

Patients as parents

Addressing the needs, including the safety,
of children whose parents have mental
illness

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The Working Party

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 ill health.

This was a response to increasing recognition of the effects on all family members when someone has a mental illness, as well as a wish for the College to assist in raising awareness and promoting good practice nationally. Care in the community has meant that an increasing number of adults with psychiatric disorder are treated while living with their families, including children. The possible impact of this on the affected adult who has parenting responsibilities as well as on other family members, including dependent children, has rightly raised concern in several areas, including the Royal College of Psychiatrists.

The intention was to provide a brief and practical summary of key issues. This report is not, therefore, an exhaustive review of the interaction between parental psychiatric disorder and child health. Rather, it is about how psychiatrists can help in a situation where people with a psychiatric disorder or who abuse drugs or alcohol also have child care responsibilities or contact with dependent children.

The emphasis is on roles and responsibilities for psychiatrists across all faculties and the need for closer, more effective collaboration with other services and agencies. In particular, psychiatrists who see children and those who see adult patients need to be aware of the issues for at least three reasons:

- 1 For most adults, being a parent of a child is a satisfying but challenging role. It is a responsibility that virtually everyone takes seriously. No one wants to be a bad parent but, for various reasons which are usually beyond their control, some parents with a psychiatric disorder are unable to be the parents they would hope to be. This may put children at risk or in danger of abuse.
- 2 Psychiatric disorder in an adult who is a parent is associated with an increased risk of psychiatric disorder in her or his child. These links are explored briefly later.
- 3 The presence of chronic ill health (including mental disorder) in children is associated with significant stress in parents, as well as the onset or exacerbation of mental health problems.

Psychiatrists can act positively regarding these issues. They can:

- help their patients who are parents to meet the needs of their children and ensure their safety
- help to ensure that suffering in a child or parent does not go undetected or untreated by being aware that psychiatric disorder in parents and children occurs more often than by chance and that there are important bi-directional influences and interactions

- promote good practice by helping to ameliorate the adverse consequences of psychiatric disorder for both parents and children and facilitate earlier intervention and promotion of mental health for all family members.

This report promotes an ecological approach in which mental illness is firmly embedded within a family and social context. Recognition of workload demands, resource constraints and national priorities meant that members of the working party were mindful of the need to achieve a balance between excessive demands on services while ensuring that the needs of this neglected group of families were addressed. Nevertheless, there are both training and resource implications arising out of this report's recommendations, which should be considered within the *National Service Framework for the Mental Health of Working Age Adults* (Department of Health, 1999) and the forthcoming *Children's National Service Framework*.

While this document provides a summary of basic principles for good practice which cut across specific adult diagnostic categories, it is important to emphasise that:

- comorbid conditions (for example, substance misuse – alcohol and/or drugs – together with psychiatric disorder and/or personality disorder) can dramatically increase the risks to children's well-being and safety
- patterns of coercive interaction between mothers with eating disorders and their children, particularly around mealtimes, are being increasingly well described
- the prevalence of maternal depression and anxiety in primary care settings requires much greater collaboration with specialist services
- the perinatal period provides good opportunities for targeted screening and earlier intervention which should, where relevant, continue beyond the first year of the mother-child relationship via closer links with community mental health and primary care services (Oates, 2000)
- adults with mental illness and learning disability who have parental responsibilities are likely to need specific support to ensure that they are able to meet their children's needs and ensure their safety.

A number of UK texts which provide more detailed and comprehensive coverage of the issues are included after the references.

Membership of the Working Party

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Introduction

The scale of the problem

The link between mental illness in parents and a range of adverse outcomes for their children is well-established (Rutter, 1966; Watt *et al*, 1984; Derrin, 1986; West & Prinz, 1987; Downey & Coyne, 1990; Gopfert *et al*, 1996; Cleaver *et al*, 1999). It is less clear what proportion of adults experiencing mental ill health are parents and the nature and extent of (associated) emotional and behavioural problems in the children concerned (Reder *et al*, 2000).

