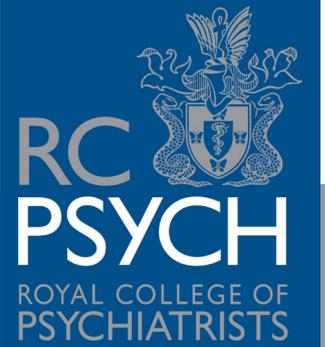CR164

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Parents as patients:
supporting the needs of patients
who are parents and their children

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Contents

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Executive summary and recommendations

The Working Group was established in 2007 to update the 2002 Royal College of Psychiatrists' report, *Patients as Parents: Addressing the Needs, Including the Safety, of Children whose Parents have Mental Illness (CR105)*, in the light of the recent evidence base, demographic changes, changes in policy and services and new legislation. Recent data indicate that 10–15% of children in the UK live with a parent who has a mental disorder and 28% are the children of lone parents with a mental disorder (Cleaver *et al*, 1999). In Australia, 20–60% of people accessing mental health services are parents (Hearle et al, 1999; Maybery et al, 2009).

The experience of parents with mental illness

Many experiences of parents with mental illness are similar to those of all parents. They describe the relationship with their children and fulfilling the parenting role as extremely important and one that comes before being a parent with a mental disorder. However, many are aware of the negative impact of their problems on their children and are fearful of losing custody of their children.

Young carers

As many as 29% of all young carers are caring for someone with mental health problems and many have multiple responsibilities, including caring for several members of the family, mediating family conflicts and having to seek out help for the 'looked-after' person. This can restrict their opportunities for leisure, social networking and peer relationships. Young carers may have their own problems and fear professional involvement. Article 12 of the United Nations Convention on the Rights of the Child states that children have a right to be listened to and have their views taken into account on matters that affect them. Young carers from the Barnardo's project in Liverpool have articulated clear messages for mental health professionals, which will be discussed later on in this report (p. 17).

Impact of parental psychiatric disorder on children

There are well-established links between parental mental disorder and poor outcomes in children, although not all children are at risk. Effects can

be exerted from conception onwards and the impact felt right up to adult life. These effects may be genetic in nature, direct or indirect effects of the symptoms of mental illness plus stigma and separation, temporary or permanent. The impact of severe and common mental disorders, substance misuse, personality disorder and intellectual disability on children is reviewed in this report and the interventions known to be effective in reducing this impact are discussed.

Child abuse and death

Most parents with mental illness do not abuse their children and most adults who do abuse children are not mentally ill. However, parental mental disorder is associated with use of physical punishment and child abuse and mental health problems or substance misuse is a factor in a third of cases of death of or serious injury to children. The relative risk of neonatal and postnatal death is increased in parents with a history of alcohol misuse or psychiatric admission and a history of admission or maternal depression increases the risk of sudden infant death syndrome. Parental antisocial personality disorder increases the risks of abuse and mothers with personality disorder are more likely to use harsh and problematic parenting measures. Neonaticide is associated with concealed pregnancy, with the most common diagnosis being personality disorder. Infanticide and filicide are more closely related to maternal mental illness. Men commit filicide more often than women and are more likely to have a history of violence towards their children (Bourget *et al*, 2007). Men are also more likely to die by suicide and 25% kill in response to a threatened separation or divorce (Liem & Koenraadt, 2008).

Fathers with mental illness

Although less studied than mothers with mental illness, lone fathers are almost four times more likely to have a common mental disorder than other men (Cooper *et al*, 2007). The impact of maternal anxiety and depression and attention-deficit hyperactivity disorder (ADHD) on children is exacerbated if a resident father is also experiencing these disorders. Several studies report links between paternal depression and depression or other mental health problems in the offspring. Fathers with severe mental illness may be more likely than mothers to misuse alcohol and drugs. Despite this, the Think Fathers government campaign in 2008 did not specifically address the needs of fathers with mental illness.

Mental illness in asylum seekers and refugees who are parents

Refugees and asylum seekers have more needs than comparable psychiatric populations and their needs are more complex. Women may have acquired sexually transmitted diseases (e.g. as the result of rape) and may arrive in the UK in late pregnancy having had no antenatal care, with a higher incidence of complications such as urinary tract infections or anaemia. They may have been subjected to violence in pregnancy and, in some cases, to

female genital mutilation. The Royal College of General Practitioners has produced guidance on managing mental health problems in asylum seekers and refugees (Ashton & Moore, 2009).

ISSUES FOR PROFESSIONALS

Children are often 'invisible' to mental health professionals who are poor at enquiring about and collecting information on them, perhaps feeling that it is not their role. However, there are clear legislation and policy frameworks providing guidance in the four UK jurisdictions that this report addresses and we have focused on what this means for colleagues working in the following areas or with parents with specific problems: acute services, parental self-harm, Mental Health Act assessments, in-patient services, substance misuse services, those working with people with personality disorder and intellectual disability and those in continuing care and recovery.

RECOMMENDATIONS

1   All psychiatrists and members of multidisciplinary teams should be familiar with legal and policy frameworks in their jurisdiction in relation to safeguarding children.

2   Safeguarding training that includes the risks posed to children from parents with delusional beliefs involving their children or who might harm their children as part of a suicide plan is an essential requirement for all staff. Attendance, knowledge and competence levels should be regularly audited, and any lapses urgently acted on.

3   All assessment, care programme approach (CPA) monitoring, review and discharge planning documentation and procedures should prompt staff to consider whether the service user is likely to have or resume contact with their own child or other children in their network of family and friends, even when the children are not living with the service user, or when the parent is temporarily separated from their children, for example when in prison or custody.

4   Any assessment should measure the potential or actual impact of mental health on parenting, the parent/child relationship and the child, as well as the impact of parenting on the adult's mental health. Appropriate support and ways of accessing it should also be considered in the assessment. Remember that children's rights to be safeguarded are paramount, even when they are perceived as interfering with the therapeutic relationship between the adult patient and the professional.

5   Referrals should be made to children's social care services under local safeguarding procedures as soon as a problem, suspicion or concern about a child becomes apparent, or if the child's own needs are not being met.

Referrals must be made:
a   if service users express delusional beliefs involving their child, and/or
b   if service users might harm their child as part of a suicide plan.

6   Staff working in mental health services should be given clear guidance on how to make referrals to children's social care services, including information sharing, the role of their organisation's designated lead for child protection, and what to do when a concern becomes apparent outside normal office hours.

7   Those working with women of reproductive potential who have an existing mental disorder and/or are taking psychotropic medication should consider the possibility of unplanned pregnancy, and discuss contraception as well as the risk of pregnancy with all such patients. Women who are pregnant or planning a pregnancy, and women who develop a mental disorder during pregnancy or in the postnatal period, should be given culturally sensitive information at each stage of assessment, diagnosis, disorder course and treatment about the impact of the disorder and its treatment, including medication, on their health and the health of the fetus/child. Pre-conception counselling should be provided for women of childbearing age with pre-existing serious mental health conditions that may be aggravated by pregnancy.

8   When intervening in the community where children may be part of the household, note that the Mental Capacity Act does not have provision for the protection of others. Therefore, if an intervention is needed in individuals who are parents, partly for the protection of children, the Mental Health Act must be used. In Scotland, the Children (Scotland) Act (1995) allows the removal of an adult from the house if a child is going to come to harm at the hand of that adult. Contact details related to the children should, wherever possible, be sought before the assessment. When arranging the Mental Health Act assessment, the local safeguarding team should be contacted and any relevant information sought from them.

9   Those working in in-patient settings should ensure that contact between parents and children when a parent is in hospital is actively encouraged and that there are family visiting rooms which are accessible, warm, clean and well equipped. Consider using a checklist for in-patient service providers (Appendix).

Introduction

In 1999, a College Working Party was established to consider the issues posed by 'the patient as parent' and the implications for children whose parents experience mental disorders. In 2002, the first *Patients as Parents* report was produced. The current Working Group was set up in 2007 to revise and update this report in the light of changes in policy, legislation, service configuration, demography and the accumulating evidence base.

THE SCALE OF THE PROBLEM

In 2006, there were 17.1 million families in the UK, 38.5% of whom had dependent children (Smallwood & Wilson, 2007); 2.3 million of these families were lone mothers, 73% of whom had dependent children.

Estimating the prevalence of mental disorder in these parents is not easy; the available data are presented in Table 1.

Black Caribbean children have a 50% chance of being born to a lone parent (Platt, 2002) and Black Caribbean single mothers have higher rates of severe mental illness than married women.

A recent systematic review estimates that in the UK, at any given time, 9–10% of women and 5–6% of men will be parents with mental disorder. Less than 0.5% will have a psychotic disorder, the majority having common mental disorders such as depression or anxiety (Parker *et al*, 2008). Most of the studies did not include those with personality disorder.

Recent estimates of the proportion of people accessing mental health services who are parents range from 20 to 60% (Table 2).

In addition, the prevalence of all personality disorders in the UK is about 4% (Coid *et al*, 2006). A significant proportion of people with a personality disorder will be parents, especially those diagnosed with emotionally unstable personality disorder, who are more likely to be female.

In their report *Social Exclusion and Mental Health*, the Social Exclusion Unit (2004) identified parents with mental health problems and their children as one of the four groups most likely to have difficulties getting their needs

Table 1 Mental disorder in parents

Bassani *et al* (2009), Canada	One in ten children is living with a parent who has a mental illness
Cleaver *et al* (1999), UK	15.9% of couples with children and 28% of lone parents had at least one parent with a mental illness
Crosier *et al* (2007), Australia	15.7% of mothers who had a partner and 28.7% of single mothers had a mental illness

Table 2 Percentage of mental health service users who are parents

Study	Country	Patients who are parents, %		Study population
Hearle *et al*, 1999	Australia	Women 59%	Men 25%	People with psychosis
Ahern, 2003	Australia	55%		People attending community mental health centre
Nicholson *et al*, 2004	USA	Women 68%	Men 54.5%	People with psychiatric disorder
Maybery *et al*, 2009	Australia	20.4%		People accessing mental health services

addressed. It is estimated that 2% (140 000) of families in the UK suffer from the combined impact of more than five disadvantages and they have some of the poorest outcomes (Social Exclusion Task Force, 2008*a*).

A report published by the Advisory Council on the Misuse of Drugs in 2003, *Hidden Harm*, estimated there are between 200 000 and 300 000 children in England and Wales with one or both parents who have serious drug problems. In Scotland, between 41 000 and 59 000 children have a parent with problem drug use. This represents about 2–3% of children under 16 in England and Wales and 4–6% in Scotland. Many others will be living with a parent who has an alcohol problem. In this study, only 37% of fathers and 64% of mothers were still living with their children.

