to account to risk manage the adult in their life.

Learning

Any engagement or dis-engagement issues should be considered by practitioners as a potential child protection matter.

Professionals should not be drawn into a false sense of security regarding risk management relating to the parent.

Children cannot take responsibility for managing parents' behaviours and therefore assessments should not identify children as protective factors

NSPCC *'Parental Mental Health: Learning from case Reviews, 2015'* The stresses of parenting can exacerbate mental health problems which may impact on the welfare of the child. Not getting enough sleep or having to adapt to a baby's routine can make it more difficult for parents to cope with a mental health problem such as anxiety or depression.

Learning

Potential Child Protection implications should always be considered particularly when specialist adult services consider their input to have limited impact on the protection of any children in the household.

Practitioner Engagement

The Panel noted that as of March 2018 suicidal intention was escalating and therefore, professional intervention should have 'shifted' in focus. There were several practitioners involved at this time but there was no one consistent worker. The Panel recognised that the nature of the Crisis Intervention service allows multiple practitioners to be engaged with service users which may lead to inconsistency and limited oversight of risk management.

Learning

The Crisis Team/ Home Treatment Team Policy and Standard Operating Procedure (SOP) to be reviewed to ensure that all involved workers assessments are informed by a robust understanding of the review plans.

Risk assessments should consider all potential factors that impact on an individual's presentation

All agencies actively engaged should be advised where there is a deterioration in Mental Health

Recommendations

1. WSB to promote PND identification and management across the Health and Social workforce.

2. Health and Social care professionals must recognise the relationship between Adult Mental health and child protection. Children should not be considered as protective factors when parents experience mental health problems.

3. Health Visiting Records and any other relevant practitioners must demonstrate that PND checks are undertaken throughout the post- natal period and the outcome of these are documented.

4. As a minimum Health visiting records should include comment, from the relevant sections, on each of the areas outlined in the HV Practice handbook.

5. Practitioners must exercise professional curiosity and where concerns arise and there is a reduction in a patient's Mental health professionals must escalate appropriately in line with the development of the Multi agency pathway in order for multi-agency management plans to be devised.

6. All agencies to review their Risk assessment documentation to ensure to consider all potential factors that impact on an individual's presentation.

7. BCPFT Crisis Team/ Home Treatment Team Policy and SOP to be reviewed to ensure that all involved workers assessments are informed by robust understanding of review plans.

8. Where a practitioner identifies a reduction in a patient's mental health they have a duty to notify other professionals who are working with the individual/family, so multi-agency management plans can be devised.