Epidemiological and case register evidence suggests that this is a substantial public health issue with implications for all mental health services including earlier intervention, health promotion and more effective cross-service and inter-agency collaboration. For example, a survey by the Office for National Statistics (Meltzer *et al*, 2000) demonstrated that children with parents who screened positive on the General Health Questionnaire (GHQ-12) were three times more likely to have a mental disorder than those whose parents had sub-threshold scores. The proportion of children with mental disorders rose steadily with increases in parental GHQ score. The Nottingham psychiatric case register reveals that 10% of all new female referrals aged 15–60 have a child under the age of 1 year and 25% have a child who is not yet 5 years old (Oates, 1997). The *National Household Survey of Psychiatric Morbidity in Great Britain* (Meltzer *et al*, 1995) indicated that the prevalence of any neurotic disorder (especially depression, mixed anxiety–depression and alcoholism) was highest among lone parents.

Various smaller-scale surveys and audits suggest that at least 20%, probably one-third and in some cases up to 50% of adults known to mental health services have children, but that much less is known about the extent and nature of these children's needs, including their safety and protection (Falkov, 1998). Between one-third and two-thirds of these children will experience difficulties, dysfunction or disorder, depending on sampling and assessment criteria. Around one-third of the parents of children who are referred to a child and adolescent mental health service will themselves have a psychiatric disorder (Dover *et al*, 1994).

Although the evidence for this association is compelling, there is much that remains to be elucidated regarding the mechanisms involved. Further development of services is required to recognise and address the mental health needs of all family members (Kaplan, 1983; Blanch *et al*, 1994; Hatfield *et al*, 1997; Hetherington, 2000; Kearney *et al*, 2000; Reder *et al*, 2000).

Association between psychiatric disorder in parents and mental health problems in their children

At least three pathways are implicated:

- psychiatric disorder in a parent may cause disorder in one or more of their children
- psychiatric disorder in the child may cause disorder in the parent
- psychiatric and other common factors may underlie the presence or emergence of disorder in both parent and child.

These problems may coexist and there is a variety of highly significant contextual, biological, family and social factors that can precipitate, maintain and/or exacerbate psychiatric disorder. The mechanisms involved in the emergence of disorders and problems in parents and children will include some or all of the following: genetic factors; the quality of the child's early attachments, rearing environment and parenting; life events; family discord; the nature of the psychiatric disorder and its associated manifestations; and social and economic factors.

A continuum in the quality of child–parent–professional interactions

The quality of parent–child relationships varies widely when one or both of a child's parents experiences mental ill health. Many parents cope exceptionally well despite the presence of significant mental health problems and some children show few, if any, adverse effects (Anthony & Cohler, 1987; Cox *et al*, 1987; Rolf *et al*, 1990). However, the presence of a mental illness in a parent can adversely affect the way in which that parent accomplishes the tasks and responsibilities of parenthood and, similarly, the stresses of parenthood can precipitate or exacerbate mental ill health. Furthermore, children, especially those with chronic physical/developmental or emotional disorders, can precipitate or exacerbate parental mental illness.

Although the majority of parents with mental illness do not abuse their children (and the majority of adults who abuse children are not mentally ill), it is important that there is a routine consideration of the needs of all children, including their safety, and the capacity of their parents to meet those needs. Individual risk factors and stressors tend to be insufficient as sole causes of serious parental inability to meet children's needs. It is the combination of personality factors, coping skills, social supports and factors within the child as well as the presence of mental illness in a parent, that cumulatively determine whether maltreatment occurs (Falkov, 1997; Cleaver *et al*, 1999).

Although maltreatment of a child is not an inevitable accompaniment to parental mental illness, there is, nevertheless, evidence that some parents with mental illness are unable to meet the needs of their children and there is, therefore, a greater risk of the children being removed from their care (Oliver, 1985; Isaac *et*

al, 1986; Grunbaum & Gammeltoft, 1993; Sheppard, 1997). This group constitutes a small but significant number of families in which the presence of a mental illness, in conjunction with other risks and stressors, serves to outweigh the capacities of parents to cope and social supports, thereby preventing parents from meeting their children's needs and ensuring their safety.