The more serious the drug problem, the less likely it is for the parent still to be living with the child. *Hidden Harm* reported that most children not living with their natural parents were living with other relatives but about 5% of all children were in care.

Children of parents who have a mental illness may be living with their birth parent(s), in step-families, with other relatives, in foster care or in other informal or formal care arrangements that may change frequently. Women with severe mental illness are more likely to have involvement with children's Social Services or to have children in care than mothers with common mental health problems (Park *et al*, 2006).

Hearle *et al* (1999) found that most of their sample relied on relatives and friends for child care support. Barriers to asking for help from other agencies were:

- a desire to manage alone

- concern about not being able to afford help

- not thinking of getting help or knowing where to get it

- being embarrassed about asking

- fearing children would be removed.

In a systematic review (Beresford *et al*, 2008) the following barriers to accessing services were identified:

- individual beliefs about help-seeking

- knowledge of services

- fears about losing custody

- stigma

- conflicting demands on parents

■   the presence of other stresses and difficulties

■   problems with access, transport and child care.

Relatives, particularly grandparents and aunts, are more likely than more formal arrangements to be providing surrogate care and in some cases are more significant nurturing figures than the biological parents (Caton *et al*, 1998).

The prevalence of dual diagnoses is high in patients attending both general adult psychiatry and substance misuse services. Weaver *et al* (2003) found that 44% of community mental health patients reported problem drug use, harmful alcohol use or both in the past year. In drug and alcohol treatment services 75% and 85% of patients respectively had psychiatric disorder in the previous year – most had affective disorders (depression) and anxiety disorders. Many of these individuals will also be parents. With these levels of dual diagnoses it is likely that many parents will have both substance misuse and mental health problems.

Women with severe mental illness and substance misuse are more likely to experience intimate partner violence, with younger women (in their twenties) being at greater risk than older women (McPherson *et al*, 2007). In any setting where violence occurs in the home, children are at risk of physical harm or emotional harm from witnessing violence.

Good-enough parenting and the needs of children

The expression 'a good-enough mother' was coined by Donald Winnicott, a paediatrician and psychoanalyst, in the 1950s. 'The good-enough mother…starts off with an almost complete adaptation to her infant's needs, and as time proceeds she adapts less and less completely, gradually, according to the infant's growing ability to deal with her failure' (Winnicott, 1953).

In 1987, the concept was expanded to 'a good-enough parent' by another analyst, Bruno Bettelheim. Both theorists were trying to define the emotional components of good parenting while taking into account basic needs such as nourishment, shelter and physical care and protection.

Much has been written on the basic needs of children and on what constitutes a good-enough parent but most experts would agree that a secure attachment between caregivers and child is an important foundation for sound emotional development in a child. Parents/caregivers need to provide consistent and affectionate care with clear boundaries and expectations of the child, appropriate for the child's level of development and understanding. Parents/caregivers need to have the capacity to understand and respect their children's developing autonomy and to allow them to become individuals with their own views and ideas, rather than fulfilling parental hopes or aspirations. Children need to be adequately protected from adult concerns. At the same time as nurturing their children's individuality, parents must maintain the level of authority necessary to ensure the health and safety of their children, to enable them to access education and leisure facilities and to provide opportunities for interaction with other children.

Modern parents/caregivers must compete to share their values with other role models (e.g. from the media) as well as with the peer pressure of their children's friends, and yet parents/carers remain the most influential people in forming their children's opinions. They need to exercise their responsibility to proactively inform and educate their children about such difficult matters as sexuality and relationships, substance use, etc. Parents/carers working together to bring up a child need to be aware that the quality of adult relationships around the child will have a profound influence. It is vitally important that the child experiences the parents/carers working together in his or her best interest.

A good-enough parent must have the capacity to prioritise the needs of their children, which requires a degree of selflessness that may never previously have been required. At the same time, parents/carers need to be able to deny or refuse their children's requests or demands when appropriate and to tolerate and understand the negative feelings towards them, which may ensue.

It is often said that parenting is the hardest job in the world. To juggle the need for parental authority while simultaneously nurturing the individuality of one's child and to provide consistency in boundaries and expectations while dealing with the vagaries of modern life may feel overwhelming and impossible. Yet the message from Winnicott and Bettelheim is clear. No parent could or should manage perfectly. Indeed, what child could live up to a perfect parent? Parents can and do make mistakes with their children all the time and the way that these mistakes are negotiated within the relationship provides valuable lessons in the child's development.

A good-enough parent/carer will provide a secure enough base to facilitate good attachments, which will enable the child to form other healthy relationships throughout his or her life. He or she will strive to see their child as a separate being and gradually and appropriately extend the level of autonomy of the child. At the same time, a good-enough parent will exercise the necessary authority to set safe boundaries and will be robust in managing any ensuing hostility without retaliating. He or she will try to ensure that lines of communication are open between parent and child within an underlying background of affection, warmth and valuing of the child.

The experience of parents with mental illness

Many of the experiences of parents with mental illness are similar to those of all parents in that they describe the relationship with their children and fulfilling the parenting role as extremely important to them (Nicholson *et al*, 1998). However, they are very aware of the negative impact of the illness upon their children, particularly disruption to everyday life, and have concerns about significant behaviour problems that may arise in their children (Stallard *et al*, 2004). They may also worry about the risk of genetic transmission of their mental illness to their children and children mimicking their behaviour (Aldridge & Becker, 2003).

Mothers with mental illness feel socially isolated; they fear that they will lose custody of their children and worry about who will look after their child if they become ill again. They feel traumatised by their admissions to hospital and want more community supports. The relationship with their children is extremely important but they feel stigmatised as parents because they have a mental illness (Bassett *et al*, 1999). Fears of losing visitation rights or custody if they fail to attend appointments or adhere to medication occurred in almost a fifth of patients from US community mental health centres. Family members were identified as the most common source of these fears (Busch & Redlich, 2007). Some women feel they are the victims of negative societal attitudes towards parents with mental illness even before they become pregnant (Nicholson *et al*, 1998; Savidou *et al*, 2003).

Keeping their children close is important to mothers and maintaining the pretence of well-being by masking symptoms and censoring speech while carrying out child care in a 'mechanical' or 'automatic' mode in order to meet children's basic needs has been described (Montgomery *et al*, 2006). Losing custody of a child can cause profound distress in women with mental illness (Apfel & Hardel, 1993) and those who have been separated from their children describe needing help to cope with their sadness even many years later (Nicholson *et al*, 1998; Joseph *et al*, 1999).

What do parents want?

The following list has been adapted from Cowling (2004).

- Being a parent should come before being a person with a mental illness.
- Parents feel supported when the needs of their children are met.

- Professionals may not think so but parents may know, and be sensitively tuned into, the needs of their child.

- Service providers should work out the best way of ensuring the health and safety of the child without excluding the parent from the decision-making process when other family members are involved.

- Professionals should be more willing to listen to and value a parent's point of view and feelings.

- Parental ability should be evaluated before removing children without question.

- Professionals should give the parent with mental illness and their partner information about the effects of medication, possible side-effects and the effects on the person's behaviour.

- Professional support is needed for the partner when a parent is acutely ill and education is required to prepare for ongoing treatment, convalescence and recovery.

- Professionals should respect confidentiality with regard to sharing information with family members.

- The most profound loss for some parents with mental illness is the loss of their children if they are taken away.

- Schools need to understand how mental illness might influence a child and might avoid suspending a child for bad behaviour.

- Parents want their right to privacy respected.

- Services should be sensitive to the parents' cultural background.

- Service providers should be educated to network services and link parents into the most useful ones.

- Parents want to be viewed as persistent and zealous and working to battle prejudice and injustice.

Young carers

A young carer is defined as someone under the age of 18 who is the primary carer of someone who, in this context, is experiencing a mental disorder. They may be a young child or a teenager, and are more likely to be a girl rather than a boy. The majority are of school age and 54% live in lone parent families. Overall, 29% of all young carers are caring for someone with mental health problems.

Many young carers have multiple responsibilities, such as caring for several members of the family; mediating family conflicts; seeking out help for the 'looked-after' person (Grant *et al*, 2008).

Their caring role can restrict opportunities for social networking and peer relationships and reduce time spent on leisure activities. Young carers themselves may have physical health problems, emotional and educational problems and may suffer from stigma by association with the parent who has mental health or substance misuse problems. They may fear professional involvement as it can lead to separation and/or public hostility, and are less likely than other carers to receive a carer's assessment (Stanley *et al*, 2003*a*).

Article 12 of the United Nations Convention on the Rights of the Child states that children have a right to be listened to and have their views taken into account on matters that affect them.

Young carers from a Barnardo's project in Liverpool (Bilsborough, 2004) have the following messages for mental health professionals.

1   Introduce yourself. Tell us who you are and what your job is.

2   Give us as much information as you can.

3   Tell us what is wrong with our parents.

4   Tell us what is going to happen next.

5   Talk to us and listen to us. Remember, it is not hard to speak to us; we are not aliens.

6   Ask us what we know and what we think. We live with our parents; we know how they have been behaving.

7   Tell us it is not our fault. We can feel really guilty if our mum or dad is ill. We need to know we are not to blame.

8   Please don't ignore us. Remember we are part of the family and we live there too.

9   Keep on talking to us and keep us informed. We need to know what is happening.

10   Tell us if there is anyone we can talk to. MAYBE IT COULD BE YOU.

Further reading

Aldridge, J. & Becker, S. (2003) *Children Caring for Parents with Mental Illness: Perspectives of Young Carers, Parents and Professionals*. Policy Press.

Social Care Institute for Excellence (2004) *Experiences of Children and Young People Caring for a Parent with a Mental Health Problem*. SCIE.

The impact of parental mental disorder on children

Mental disorder in a parent can have an impact on the needs of a child in a variety of ways and is strongly associated with poor outcomes in children. However, it is also important to remember that not all children of parents who have mental illness are at risk and that in any family there may be protective factors at work. Both parents and children can be remarkably resilient (Kim-Cohen, 2007) .

The relationship between parental mental disorder and adverse outcomes for children is well established (Berg-Nielsen *et al*, 2002). The effects of parental psychopathology can be exerted from conception onwards and the impact felt long beyond early childhood into teenage years and adult life. Diagnosis alone conveys little about all the risks and there are several ways in which effects of a mental disorder in a parent can have impact on both fetal and child well-being, development and safety, adjustment, transition to adulthood and future parenthood. Vulnerability may also depend upon the age of the child and whether or not the child is at a particular stage of development.

First, there may be a genetic risk transmitted from parent to child, increasing the child's risk of developing the same disorder as their parent. There is now strong evidence for the familial nature of serious mental disorders. However, Rutter & Silberg (2002) highlight gene–environment interactions, which can be as important as direct genetic effects.

Parental mental disorder may act directly (e.g. via symptoms or the side-effects of medication) or indirectly. Current psychiatric symptoms accounted for most of the variance in community functioning in a study of mothers with a mental illness (Bybee *et al*, 2003). Specific symptoms may confer particular risks to children; for example, they may become the focus of delusional thoughts or a parent may experience command hallucinations telling them to harm a child.

Behaviour associated with mental illness can lead to physical and emotional abuse or neglect; domestic violence; dangerously inadequate supervision; other inappropriate parenting practices; the presence of toxic substances in the home (prescribed and non-prescribed); exposure to criminal or other inappropriate adult behaviour; and social isolation. These risks may interact with and exacerbate other parental difficulties such as educational underattainment.

Mothers who have a mental illness are more likely than other low-income, urban populations to report (Mowbray *et al*, 2000, 2001):

- severe financial difficulty
- physical health problems

- an excess of crises including
  - □ loss of significant others
  - □ assaults
  - □ other negative life events
- stressors such as
  - □ living alone with their children
  - □ child behaviour problems.

In addition to the stresses children living in poverty are exposed to, those whose parents have a mental illness may also experience stigma (Somers, 2007). Behavioural and emotional problems in children appear to be more severe if both parents have mental health problems (Kahn *et al*, 2004).

Mothers with unrealistic caregiving attitudes (such as believing that a child should be offering the parent support and comfort) are more likely to demonstrate insensitive behaviour when interacting with their children (Leventhal *et al*, 2004). Mothers who are afraid of losing their children's love may not be able to set them appropriate limits, thereby leading to children growing up with unrealistic expectations of what society should provide, an unrealistic sense of entitlement and need for immediate gratification, which may lead to drug misuse and criminal behaviours.

Children may also experience intermittent or permanent separation (resulting from parental hospital admissions or the child's receipt into care); inadequate accommodation and/or frequent changes in residence; interrupted or otherwise unsatisfactory education and socialisation. Losses may also arise in relation to the suicide or early death of a parent.

EFFECTS OF SEVERE MENTAL ILLNESS ON CHILDREN

Women with serious mental illness are at increased risk when becoming mothers, not only in pregnancy but also after childbirth, and the effects of their illness on their children are long term.

PREGNANCY

- Pregnancy loss (Gold *et al*, 2007).
- Obstetric complications (Bennedsen *et al*, 2001).
- Fetal death, stillbirth, neonatal death and fatal birth defects (Howard *et al*, 2003; Webb *et al*, 2005, 2008).

  Women with psychotic disorders are more likely than controls to:
- use illicit drugs before pregnancy
- drink alcohol and/or use illicit drugs during pregnancy (Howard *et al*, 2004; Shah & Howard, 2006).

Women with mental illness (psychotic and non-psychotic disorders) are less likely to attend antenatal appointments (Kelly *et al*, 2001). In such women, antenatal care is less likely to address smoking and alcohol consumption compared with other women in maternity services (Howard *et al*, 2003).

Postpartum

■ Women with a history of psychotic disorder (particularly bipolar disorder) are at increased risk of relapse in the postnatal period (Harlow *et al*, 2007).

■ A parental history of psychiatric admission is associated with a twofold increase in the risk of sudden infant death syndrome (King-Hele *et al*, 2007).

■ Offspring of both women and men with schizophrenia have a doubled risk of infant mortality (Nilsson *et al*, 2008).

Childhood

■ Women with schizophrenia may have disturbed or poor interactions with their infants (Riordan *et al*, 1999; Snellen *et al*, 1999; Wan *et al*, 2007) and infants may show anxious or disorganised attachment (Persson-Blennow *et al*, 1986; Jacobsen & Miller, 1999).

■ Delayed walking, visual dysfunction, language disorders, enuresis and disturbed behaviour are significantly increased in the offspring of mothers with schizophrenia whereas the infants of mothers with affective psychosis show only delayed walking (Henriksson & McNeil, 2004).

■ A significant proportion of mothers with psychotic disorders and severe personality disorders have parenting difficulties and may lose custody of their infant (Wang & Goldschmidt, 1994; Howard *et al*, 2003).

■ Many women with mental illness may be reluctant to seek help with child care because they are frightened that their children will be taken away (Herle & McGrath, 2000; Krumm & Becker, 2006).

■ Children of a parent with schizophrenia show more disturbance, more problems associated with school, have less contact with relatives, spend more time at home and are upset by hospital visiting (Somers, 2007).

■ Parental mental illness is associated with dropping out of high school, particularly for girls (Farahati *et al*, 2003).

Long-term effects on children

Individuals who have a parent with schizophrenia are less likely to be married than the general population, are in a poorer employment situation (Terzian *et al*, 2007) and have a higher risk of premature death (Suvisaari *et al*, 2008).

Effects of common mental disorders on children

There is now substantial evidence linking anxiety, stress and depression during pregnancy and maternal depression postpartum with impaired infant development, and childhood cognitive, emotional and behavioural problems

(Grace *et al*, 2003; van den Bergh *et al*, 2005; Field *et al*, 2006; Talge *et al*, 2007) and depression in adolescent offspring (Halligan *et al*, 2007; Pawlby *et al*, 2008). Other mental health problems in parents and their influence on children are discussed below.

- Mood disturbance during pregnancy is associated with sleep problems in infants and toddlers (O'Connor *et al*, 2006) and maternal reports of 'difficult' infant temperament (Austin *et al*, 2005).

- Postnatal depression is associated with poor infant growth in the UK and low-income countries (Stewart, 2007).

- Paternal depression in the postpartum period is associated with behavioural and conduct problems in pre-school children, particularly boys (Ramchandani *et al*, 2005), even after controlling for maternal depression.

- Depression during pregnancy and to a lesser extent, during the first 6 months postpartum is associated with sudden infant death syndrome (Howard *et al*, 2007).

- Mothers who have depression are less likely to have smoke alarms in the home or to place infants in the back sleep position known to reduce the risk of sudden infant death syndrome (Chung *et al*, 2004).

- Infants of mothers who have depression have more routine visits to the doctor (Chee *et al*, 2008), more emergency department visits (Minkovitz *et al*, 2005) and increased rates of hospital admission (Chung *et al*, 2004).

- Meta-analyses have shown maternal depression to be related to conduct behaviour problems in children (Beck, 1999) whereas paternal depression is associated with internalising and externalising childhood problems and father–child conflict (Kane & Garber, 2004).

- Maternal depression up to age 10 predicts adolescent depression (Hammen & Brennan, 2003).

- Depression in a parent can give rise to disengagement or neglect and has strong associations with irritability and hostility towards a child (Lovejoy *et al*, 2000).

- Mothers who have depression are more likely to use corporal or harsh punishment (Chung *et al*, 2004; Johnson *et al*, 2006).

- High levels of distress are associated with lack of engagement with daily routines (Leiferman *et al*, 2005).

- Having a parent with ADHD increases the risk of a child having ADHD, the risk increasing if there is also parental substance misuse (Wilens *et al*, 2005).

- A small but significant increase in criminality has been observed in the adult offspring of mothers who had depression during pregnancy (Mäki *et al*, 2003) and an increase in rates of anxiety disorders and substance misuse in adult children of parents who have depression (Peisah *et al*, 2004).

The impact of parental substance misuse on children

Parental substance misuse is a difficult and controversial subject, which attracts interest from politicians, professionals and the public alike. A

substantial number of clients attending substance misuse services are parents. Their problems vary in severity and so does the level of impact on their children.

Problem drug use in the UK (e.g. use of heroin, cocaine and other drugs) is characterised by the use of multiple drugs, often by injection, and is strongly associated with socioeconomic deprivation, dual diagnosis and other factors that may affect parenting capacity. It is typically chaotic and unpredictable. Serious health and social consequences are common. Problem drug and/or alcohol use in a parent can and often does compromise children's health and development at every stage of development, from conception onwards.

Maternal drug or alcohol use during pregnancy can seriously affect fetal growth, but assessing the impact is usually impossible, with multiple drugs being taken in various doses against a background of other unfavourable circumstances. There is serious concern about the effect of cocaine on fetal development. Heroin and other opiates, cocaine and benzodiazepines can all cause severe neonatal withdrawal symptoms. The damaging effects of tobacco and alcohol are well established, and cannabis is not risk-free. Maternal drug injecting carries the risk of transmission of HIV and viral hepatitis to the baby. Mothers who misuse alcohol and/or drugs may have poor nutrition and receive inadequate antenatal care.

After birth, the child may be exposed to many sustained or intermittent hazards as a result of parental problem drug or alcohol use. These include: poverty; physical and emotional abuse or neglect; domestic violence; dangerously inadequate supervision; other inappropriate parenting practices; intermittent or permanent separation; inadequate accommodation and frequent changes in residence; toxic substances in the home (prescribed and non-prescribed); interrupted or otherwise unsatisfactory education and socialisation; exposure to criminal or other inappropriate adult behaviour; and social isolation.

These hazards often interact with and exacerbate other parental difficulties such as educational underattainment and mental health problems. The adverse consequences for children are typically multiple and cumulative and will vary according to the child's stage of development. They include failure to thrive; blood-borne virus infections; incomplete immunisation and otherwise inadequate healthcare; a wide range of emotional, cognitive, behavioural and other psychological problems; early substance misuse and offending behaviour; and poor educational attainment. These can range greatly in severity and may often be subtle and difficult to detect.

THE IMPACT OF EATING DISORDERS IN PARENTS ON CHILDREN

Eating disorders most often occur in women during the childbearing years. The average prevalence rates for women are 0.3% for anorexia nervosa and 1% for bulimia nervosa (Hoek, 2006). Inclusion of those with extreme concerns about body shape and weight and disrupted eating patterns who do not meet diagnostic criteria increases the prevalence to a conservative estimate of 4%. Perhaps more importantly eating disorder pathology can be affected by pregnancy, with symptoms reported by 11.5% of women 3–7 months postpartum (Larsson & Anderson–Ellstron, 2003).

Being overweight and having folate deficiency when pregnant (which may relate to poor diet and lack of exercise, weight gain on

atypical antipsychotics or which may be a direct metabolic consequence of schizophrenia) increases the risk of neural tube defects (Koren *et al*, 2002).