In extreme cases, fatal abuse and neglect of children by their parent(s) can occur (D'Orban, 1979; Woodley, 1995; Boyd, 1996; Falkov, 1996). While the number of these tragedies is small, there is an important link between fatal child maltreatment and parental psychiatric disorder. However, although a child's death can highlight poor practice, it is debatable how many fatalities of individual children can be prevented. As with adult homicide enquiries, the importance of 'lesson learning' lies less in the prevention of rare but tragic and sensationalised individual deaths and more in the positive impact on procedures and practices (Taylor & Gunn, 1999). Improving awareness, knowledge and skills can help the much larger group of children who are abused but not killed, and who constitute the 'at risk' population from which many child fatalities arise. Nevertheless, given that psychiatrists will, at times, deal with individuals and their families who present with complex and challenging problems, the possibility of extreme outcomes for children must always be borne in mind. Knowing which patients are parents is therefore fundamental.

The family

Social inclusion

The links between poverty, mental ill health, discrimination and social exclusion are compelling (Slade *et al*, 1995; Brown & Harris, 1978; Bifulco & Moran, 1998; Meltzer *et al*, 1995, 2000) and any attempt to improve the life chances for patients who are parents and for their children must be based on a good understanding of child and parent within the family context. This includes parents or caregivers and the wider family, as well as neighbourhood, community and cultural influences.

There are about 11 million children in England, well over 3 million of whom are living in poverty (Utting, 1995):

‘Living on a low income in a rundown neighbourhood does not make it impossible to be the affectionate, authoritative parent of healthy, sociable children. But it does, undeniably, make it more difficult’ (Utting, 1995: p. 40).

The combination of ethnic minority status and female gender, coupled with parental responsibilities, enhances the risks for the onset and/or exacerbation of mental illness which, in turn, compounds the experience of discrimination and social exclusion for all family members.

Promoting positive mental health across the life span and between generations will require broader approaches to assessment and treatment, incorporation of a perspective on prevention into daily practice and good collaboration between all mental health services and a wide range of other agencies (Oliver, 1985; Department of Health, 1999; Department of Health *et al*, 2000; Royal College of Psychiatrists, 2002).

The family model – a systemic conceptual framework

An integrated, ecological model of influences and interactions between mental illness, parenting, family relationships, child development and environmental risk factors and protectors was developed in *Crossing Bridges* – training materials, sponsored by the Department of Health, on the impact of parental mental illness on children (Falkov, 1998). This model emphasises the relevance of a systems approach to assessment and intervention. Each component affects, and is affected by, every other component. Such an approach requires consideration of:

- the tasks and responsibilities of parenthood and an individual’s coping resources (including family of origin and childhood experiences as well as susceptibility to difficulties in the transition to parenthood)
- unique aspects of the relationship between a parent and child
- the nature of the mental illness experienced by the adult

- the child's own needs according to his or her developmental stage and ability, as well as temperament, physical and mental/emotional health
- the family, social and environmental context in which these interactions take place and the impact of this context on those interactions.

How these core components interact and influence each other determines the quality of an individual's adjustment within his or her family, as well as the adequacy of the whole family's adaptation to living with a member who has a mental illness.

Parenting

Recognisable patterns and styles

In the struggle to attend to their own as well as their children's needs, parents can react in a variety of ways. These parent-child relationships may show certain observable qualities/styles in their interactions. These may be styles that pre-date the parent's illness, or reflect changes subsequent to the onset of mental illness. Most of these patterns are not unique to parents who have a mental illness and these features, such as less emotional responsiveness, increased irritability or lack of decisiveness, are themselves not specific to any particular mental illness. Therefore, some parents may:

- be unable to ensure the basic (physical) care and safety of children
- readily attend to a child's physical needs (such as maintaining a 'spotless home environment') but struggle with the provision of warmth and praise
- not appreciate their child as an autonomous individual with his or her own separate, age-dependent needs
- expect their child to behave as an adult and to undertake a variety of adult tasks and responsibilities (for example, role reversal with developmentally inappropriate expectations)
- be unable to play with and provide adequate stimulation for their child
- struggle to provide appropriate guidance, boundaries and necessary stability for their children
- become frustrated when efforts to discipline their children are unsuccessful (escalating cycles of coercive exchange have been well described; criticism and hostile responses may occur and physical punishments ensue, which may in turn result in physical harm)
- be unaware of the nature and extent of their children's emotional needs.