Parental eating problems may affect their offspring through mechanisms ranging from pre-conception to adulthood (Box 1). Although there are numerous case reports and series, there have been very few systematic controlled studies and virtually no reports on the effect of fathers with eating disorders. Notably, a significant proportion of children in community samples are not affected by their mother's eating disorder but some adverse effects are recognised. Increased awareness of the potential risks and more effective identification of eating disorders in pregnant women and parents could improve the outcome for both the parent with an eating disorder and their children.

Pregnancy and the puerperal period are a vulnerable time for the onset or exacerbation of eating disorder pathology. Eating disorders, particularly anorexia nervosa, even after recovery, are associated with an increased risk of fertility problems (Brinch *et al*, 1988). However, many women do conceive and may be adversely affected by the stresses of pregnancy and parenthood. Weight gain and change in body shape during pregnancy can present particular difficulties. There is some evidence of a higher rate of perinatal complications. Women with eating disorders are also at increased risk of developing postnatal depression (Franko *et al*, 2001).

However, for some patients pregnancy heralds a remission of symptoms as mothers become concerned about the effects on their unborn child.

Familial transmission of eating disorders is well recognised, with a reported seven- to twelvefold increase in prevalence in first-degree relatives of those affected compared with controls (Strober *et al*, 2000). There is robust evidence for an aetiological role for both genetic and environmental factors.

In infanthood feeding is a significant component of the parenting role. Studies of mothers with eating disorders have shown an increased level of conflict during mealtimes with disorganised and intrusive parental behaviour. The degree of conflict was found to be directly related to lower child weight (Stein *et al*, 1994). Some parents may impose their own drive for thinness and control on their children by withholding food (Russell *et al*, 1998). Children may also model parental eating attitudes and behaviours. This appears to be more prevalent in daughters of mothers with anorexia

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Box 1 Summary of effect of parental eating disorders on offspring

The effects of eating disorders in parents on children may be varied:
- genetic vulnerability
- fertility and obstetric complications
- conflict during mealtimes associated with low weight
- controlling, intrusive parenting style
- neglect
- modelling eating disorder pathology
- family discord
- additional effect of comorbid problems.

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nervosa (Park *et al*, 2003). There is a significant relationship between dieting concerns of young girls and their mothers (Hill *et al*, 1990). Case series have reported psychological disturbance in domains other than eating, including: enuresis, speech and language disorders and emotional problems (Franzen & Gerlinghoff, 1997).

Controlling parenting styles are not limited to mealtimes but also appear during play. Mothers have been observed to be more intrusive and less facilitating, with their infants and children displaying lowered emotional tone and negative affect (Agras *et al*, 1999). In addition, a parent's preoccupation with eating-disordered behaviours may result in neglect of a child's needs. In fact, sometimes role reversal may develop and the child becomes the caregiver within the relationship (Park *et al*, 2003).

In addition to the direct effect on parenting, the presence of an eating disorder can severely disrupt marital and family relationships. A tense atmosphere often develops in an environment where an eating disorder is either accommodated or challenged. These factors have been clearly shown to adversely affect child development.

Finally, eating disorders are associated with a high degree of comorbidity, particularly depressive disorder, obsessive–compulsive disorder and personality disorder, which may also have consequences for the welfare of offspring.

Effect of personality disorders on children

Personality disorder is characterised by comorbidity with other disorders, including Axis I disorders, so psychiatrists treating patients with severe mental illness should consider whether their patients also have personality disorders. Psychiatrists may also be asked to assess parents who are struggling to care for their children, who have hurt them, and may then make the diagnosis of personality disorder.

'Personality disorder' is best understood as a developmental disorder of interpersonal dysfunction, often accompanied by behavioural disorders (Adshead *et al*, 2004). The dysfunction is probably best understood as the result of highly dysregulated affect and arousal systems at times of threat. At these times, when non-disordered personalities would successfully elicit care and soothing from caregivers, people with personality disorders become either highly aroused and distressed, or dismissive, withdrawn and emotionally cold. In evolutionary terms, they tend to categorise others as predator or prey; they also tend to use immature defence mechanisms, such as projection, splitting and acting out, which alienate others.

Affect and arousal regulatory capacities involve both neurophysiological and psychological elements. Individuals develop personality disorders as a result of an interaction of genetic vulnerability and adverse childhood experience with attachment figures, usually child maltreatment (Goodman *et al*, 2004). Attachment relationships are an interaction of caregiving and care-eliciting behaviours, and early attachment experiences have a significant influence on later parenting skills (George & Solomon 1996; Hill, 2004); parents who have secure mental attachment models tend to provide that type of care to their children, which allows them to make secure attachment relationships (van Ijzendoorn, 1995).

The developmental literature should then lead us to expect that people with personality disorders will struggle to be successful parents. There is

indeed evidence that this is so. A substantial proportion of self-reported child abusers are diagnosed with personality disorder and it is a diagnosis commonly made by professionals reporting in child protection proceedings (Famularo *et al*, 1992; Dinwiddie & Bucholz, 1993; Stanley & Penhale, 1999). In cases of child maltreatment, where attempts were made to reunite the families, the presence of antisocial personality disorder in particular made reunification unlikely (Jones, 1987). In one small study of maltreating mothers, half of the sample had a diagnosis of a personality disorder (Bools *et al*, 1994).

Parents who have a personality disorder are likely to struggle for three reasons:

1   having a child will stimulate their attachment system

2   their capacity to manage and self-soothe their own arousal is limited, and

3   they will not be able to soothe their own child's distress, but instead respond with hostility or fear.

This then leads to a vicious cycle, in which the child gets more distressed, and the parent becomes either more frightened or frightening; which in turn makes it likely that the child will become insecurely attached. If the parent feels helpless and hostile, they are more likely to treat their child as an adult or peer, which may then lead to role reversal or attack behaviours. If a parent has experienced maltreatment as child, they are likely to resort to learnt behaviours/modelling with their own children.

The presence of personality disorder therefore compromises parenting to the same extent as severe mental illness does, and perhaps even more (Berg-Nielsen *et al*, 2002; Johnson *et al*, 2006).

Parents with intellectual disability

Parents with intellectual disability have an increased risk of developing mental health problems. Recent research suggests that they have high levels of psychopathology (e.g. Feldman *et al* 2002; McGaw *et al* 2007). Mental illness and mental disorders manifest as enduring factors affecting the competence of many parents with intellectual disability.

Men and women with intellectual disability have their own set of issues, risks and vulnerabilities because of their disability and society's response to them. It also increases their vulnerability to exploitation and abuse. Such individuals are more likely than the general adult population to have been abused as children; many also suffer from poorer physical health, and have experienced domestic violence and growing up in care (Cleaver & Nicholson, 2008). There are often additional complex abusive relationship issues.

Access to appropriate services and supports for a parent with intellectual disability can be a challenge as there are often different eligibility criteria between and within health and social services in one locality and across the country. Many parents identified as having intellectual disability function within the borderline intellectual disability range, where eligibility for intellectual disability services is a real issue.

Such parents often have to prove to services that they are competent to be parents – a requirement no other section of society is obliged to follow. This form of discrimination can of course be positive, if it means that family needs are identified early and appropriate supports made available to

support the pregnancy and parenting role. However, up to 50% of children are removed from their parent if the parent has intellectual disability owing to a lack of appropriate support to the family or concerns about the welfare or development of the children (Booth *et al*, 2005). Services are often wholly inadequate, fail to address the complexities involved and are crisis driven; they are unable to act proactively and in a preventative way to support families with a parent who has an intellectual disability. The psychological repercussions of this are often not addressed.

Child abuse and death

The majority of parents with mental illness do not abuse their children and most adults who do abuse children are not mentally ill. However, parental mental disorder is associated with use of physical punishment and child abuse (Afifi *et al*, 2006). Parents of maltreated children are more likely to be diagnosed with a mental disorder (De Bellis *et al*, 2001) or to have a past history of psychiatric illness (Sidebotham & Golding, 2001). In this latter study, acts of commission were more likely to be perpetrated by fathers or a mother's live-in partner, whereas acts of omission were more likely to be perpetrated by mothers.

A report on serious case reviews 2003–2005 (Brandon *et al*, 2008) noted that domestic violence was a factor in two-thirds of death or serious injury cases and mental health problems or substance misuse were factors in a third of such cases. These three factors coexisted in 34% of cases. In the eight cases in which an infant under the age of 1 year sustained serious head injury ('shaken babies') the mothers were noted to have a significant mental illness requiring hospitalisation during pregnancy, and some of them had discharged themselves against medical advice. Adult mental health teams were already involved with a third of all the cases reviewed and a lack of links between agencies was cited as a significant problem.

A parental history of antisocial personality disorder increases the risk of physical abuse (odds ratio (OR) = 6.1) and any abuse (physical or sexual, OR = 7.5) (Walsh *et al*, 2002).

Mothers with personality disorder have been reported as more likely to exhibit problematic behaviours towards their children (Johnson *et al*, 2006), including:

- harsh punishment
- possessiveness
- verbal abuse
- use of guilt to control behaviour
- inconsistent enforcement of rules
- frequent loud or 'rough' arguments with their partner.

CHILD DEATH

There is an increased risk of unnatural death from childhood to early adulthood in the offspring of parents who have had psychotic admissions (Webb *et al*, 2007). The relative risks (RR) of neonatal and post-neonatal deaths in the infants of women with a diagnosis of an alcohol-related

disorder and who had previously had a psychiatric admission are 2.59 and 3.83 respectively (Webb *et al*, 2006). A past history of maternal or paternal psychiatric admission (King-Hele *et al*, 2007) or the presence of maternal depression (Howard *et al*, 2007) increases the risk of sudden infant death syndrome. The risk is particularly high (RR = 6.9) if both parents have been admitted. Alcohol and drug-related diagnoses (especially in the mother) confer higher risks than other mental disorders.

Neonaticide (murder of an infant during the first 24 hours of life) is most likely to be carried out by a young, single woman of low socioeconomic status who is still living with her parents. The pregnancy is likely to have been concealed or denied, with no or little antenatal care, and the woman may have delivered alone. Personality disorder is a more common diagnosis than Axis I mental disorder and symptoms such as depersonalisation, dissociative hallucinations, numbness and intermittent amnesia are frequently reported (Friedman *et al*, 2005*a*).

In contrast, infanticide (killing a child aged up to 1 year) and filicide (killing an older child) are both much more closely related to maternal mental illness. Mothers who commit filicide are often disadvantaged, with histories of abuse and substance misuse. Some studies have noted persistent crying as a precipitant of maternal violence. It is likely, however, that different risk factors distinguish mothers who kill during an episode of acute mental illness and those who kill at other times (Friedman *et al*, 2005*b*). A third of women found 'not guilty by reason of insanity' in the USA had an infant under the age of 1 year. Half had previous suicide attempts and had planned suicide–filicide events. Command hallucinations and delusions about their children were common and a third were pregnant or postpartum. In addition to their mental illness (most often a psychotic disorder or mood disorder with psychotic features), other stressors were present (Friedman *et al*, 2005*b*).

Men commit filicide more often than women and are similar with respect to the prevalence of personality disorder, the presence of life stressors, social isolation and lack of support. However, filicidal fathers are more likely to have a history of violence towards their children, more likely to also die by suicide (Bourget *et al*, 2007) and 25% kill in response to a threatened separation or divorce (Liem & Koenraadt, 2008).

Further reading

Royal College of Psychiatrists (2004) *Child Abuse and Neglect: The Role of Mental Health Services (College Report CR120)*. Royal College of Psychiatrists.

National Institute for Health and Clinical Excellence (2009) *When to Suspect Child Maltreatment*. NICE.

Fathers with mental illness

Mothers with mental illness have been systematically studied much more than fathers (Styron *et al*, 2002) and some clinicians consider children to be significantly more important to mothers than fathers (Nicholson *et al*, 1999). Lone fathers are more likely to have non-dependent children (Smallwood & Wilson, 2007) but they are almost four times more likely to have a common mental disorder than other men (Cooper *et al*, 2007). The impact of maternal anxiety and depression on children is exacerbated if a resident father is also experiencing these disorders (Meadows *et al*, 2007), and whereas mother's ADHD ameliorates the negative effect of children's ADHD on parenting, if a father has ADHD in addition to the child, the effects are exacerbated (Psychogiou *et al*, 2007). There are several studies reporting links between paternal depression and depression or other mental health problems in the offspring (for a review, see Spector, 2006).

Fathers with severe mental illness share many similarities with mothers who have mental illness, although in one study fathers were more likely to misuse drugs or alcohol (Nicholson *et al*, 1999). Styron *et al* (2002) argue that as fathers with serious mental illness constitute a substantial population whose needs are similar to both fathers in the general population and mothers with a mental illness, both individual clinicians and services must recognise the importance of parenting in their lives and provide appropriate support and care to enable them to carry out their role as fathers.

In November 2008, UK Children's Minister, Beverley Hughes, announced a Think Fathers campaign to dispel the myth that they are the 'invisible parent'. Research published by the government (Page *et al*, 2008) shows that public, health and family services across the board need to go much further in recognising and working with fathers. However, this programme does not specifically address the needs of fathers with mental illness.

Asylum seekers and refugees

It is estimated that 3% of the world's 10 million refugees and asylum seekers reside in the UK. They are among the most marginalised groups in our society and experience high rates of psychological problems. Studies in the UK have identified 11% of people attending a London community mental health team (CMHT) (McColl & Johnson, 2006) and 4.5% of an in-patient population (Bhui *et al*, 2006) as refugees or asylum seekers.

The following definitions apply in the UK.

■ An asylum seeker is a person who has made a formal application to the Home Office for asylum status and is waiting for a decision.

■ A refugee is a person whose asylum application has been successful. She or he is granted permission to stay in the country under the terms of the 1951 UN Convention on the Status of Refugees, which states that a refugee must be outside their country; have a well-founded fear of persecution because of his or her race, religion, nationality, membership of a social group or political opinion; and be unable or unwilling to return to the country for fear of persecution.

Seeking asylum can be a long and drawn out process. If an initial application is turned down this may lead to appeal and an application can only be considered failed when the legal process has been exhausted. Even then there may be clear reasons why the Home Office cannot remove the person, such as ill health or if their home country is deemed too dangerous.

Refugees and asylum seekers may have experienced sequential trauma both before and after migration (e.g. violence or witnessing violence, rape or torture; imprisonment; loss of or separation from relatives (including children) or home; poverty and financial loss; pregnancy (wanted or otherwise); racism; stigmatisation; multiple moves) in addition to the stresses involved in making an asylum claim. They have more needs than comparable psychiatric populations and their needs are more complex.

In addition to mental health problems, asylum seekers and refugees may have injuries or disabilities consequent upon wars or torture and pre-existing physical health problems (including communicable diseases). Women may have acquired HIV or other sexually transmitted diseases as the result of rape. They may arrive in the UK in late pregnancy having had no antenatal care, with a higher incidence of complications such as urinary tract infections, anaemia and, in some cases, female genital mutilation. They may show anxiety regarding vaginal examination and delivery if they experienced sexual assault (McCrone *et al*, 2005). As many as 75% of a group of pregnant 'undocumented migrants' in Switzerland reported their pregnancy as being unwanted and were more likely than controls to have experienced violence during their pregnancy (Wolff *et al*, 2008).

For more information, including entitlements to National Health Service (NHS) care, see Ashton & Moore (2009).

The role of the professionals in caring about patients–parents

Mental health professionals are poor at collecting information regarding the parenting status of their patients and tend not to enquire about children's welfare and needs (Manderson & McCune, 2004). Hence, Gladstone *et al* (2006) described the 'invisible child'. In a sample of women from a rehabilitation service, paucity of information relating to their role as a mother included no mention of children, incorrect information and lack of recording of a major trauma such as the death of a child (Dipple *et al*, 2002). Professionals may agree that offering support to the children of their patients is important but often feel that this is not their role, whereas their natural sympathy and alliance with their patient may lead to blindness about seeing the needs of the child.

Staff in in-patient settings are less likely than those in community settings to say that they would assess the need for referral to another agency (Slack & Webber, 2008). Community psychiatric nurses are more likely to say they act as an advocate for the needs of a mother than a child whereas child social workers identified general practitioners (GPs) and psychiatrists as having most problems with inter-professional coordination (Stanley *et al*, 2003*b*). Others have identified mutual distrust between mental health and child protection workers, lack of time and resources, unrealistic expectations, confidentiality issues and professional domains and boundaries as barriers to inter-agency collaboration (Darlington *et al*, 2005). In addition, mental health professionals report patients' lack of insight regarding the illness and its impact on children, insufficient knowledge and skills and concerns that discussing parenting and child-related issues might impair the relationship they have with their patient (Maybery & Reupert, 2006).

What should services and professionals do?

LEGISLATION AND POLICY FRAMEWORKS

All psychiatrists and members of multidisciplinary teams should be familiar with legal and policy frameworks.

THE NATIONAL CONTEXT – POLICY AND LEGAL FRAMEWORK IN ENGLAND AND WALES

In January 2003, Lord Laming presented his report on the inquiry into the death of Victoria Climbié (Laming, 2003). In addition to a detailed response to the inquiry, the government produced a consultation green paper, published in September 2003, called *Every Child Matters* (HM Government, 2003). The central aim of *Every Child Matters* was to establish coordinated services for children under the sponsorship of the local authority with the aim of achieving five outcomes for all children. These are to:

1   stay safe

2   be healthy

3   enjoy and achieve

4   make a positive contribution

5   achieve economic well-being.

These outcomes were to be achieved through supporting parents and carers, early intervention and effective protection, accountability and integration, on a local, regional and national level and through workforce reform. The Children Act 1989 was updated in 2004 and guidance *Working Together to Safeguard Children*, issued in 2006, was reviewed and updated in 2010 (HM Government, 2010). These documents together provided a framework that established local safeguarding children's boards; created actual or virtual 'children's trusts' under the auspices of local authorities; and clarified the duty of all agencies to make arrangements to safeguard and promote the welfare of children. (In this context, a child is defined as anyone who has not yet reached their 18th birthday.)

Safeguarding and promoting the welfare of children is defined as:

■   protecting children from maltreatment

■   preventing impairment of children's health and development

- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care, and

- undertaking the role so as to enable those children to have optimum life chances and to enter adulthood successfully (HM Government, 2007, 2010).

Child protection, which forms part of safeguarding, is undertaken to protect specific children who are suffering, or are at risk of suffering, significant harm such as physical abuse, sexual abuse, emotional abuse or neglect.

Of relevance to mental health professionals, especially those working with adults who may be parents or carers of children, Section 11 of the Children Act 2004 places a duty on strategic health authorities, special hospitals, primary care trusts (PCTs), NHS trusts and foundation trusts to ensure that they have regard to the need to safeguard and promote the welfare of children. Adult mental health practitioners including those providing general adult and community services, forensic, learning disability, psychotherapy, alcohol and substance misuse services should routinely record details of patients' responsibilities in relation to children as part of the CPA process. They should also be aware of potential risks to non-related children by known child abusers and should follow local child protection procedures as necessary.

The Department for Children, Schools and Families and the Department of Health published a joint statement (2007) on the duties of doctors and other professionals in investigations of child abuse. Specifically, all health professionals should be able to understand the risk factors relevant to safeguarding issues, including the needs of parents for support and the risks to unborn children, and know where to refer for help. They should be prepared to share appropriate information with other agencies, contribute to assessments of parenting capacity (and for children's health professionals – the assessment of children's needs), plan and respond to planning for vulnerable children and those in need of protection and contribute to child protection conferences including those on issues such as domestic violence or parental substance misuse. They should also contribute to serious case reviews and the implementation of action plans arising from these (Box 2).

To assist in carrying out these duties, all staff should have access to training in safeguarding and promoting the welfare of children.

Each trust that provides mental health services should either have a designated doctor and designated nurse (if a PCT) or a named doctor and named nurse (if other form of trust) with lead responsibility and expertise

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Box 2 Useful resources for staff investigating child abuse

What to do if You're Worried a Child is Being Abused (HM Government, 2006).

Responding to Domestic Abuse: A Handbook for Health Professionals (Department of Health, 2005).

Information Sharing: Guidance for Practitioners and Managers (HM Government, 2008).

for promoting good professional practice in safeguarding. In addition, all mental health in-patient services must have policies and procedures relating to children visiting in-patients (Department of Health, 1999). Planning for such visits should always make paramount the best interest of the child/ children involved.

Referral to the local authority children's social care services in relation to child protection or other safeguarding concerns may be done through an inter-agency referral form or increasingly through the completion of a common assessment framework process (CAF). The common assessment framework has been developed to provide a single inter-agency recording structure for children who require more than universally available support services to achieve the five outcomes of *Every Child Matters* (see p. 33). The completed assessment tool will have information on the child's developmental needs, the support provided by and to parents and carers, and family and environmental factors.