Family of origin experiences and the transition to parenthood

Many parents with mental illness will have experienced a variety of adverse and traumatic circumstances in childhood. These are known to increase the likelihood of such a person experiencing mental illness in adulthood as well as finding the transition to parenthood difficult. Such experiences include:

- childhood sexual abuse and the onset of depression in adulthood (Bifulco *et al*, 1991)
- disturbed early attachments and later difficulties in forming stable relationships, the most extreme being personality disorder (Bowlby, 1969; Paris & Frank, 1989; Fonagy *et al*, 1991).

Mental illness in adulthood is therefore one of a number of long-term outcomes associated with trauma and adversity in childhood. The fact that many childhood-onset psychiatric conditions show considerable continuity into adulthood lends additional weight to the preventive opportunities of earlier support and intervention for families in which parents and/or carers with mental illness live with dependent children (Quinton *et al*, 1990).

Quality of current family relationships and child–parent interactions

Patterns in child–parent relationships can be conceptualised along quantitative (how much) and qualitative (how appropriate) dimensions (Falkov, 1998). The quantitative dimension emphasises that normally occurring parental behaviour may be inappropriate; for example, if there is excessive interaction (too severe or frequent) or insufficient involvement (physical or emotional neglect). Excessive interaction may be positive (overinvolvement and overprotection) or negative (critical, hostile, lacking empathy in interactions or too-frequent discipline). The qualitative dimension draws attention to interaction which is inappropriate regardless of its frequency (for example, involvement of children in parental delusions).

Difficulties are more likely when the parent–child relationship is characterised by more extreme or inappropriate patterns of interaction. It is when these (more extreme) patterns occur that children’s needs, including the need for protection, are least likely to be met. These will also be the situations that generate most uncertainty for practitioners when deciding about intervention and balancing children’s needs for safety with the needs and rights of their parents who have mental illness.

Effects and outcomes for children and parents must always be considered within their broader family, social and cultural context and, more specifically, according to the child’s age and the particular constellation of stressors affecting, and resources available to, individual family members. For example, children are much more likely to develop emotional and behavioural problems and parents more likely to struggle to meet their needs when mental illness occurs together with parental hostility, discord and violence, or the combination of mental illness and substance misuse come together with adverse social circumstances (Emery *et al*, 1982; Stoneman *et al*, 1989).

Practice guidelines

Some factors associated with a greater likelihood of parents struggling to meet their children’s needs and ensure their safety include:

- the impact of the illness on the adult (being a parent *and* having a mental illness), especially chronic severe illness with comorbid disorders, such as episodes of mental illness complicated by substance misuse or the presence of a personality disorder

- poor compliance with treatment, problematic relationships with professionals and diagnostic uncertainty
- parental personality factors (pre-existing and/or exacerbated by the illness, e.g. irritability, hostility, inability to cope, self-preoccupation, etc.)
- a history of overdose and self-harm (prior to and especially since having children), especially when there has been more than one such action
- a parent's own experience of severe childhood trauma and adversity, including discontinuities in carers and experience of abuse and being 'looked after' (in care)
- a history of violence (as a perpetrator or a victim) with unstable, discordant parental relationships
- environmental stressors outweighing support and protective factors – for example, poor-quality support and social isolation in association with multiple adversities such as discrimination (on grounds of gender, ethnic minority status and mental illness), material deprivation and poverty
- parents with a learning disability.

Child maltreatment and parental mental illness

Types of maltreatment

Most studies have focused on physical abuse and neglect but, increasingly, subtypes of abuse are being delineated. A few studies have described specific associations between parental disorder and child maltreatment, for example, between parental alcoholism and child abuse and neglect; depression or anxiety and child neglect; cocaine use and child sexual abuse; and alcohol dependence and physical maltreatment of children (Famularo *et al*, 1992; Egami *et al*, 1996).

More information is available in the related document, *Child Abuse and Neglect and Mental Health Services*, in preparation for the College (further details available from Andrea Woolf (Committee Manager, Policy) – awoolf@rcpsych.ac.uk). This document emphasises the need for all psychiatrists to be constantly aware of the possibility of abuse or neglect in cases where children are involved; the importance of collaborative, multi-disciplinary and inter-agency approaches; and that the general duty to patients, including that of confidentiality, is overridden by the duty to protect children. Details are given of the responsibilities and contributions of psychiatrists and their multi-disciplinary teams in relation to all aspects of child abuse and neglect. The document defines the various forms of maltreatment in the context of significant harm and summarises key documents and frameworks for practice. It includes advice on practice issues such as domestic violence, confidentiality and the effects of abuse on children, and how to recognise and respond to indicators of abuse.