The *Families at Risk* review (Social Exclusion Task Force, 2007), part of the *Children's Plan* (Department for Children, Schools and Families, 2007) identified that 2% of British families experience five or more disadvantages, including maternal mental illness. This led to the Think Family initiative (Social Exclusion Task Force, 2008*b*) which aims to join up adult and children's services, with 'no wrong door'.

Legal framework in Scotland

1 The legal framework that covers these issues includes the following.

a The Age of Legal Capacity (Scotland) Act 1991, which allows children under 16 years to make decisions regarding their own treatment where they are judged to understand the nature and consequences of that treatment.

b Children (Scotland) Act 1995, which sets out the mechanism for ensuring children's welfare through the legal and compulsory means of the children's hearings system. If a child is deemed to be in need of compulsory measures of care to ensure his or her welfare (this would include being beyond parental control), referral is made to the children's reporter who collects the evidence and determines whether there is a case to bring the child to the hearing. The grounds of referral have to be agreed by the parents and child (age permitting) or, if necessary, by a sheriff court. This system is designed to deal with issues relating to children's welfare (as well as offending), the child's best interests being the key factor. If the health of a parent is considered detrimental to a child's welfare, this is referred to the hearing.

c The Mental Health (Care and Treatment) (Scotland) Act 2003, which places a specific responsibility on those involved in the detention of an adult or child to mitigate any detrimental effects on parenting. It also places an onus on providers of mental healthcare to ensure that facilities are available to admit mothers with their babies up to the age of 1 year.

2 *Delivering a Healthy Future: an Action Framework for Children and Young People's Health in Scotland* (Scottish Government, 2007) sets out the policy on delivering child and adolescent mental health

services. The document also details government policy on parenting initiatives and how these will be further promoted.

3   The Mental Welfare Commission has responsibility for the welfare of all children and adolescents in psychiatric hospital.

The Scottish Government is currently consulting on revised guidance on child protection, to replace the 1998 guidance *Protecting Children – A Shared Responsibility: Guidance on Inter-Agency Co-operation* (Scottish Office, 1998).

Northern Ireland

Area Child Protection Committees' Regional Policy and Procedures, April 2005.

The first edition of the regional child protection policy and procedures has been written to reflect the changes in thinking and practice, which are contained in *Co-operating to Safeguard Children* (May 2003). It replaces *Co-operating to Protect Children*, which was issued in November 1996 as Volume 6 of the *Regulations and Guidance to the Children (Northern Ireland) Order 1995*. The *Policy and Procedures* also incorporate lessons learnt from the Victoria Climbié inquiry report (Laming, 2003), the Department of Health, the *Review of Health and Social Services in the Case of David and Samuel Briggs* (Lewis *et al*, 2003) and the Bichard Inquiry report (2004).

Further reading: relevant Northern Ireland publications

Department of Health, Social Services and Public Safety (2003) *Co-operating to Safeguard Children*. DHSSPS.

Department of Health, Social Services and Public Safety (2003) *Good Practice in Consent for Examination, Treatment or Care: A Handbook for the HPSS*. DHSSPS.

Department of Health, Social Services and Public Safety (2003) *Seeking Consent: Working with Children*. DHSSPS.

Department of Health, Social Services and Public Safety (2004) *Protection of Children and Vulnerable Adults (NI) Order (2003) – Information Note 1: Disqualification from Working with Children*. DHSSPS.

Department of Health, Social Services and Public Safety (2004) *Protection of Children and Vulnerable Adults (NI) Order (2003) – Information Note 2: Disqualification from Working with Children and Vulnerable Adults*. DHSSPS.

Northern Ireland Office (2001) *Guidance on the Processes for the Assessment and Management of Risk of Sex Offenders and Offenders against Children*. Northern Ireland Office.

Police Service of Northern Ireland, NSPCC and the four HSS Boards (2004) *The Protocol for Joint Investigation by Police Officers and Social Workers of Alleged and Suspected Cases of Child Abuse – Northern Ireland*.

National guidance

In May 2009, the National Patient Safety Agency issued a rapid response report requiring all chief executives providing adult mental health services to ensure that:

1.   All assessment, CPA monitoring, review, and discharge planning documentation and procedures should prompt staff to consider if the service user is likely to have or resume contact with their own

child or other children in their network of family and friends, even when the children are not living with the service user.

2. If the service user has or may resume contact with children, this should trigger an assessment of whether there are any actual or potential risks to the children, including delusional beliefs involving them, and drawing on as many sources of information as possible, including compliance with treatment.

3. Referrals should be made to children's social care services under local safeguarding procedures as soon as a problem, suspicion or concern about a child becomes apparent, or if the child's own needs are not being met. A referral must be made:

a) If service users express delusional beliefs involving their child *and/or*

b) If service users might harm their child as part of a suicide plan.

4. Staff working in mental health services should be given clear guidance on how to make such referrals, including information sharing, the role of their organisation's designated lead for child protection, and what to do when a concern becomes apparent outside normal office hours.

5. A consultant psychiatrist should be directly involved in all clinical decision making for service users who may pose a risk to children.

6. Safeguarding training that includes the risks posed to children from parents with delusional beliefs involving their children or who might harm their children as part of a suicide plan is an essential requirement for all staff. Attendance, knowledge, and competency levels should be regularly audited, and any lapses urgently acted on.

Acute services

Psychiatrists and mental health professionals working in CMHTs, in-patient services and crisis resolution and home treatment teams should include the following in the initial assessment.

■ Establishing whether a service user is a parent, even where the parent is temporarily separated from their children, for example when in prison or custody (Department of Health, 2008*a*).

■ Ensuring their assessment, including risk assessment, assesses the potential or actual impact of mental health on parenting, the parent–child relationship, the child, the impact of parenting on the adult's mental health, and what appropriate support might look like and how it can be accessed (Department of Health, 2008*a*).

■ Ensuring that their assessment also addresses the indirect effects of mental illness, for example financial problems, poor housing, stigma and discrimination (Department of Health, 2008*a*).

■ Making a referral to children's Social Services under local safeguarding procedures as soon as a suspicion or concern about a child becomes apparent or if the child's needs are not being met. A referral must be made if service users express delusional beliefs about their children and/or may harm their child as part of a suicide plan (National Patient Safety Agency, 2009).

■ Remembering that children's rights to be safeguarded are paramount even when they are perceived as interfering with the therapeutic relationship between adult patient and the professional.

If working with women of reproductive potential, staff in acute psychiatric services should consider the possibility of unplanned pregnancy (in all female patients) and adhere to the following guidance.

■ Healthcare professionals should discuss contraception and the risks of pregnancy (including relapse, risk to the fetus and risks associated with stopping or changing medication) with all women of childbearing potential who have an existing mental disorder and/or who are taking psychotropic medication. Such women should be encouraged to discuss pregnancy plans with their doctor (National Institute for Health and Clinical Excellence, 2007).

■ Those women with an existing mental disorder who are pregnant or planning a pregnancy, and women who develop a mental disorder during pregnancy or the postnatal period, should be given culturally sensitive information about the impact of the disorder and its treatment on their health and the health of their fetus or child at each stage of

assessment, diagnosis, course and treatment. This information should cover the proper use and likely side-effects of medication (National Institute for Health and Clinical Excellence, 2007).

■ Pre-conception counselling and support, both opportunistic and planned, should be provided for women of childbearing age with pre-existing serious medical or mental health conditions which may be aggravated by pregnancy. This includes obesity. This recommendation especially applies to women before having assisted reproduction and other fertility treatments (Confidential Enquiry into Maternal and Child Health, 2007).

Women with mental disorder who become pregnant or who are postpartum should be managed in accordance with these guidelines and recommendations.

PARENTAL SELF-HARM

Self-harm is a significant accompaniment to severe mental illness, substance dependence and personality disorder. It has also been shown to have important associations with child maltreatment (Hawton *et al*, 1985; Falkov, 1998). Attempted suicide is also an important risk factor for those who go on to die by suicide. The phenomenon of 'extended suicide' or homicide–suicide by parents is well described (West, 1965).

Given that not all parents who attend hospital accident and emergency departments following an episode of self-harm will be admitted, their presentation provides an important opportunity to review family circumstances and the welfare and safety of children – an opportunity for preventive intervention.

PRACTICE GUIDELINES

When assessing any adult subsequent to an overdose or self-harm, seek information about the following.

■ The parental status of the person (Does he or she have responsibility for or contact with dependent children?).

■ The presence and whereabouts of all the children for whom the individual has responsibility.

■ Any agencies involved with the parents and/or their children – ensure that appropriate checks are made with local Social Services (e.g. Is the child known to Social Services? Is the child on the Child Protection Register?) as part of the care plan, even if, or especially if, the mental illness of the parent is thought not to be sufficient to warrant admission. In order to do this you will need the child's full name and date of birth.

■ Carry out a full risk assessment, including risk of further self-harm or suicide but also risk of potential harm to any children for whom the individual has responsibility. If any young person is thought to be at immediate or urgent risk of harm from the adult being assessed, the appropriate Social Service and welfare agencies should be contacted. Out of hours this should be the duty social worker.

■   The support required for a parent to meet the needs of the children, including their safety; alerting the children's health visitor can assist in developing appropriate plans to support children and their parents.

Mental Health Act Assessments

In considering the use of the Mental Health Act, taking place within the community where children may be part of the household, the patient's capacity must be considered, as well as whether the Mental Capacity Act 2005 would provide sufficient authority to provide the care or treatment needed. However, the Mental Capacity Act does not have provision for the protection of others. Therefore, in the case of parents, it is most likely that intervention will in part be needed for the protection of children; in such cases the Mental Health Act must be used (Department of Health, 2008*b*: 4.2). The *Code of Practice* (4.5) requires consideration of the impact that any future deterioration or lack of improvement in the patient's condition would have on their children.

Those who are assessed and subsequently detained are often the most unwell of our patients. However, when children are present it may be appropriate to intervene earlier rather than risk further deterioration in the parent's mental health and the potential increased risk of harm to the children. The *Code of Practice* (4.5) requires consideration of the impact that any future deterioration or lack of improvement in the patient's condition would have on their children.

In preparing for an assessment, it is essential that clinicians have information regarding the children of the patient. Contact details related to the children should wherever possible be sought prior to the assessment. Clinicians will therefore need to have kept records related to the children, including their full name, date of birth, and details of school, nursery or childminder attendance. The contact details of other relevant adults, for instance grandparents or other parent should also be known.

When contacting professionals for the assessment, the local safeguarding team should be approached and any relevant information sought from them. This will be especially important where there are known concerns about the children and should there be uncertainty about who will care for the children should the parent be admitted. It may in some cases be necessary for the children to be accommodated via the local authority if a suitable family member cannot be identified at the time of assessment. The local authority may in some cases need to also assess a placement as to its suitability and whether it is a private fostering arrangement, which will require monitoring by the Social Services department.

Mental Health Act assessments are often a time of great uncertainty and busyness with many people involved. The large number of people who may potentially enter the home can be intimidating and may provoke fear and anxiety in the children. Where possible, it is helpful therefore to limit the numbers entering the home to a safe minimum and avoid forced entry. Should it be necessary to force entry to the home, ensure a colleague or family member is available to support the children.

While assessing the parent, try to ensure that the children are kept informed of the reasons for the assessment, and that their views on their parent's illness are sought where appropriate. It is helpful to assign this role to one member of the team, who can perhaps talk to the children in

another area of the home. It is helpful to ask about any changes in their parent's behaviour, and the rules at home. Are they being fed regularly? Is their parent saying or doing things that frighten or confuse them? Ask for examples. It is important to ask the children's views to get a clear picture of the situation at home. The *Code of Practice* (2.43) stipulates that the kind and amount of information that children and young people (especially young carers) should receive about a parent's condition or treatment, as well as the interests of the child or young person, should be balanced against the patient's right to privacy and their wishes and feelings. Any information should be appropriate to the age and understanding of the child or young person.

Whatever the decision of the assessing team, this should be explained to the children in age-appropriate terms. If the decision is taken to admit the parent either formally or informally, it is essential the team make certain the arrangements for the children. Although this is defined as the role of the approved mental health practitioner if the parent is detained, it falls to everyone within the team to be certain of the arrangements. These arrangements may include staying in the home with the other parent/step-parent, going to stay with others, either family members or in foster care (either voluntarily or through care proceedings) or, in the case of older children, being supported to stay in the home alone. It is essential that a clear note be made of where the children will be staying, who with and the relevant contact details. In the case of pre-school children, the health visitor should be informed, and for those at school it may be appropriate to inform the school nurse or counsellor.

In Scotland, The Children (Scotland) Act 1995 allows the removal of an adult from the house if a child is going to come to harm at the hand of an adult with whom they live. This thereby allows the child to remain in his or her own home but in the care of another person. This could be applied in a situation where a patient who cannot be detained under the Mental Health Act was causing risk to the child. They could be removed from the household outwith mental health legislation.

While the parent is in hospital, arrangements should be made for the children to visit in an appropriate environment, provided this is in the best interests of the child; there should also be opportunities for telephone contact. The children should be offered a chance to talk about the Mental Health Act assessment and their view sought on this especially if they were present at the time.

IN-PATIENT SERVICES

Those working in in-patient settings should bear in mind that parents with psychotic disorders have identified the importance of continuity of care with least disruption to home and school for their children when they are admitted and the requirement for a suitable place for their children to visit them during the admission (Cowling, 1999).

Parental hospitalisation and separation from children is reported to increase and exacerbate family concerns because of:

■   unpredictable length of admission

■   worries about permanent separation

■   repeated admissions (Aldridge & Becker, 2003).

However, although parents in one study expressed a preference for home treatment over admission (Khalifeh *et al*, 2009), some of the children preferred admission as it removed exposure to fear arising from parental hostility, poor parental insight and poor communication. Hence, when contact with a hospitalised parent is being considered, a child-centred risk assessment should be undertaken.

A review jointly funded by the Department of Health's Child and Adolescent Mental Health Programme and the Care Services Improvement Partnership (CSIP) Social Inclusion Programme, which was undertaken in partnership with Barnardo's, the Family Welfare Association and the Mental Health Act Commission, made the following recommendations (Robinson & Scott, 2007, p. 51).

▷ Many Mental Health Trusts need to address a significant gap between what they say in their policies on family visiting and what is done in practice in in-patient services. All Trusts should review their practice in line with their policy, and in collaboration with other stakeholders, (user groups and children's services, in particular) and develop a strategic approach to supporting all mental health service users who are parents, their carers and their children.

▷ Contact between parents and children when a parent is in hospital needs to be actively encouraged by staff.

▷ Staff need information and training to increase their:

- knowledge of the benefits to parents and children of contact,

- confidence in addressing family issues with patients,

- skills in communicating helpfully with children and young people,

- ability to challenge the stigma of mental illness and the barriers that it creates between parents, carers and children.

▷ Family visiting rooms which are accessible, warm, clean and well-equipped should be available in all in-patient units/hospitals.

▷ Patients, carers and their children should be actively involved in the development of family visiting rooms.

▷ All new-build facilities should incorporate family visiting rooms in their design.

▷ Finally, and perhaps most importantly of all, services should act on the ten messages to mental health professionals written by a group of children and young people in Liverpool.[1]

It would be helpful if, after visiting a parent with a mental illness, someone from the team talks to the child/and other parent about the child's experience during visiting, their understanding of the mental illness and its treatment, and about the timeframe of the care pathway where possible.

The Australian Infant, Child, Adolescent and Family Mental Health Association (2004) have devised a checklist for in-patient service providers (Appendix).

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1   See p. 17 of this report.

SUBSTANCE MISUSE SERVICES

POLICY FRAMEWORK

Hidden Harm published by the Advisory Council on the Misuse of Drugs in 2003 highlighted to psychiatrists and others working in substance misuse services the significance of drug and alcohol problems as a problem in parents. More usefully, the document focused on the totality of the care system, embedding in policy the need to work across disciplines and care services to identify parental substance misuse and put in place measures to protect children from its effects.

The government of England and Wales and the government of Scotland responded officially to *Hidden Harm* (Scottish Executive, 2004; Department for Education and Skills, 2005) and encouraged local authorities to put local policies and protocols in place to protect children from the effects of parental substance misuse. Local drug and alcohol treatment services are therefore important elements in these partnerships and need to take a major role in them.

Government guidance to the drug misuse treatment services (Department of Health *et al*, 2007) has reinforced these messages, with the need to protect children being an important role both for individual clinicians and treatment services. These guidelines address some of the practical issues encountered when treating individuals misusing drugs such as the need to share information and breach confidentiality where there are serious risks to children.

Recommendations regarding the management of pregnant women who misuse substances are contained in Chapter 12 of *Confidential Enquiry into Maternal and Child Health* (2007).

Substance misuse services and addiction psychiatrists should:

■ record as a matter of course the names and ages of all children living with individuals who misuse drugs, even if not their parents or care-givers

■ carry out parenting risk assessments on all patients who have children living with them; these may have to be repeated if children are living with parents long-term

■ ensure that protocols for managing pregnant women contain procedures for referral to Social Services and that such women are managed by an integrated specialist service nested within the maternity services, comprising a specialist midwife and obstetrician, specialist drug treatment professionals who can manage both alcohol and drug problems, a social worker and other relevant agencies to ensure coordinated multidisciplinary and multi-agency care

■ close multidisciplinary and multi-agency care should be continued not only through pregnancy but also into the postnatal period even if the infant is removed into the care of the local authority

■ follow local area child protection protocols and take part in the development and review of such protocols

■ routinely warn all patients about the dangers of substitute medication to children and take measures to prevent these dangers, for example by issuing medication in child-proof containers

- individual psychiatrist should ensure they have skills and competencies to assess parenting risk and that these should be a subject of regular continuing professional development (CPD).

GUIDANCE FOR STAFF WORKING WITH PEOPLE WITH PERSONALITY DISORDER

Those caring for individuals with personality disorders or assessing such individuals as parents where there are concerns about care need to bear in mind the following.

- Just as for other mental disorders, the majority of individuals with personality disorders may be able, with help, to care for their children and are not a risk to them. Diagnosis alone conveys nothing about risk.

- One-off assessments of personality disorder are notoriously unreliable. Although there is no good agreement about the gold standard for personality disorder assessment, there are some instruments that have reasonable psychometric properties and in any event will be an improvement on clinical assessment alone. Repeat assessment is essential.

- There are now effective treatment programmes for mild to moderate degrees of personality disorder, especially borderline personality disorder (Haigh, 2007). It is vitally important that psychiatrists engage in the active treatment of parents with personality disorder, especially mothers, whose capacity to parent may be significantly improved with psychological therapies that aid affect regulation (such as dialectic behaviour therapy), and adequate pharmacological therapy (Adshead *et al*, 2004).

- Commissioners need to understand that provision of treatments for parents with personality disorder now may lead ultimately to greater savings in the future, in terms of reduced service utilisation and improved mental health of the next generation.

LEARNING DISABILITY SERVICES

Valuing People (Department of Health, 2001) affirms the basic human rights of people with intellectual disability to live within mainstream society with dignity, respect, independence and choice. This means people with intellectual disability have a legal right to expect services to support them in their relationships, sexuality and their parenting roles. The Joint Parliamentary Committee on Human Rights' report on the human rights of adults with an intellectual disability, *A Life Like Any Other?* (2008), reinforced the notion that unless justified as a proportionate and necessary response to a risk to the child or to others, compulsory removal of a child from the care of its parents poses a significant infringement on the rights of both the child and its parents to respect for their family life under Article 8 of the European Convention on Human Rights and the Human Rights Act 1998.

However, a small but growing body of international research suggests that parents with intellectual disability often receive a raw deal from statutory services, who are over-zealous in their approach to risk and under-invest in the kinds of services and supports that might enable mothers and fathers with intellectual disability to cope with their parental role. In early 2009,

the Department of Health launched a 3-year strategy emphasising the right of people with intellectual disability to become parents and their need for support (Department of Health, 2009).

The main predictor of adequate parenting is a firm structure of formal and informal support. Inadequate parental support includes untrained staff using interventions designed for other populations, confused multi-agency involvement that may be even more disabling, no parenting models and abusive and unsupportive relationships.

The presence or absence of social support would seem to be more important than the presence or absence of intellectual disability in terms of the implications for parenting capacity.

Families where a parent has intellectual disability have specific needs that require particular knowledge and skills if professionals are to provide equitable services to children and their parents. A specialised response is often required (Department of Health & Department for Education and Skills, 2007.) The five key features of good practice in working with parents who have intellectual disability are:

1   accessible information and communication

2   clear and coordinated referral and assessment procedures and processes, eligibility criteria and care pathways

3   support designed to meet the needs of parents and children based on assessments of their needs and strengths

4   long-term support where necessary

5   access to independent advocacy.

When psychiatrists come across parents with intellectual disability, they will need to consider:

■   involving members of the multidisciplinary community learning disability team in a coordinated and needs-led approach

■   a comprehensive multidisciplinary assessment of the adult with intellectual disability, recognising low levels of need which, if unaddressed, are likely to lead to difficulties parenting as well as the heightened vulnerability to mental health problems

■   working within agreed adult and children's services, health and social care, for referrals, assessments and care pathways in order to respond appropriately and promptly to the needs of both parents and children

■   facilitating and ensuring prompt and good communication between relevant agencies and with the parent who has intellectual disability

■   ensuring the needs of the child are paramount, but attend to the emotional and procedural needs of the parent who has intellectual disability – before, during and after any safeguarding children processes.

Eating disorder services

Practice guidance

■   For patients known to have an eating disorder who become pregnant:

□ the patient should be offered extra support by a specialist service during pregnancy and early motherhood

□ potential risks to fetus and child should be addressed in treatment

□ involvement of partner, where appropriate, should be encouraged

□ liaison between psychiatrist, GP and obstetric team is vital.

■ For patients known to have an eating disorder who are parents:

□ the psychiatrist should sensitively enquire and encourage discussion about the possible effect of the eating disorder on children and family life

□ the patient should be offered support, including family therapy

□ the psychiatrist should consider the well-being of children and make appropriate referrals (CAMHS, child and family services, voluntary agencies).

■ Others:

□ assessment of children presenting with feeding problems should routinely include an assessment of the mother's eating history.

Continuing care and recovery

In deciding whether a patient's needs should be managed by the CPA, clinicians are asked to consider a number of issues, including parenting responsibility (Department of Health, 2008a). Parents are one of the identified key groups whose holistic needs should be assessed in this way. Care plans should include the needs of the parent and the child/children and if a number of agencies are involved, care plans should describe how these will involve each other and how communication with each other and the family should be managed.

Risk management, crisis and contingency plans should include arrangements for the children if at any point their parent is unable to care for them and what steps will be taken to safeguard them. It should be clear whom both parents and children can contact should they need help.

When care plans are reviewed, the views of children and young people can be sought (with parental consent) beforehand and can provide a valuable perspective. As children grow and develop their needs will change and the care plan should reflect this and consider any additional support that might be needed. With permission, young carers should be involved in the CPA review process; if they have received a carer's assessment, this could be reviewed around the same time. Any changes made to the parent's care plan must take into account the impact that might have on children.

The period following discharge from hospital has been identified as a time when parents have reduced interaction with their children and lack motivation to engage in child care and household tasks (Thomas & Kalucy, 2003). Support in these areas to enable parents to resume their parenting roles will benefit their children and assist parents and the family in the recovery process – look for supports for all parents, for example nurseries and children's centres, Sure Start ventures, play schemes, childminders, extended school hours, etc., and look at whether they could be of assistance. After each support session, an updating of needs and further assessment

should be carried out with immediate recommendations that are practical, doable and concrete.

Resumption of social roles is part of the recovery process and parenting is a key role. Enabling children to understand their parent's illness and mobilising community support have been highlighted as ways of building strength and resilience in families in which a parent has a mental illness (Parrott *et al*, 2008).

Further reading

O'Keeffe, N. & O'Hara, J. (2008) Mental health needs of parents with intellectual disabilities. *Current Opinion in Psychiatry*, **21**, 463–468.

Parenting assessment

Adult psychiatrists may be asked to contribute to multidisciplinary parenting assessments. The psychiatric assessment of the (usually) mother in relation to parenting is an important component of the assessment. In addition to the standard psychiatric history and examination, it is necessary to consider the following issues.

- Does the mother's mental illness put her child at risk of harm?

- If the current treatment plan is changed, will parenting skills improve?

- What strengths and coping strategies are there?

Ideally the assessment would be carried out when the mother's illness is in remission or stabilised but it is also necessary to assess what risks may occur in relapses or during exacerbations. The overall prognosis, level of insight, the presence of risk factors or likely re-occurrence of risk factors and ability to adhere to the treatment plans are all important.

Child and adolescent psychiatrists and other members of the CAMHS team are usually involved in assessing the child, observing mother–child interaction and attachment and assessing the family (including partner), wider social network and supports.

A manual approach (i.e. delivered via a manual and not individually designed) has been devised for the assessment of parents with intellectual disability (Wharton & English, 2005).

Psychiatrists asked to provide information to the courts as professional or expert witnesses should adhere to the guidance contained in College report CR145 (Royal College of Psychiatrists, 2008).

Further reading

Ostler, T. (2008) *Assessment of Parenting Competency in Mothers with Mental Illness*. Paul Brookes.

Reder, P., Duncan, S. & Lucey, C. (eds) (2003) *Studies in the Assessment of Parenting*. Brunner Routledge.

Interventions

Mothers who have a mental illness say they would value parenting programmes that address their specific needs (Bassett *et al*, 1999). It is established that whereas parenting problems resulting from acute symptoms may lessen as the symptoms abate and recovery is achieved (Khang *et al*, 2008), problems arising from other impairments may persist and need specific intervention.

The SCIE systematic map published in 2006 identified over 200 interventions related to parental mental health (Social Care Institute for Excellence, 2006). However, some are population interventions and some are preventive in nature. More than 80 focused on acceptability and over 65 on accessibility. Of the remainder, some were either parenting or family interventions not all offered to children of parents with mental illness. The preponderance of interventions focused on depressive illness was noted in the literature. Brunette & Dean (2002) reviewed a number of these studies and concluded that four out of seven home parenting programmes were effective but that short-term (i.e. less than a year long) interventions were less effective than those delivered for over 12 months. They noted that further research was required to establish which interventions are effective for mothers with psychosis.

More recently, Wan *et al* (2008) reviewed those interventions that might improve maternal–infant relations in mothers with schizophrenia. They identified nine studies that included mothers with mental illness but none focused specifically on mothers with psychosis, and they also concluded that feasibility studies in this population are needed.

There is a survey and a qualitative study of programmes devised to assist parents with mental illness and their children (Hinden *et al*, 2006; Nicholson *et al*, 2007) but as yet no outcome data.

Conclusions

Although many parents with mental illness and their children can be remarkably resilient, adverse outcomes for children are associated with parental mental disorder. Hence, psychiatrists and other mental health professionals in any specialty must consider the family context of service users and consider the well-being and safety of any dependent children at any stage of the care process from assessment to discharge. This will involve working closely with other agencies, across boundaries, sharing information as appropriate and remembering that a child's needs are paramount even in situations where the necessary safeguarding action may impair the therapeutic relationship with the parent. In shaping and developing services the views of parents and young carers are essential in ensuring that their needs are heard and met.

Resources

For professionals

Social Care Institute for Excellence (2009) *SCIE Guide 30: Think Child, Think Parent, Think Family: A Guide to Parental Mental Health and Child Welfare*. SCIE (www.scie.org.uk/publications/guides/guide30/index.asp).

Cooklin, A. (2006) *Being Seen and Heard: The Needs of Children of Parents with Mental Illness (DVD)*. Royal College of Psychiatrists: a film and training pack designed for use by staff involved in the care of parents with mental illness and their children.

Cooke, E. (2008) *Positive Parenting: Supporting Parents with Learning Disabilities* (CD/MP3): this CD looks at the skills, approaches and research information needed to support families where a parent has intellectual disability.

Parental Mental Health – Keeping the Family in Mind: a continuing professional development (CPD) module from the Royal College of Psychiatrists (http://www.psychiatrycpd.co.uk/learningmodules/modulesinprogressandnext.aspx).

Parental Mental Health and Child Welfare Network (www.pmhcwn.org.uk).

Keeping the Family in Mind – resource pack. Barnado's (www.barnardos.org.uk/resources/research_and_publications/books_and_tools_health_and_disability.htm).

Social Care Institute for Excellence briefings, e.g. 6, 11, 14, 23, 24 (www.scie.org.uk/publications/briefings/index.asp).

Gutman, L. M., Brown, J. & Akerman, R. (2009) *Nurturing Parenting Capacity: The Early Years*. Centre for Research on the Wider Benefits of Learning, Institute of Education, University of London (www.learningbenefits.net/Publications/ResReps/ResRep30.pdf).

The Fatherhood Institute (www.fatherhoodinstitute.org).

For parents

Crysis: support for families with excessively crying, sleepless or demanding babies
BM Cry-sis
London WC1N 3XX
Helpline: 08451 228 669
Website: www.cry-sis.org.uk

Family Action: support network and drop-in centre for vulnerable families with young children or new babies. Offers a process of personal growth through counselling, group therapy and training
Family Action Central Office
501–505 Kingsland Road
London E8 4AU
Tel: 020 7254 6251

Family Action Northern Office
184 Lightbowne Road
Moston
Manchester M40 5EE
Tel: 0161 684 2180
Website: www.family-action.org.uk

Parentline Plus: confidential helpline for parents via their website and eight local offices
Parentline Plus
CAN Mezzanine
49–51 East Road
London N1 6AH
Telephone Helpline: 0800 800 2222
www.parentlineplus.org.uk

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Appendix

Is your adult mental health in-patient service family-friendly?[a]

	Yes	No

- Do you have a separate area where families can visit together with a degree of privacy?
    - ☐ Does it have furniture in it such as comfortable sofas where children can sit next to their parent and/or each other?
    - ☐ Is there easy access from this room to toilets and water, tea, coffee and snack making facilities?
    - ☐ Is it decorated with children/young people in mind (e.g. with colourful posters, curtains)?
- Do you have a secure outdoor area where parent/s and their children can spend time together?
- Do you have play activities available for different age groups of children (e.g. coloured pencils, books, interactive toys and games, craft activities parents and children can do together)?
- Can children easily telephone their parents and can the parent speak to them by telephone with some privacy?
- Is there a baby changing facility?
- Is there a secure children's play area/playground?
    - ☐ Does it have play equipment in it?
- Do you have age appropriate information/booklets/videos about mental illness available for parents to share with their children?
- Do you provide opportunities for children/young people to talk with staff/have their questions answered (given parental permission to do so)?
- Do staff make children feel welcome when they visit the facility? (e.g. Do they address the children directly rather than simply speaking with the accompanying adult/s?)
- Do you encourage parents to talk about their children?
- Do you encourage parents to have their children's photos by their beds?
- Can babies and/or toddlers 'room-in' with their mothers if their mothers are well enough?
- Do staff routinely ask clients/patients if they are a parent and/or if they are pregnant?
- Are families included in the discharge planning process?
- Are staff aware of local services to which family members may be referred for support (e.g. carers groups, respite services)?

a. Developed from information provided by parents with a mental illness, their partners, support people and children during Children of Parents with Mental Illness (COPMI) consultations in 2002 and with input from service providers. Australian Infant, Child, Adolescent and Family Mental Health Association (2004).

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