Emotional abuse and neglect

Although all forms of abuse can occur in the children of parents with mental illness, the issue of emotional maltreatment is highlighted here because this remains the least studied but perhaps most relevant and potentially problematic type of maltreatment. In many cases, the neglect of children's emotional needs is unintentional. A parent or carer may be doing her or his best while also struggling with serious mental illness. Nevertheless, the damaging effect on children still occurs. Negative outcomes for children include low self-esteem, educational underachievement, poor-quality relationships and emotional and behavioural problems. Many of these negative effects may well persist into adulthood with lifelong consequences.

The document *Working Together to Safeguard Children* (Department of Health *et al*, 1999) defines emotional abuse as:

'the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another

person. It may feature age or developmentally inappropriate expectations being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill treatment of a child, though it may occur alone'.

Emotional maltreatment does not present in the readily observable way that physical abuse and neglect are manifest but, if actively sought, is certainly evident in families whose children are known to child protection services. A study by Glaser & Prior (1997) of children registered for emotional abuse found that 61% of families or children had been referred to child mental health services and 43% were either known to, or were later referred to, adult mental health services.

Furthermore, high rates of undiagnosed psychiatric disorder and low referral rates to mental health services have been found among children known to social services, especially child protection services (Zuravin, 1988). It is also likely that undiagnosed or untreated psychiatric disorder contributes both to the severity of the maltreatment and to parental resistance to the usual regimen of agency support.

Practice guidelines

Child care professionals should be consulted if there are any concerns about child safety and welfare and where there is evidence of:

- persistent negative views expressed about a child, including rejection
- ongoing emotional unavailability, unresponsiveness and neglect, including lack of praise and encouragement, lack of comfort and love and lack of age-appropriate stimulation
- an inability to recognise a child's needs and to maintain appropriate parent-child boundaries
- ongoing use of a child to meet a parent's own needs
- distorted, confusing or misleading communications with a child including involvement of the child in the parent's symptoms or abnormal thinking, including, for example, delusions targeting the child, incorporation of the child into a parent's obsessional cleaning/contamination rituals, or keeping a child at home because of excessive parental anxiety or agoraphobia
- ongoing hostility, irritability and criticism of the child
- inconsistent and/or inappropriate expectations of the child.

Parental psychiatric diagnosis

Depression, substance dependence and personality disorders occurring together in various combinations and at various points in time are the most frequently reported psychiatric conditions affecting parents who abuse their children (Famularo *et al*, 1986; Zuravin, 1988; Falkov, 1997; Rydelius, 1997; Hogan, 1998; Murphy *et al*, 1991).

Parents with a diagnosis of dissociative personality disorder are more likely to exhibit hostile and irritable behaviour towards their children than parents with

any other disorder. Given the long-standing difficulties in making and sustaining relationships, such parents can find it particularly difficult to relate to a child in an age-appropriate way. This may be because of difficulty in distinguishing their own needs from those of their child or a lack of understanding about differences in children's needs compared with those of adults (Bools *et al*, 1994; Feldman *et al*, 1995). Impulsivity may lead to ill-considered physical discipline (smacking/assault) rather than verbal negotiation. High rates of comorbid Axis I disorders add to parental needs, difficulties in engagement with services and poorer prognosis regarding mental health and capacity to meet children's needs.

Although psychotic illnesses are less common than depression or anxiety disorders and substance misuse, they afflict a substantial proportion of parents who kill their children (D'Orban, 1979; Falkov, 1996).

Practice guidelines

Children who adapt well to a parent's mental illness will typically exhibit at least some of the following:

- older age at the time of the onset of their parent's illness (because of reduced opportunities for exposure to difficulties and development of a greater range of potential coping resources)
- being more sociable and able to form positive relationships (having an easier temperament)
- greater intelligence
- a parent who has discrete episodes of mental illness with a good return of skills and abilities between episodes
- alternative support from adults with whom the child has a positive, trusting relationship
- success outside of the home (e.g. at school, in sport).

Special circumstances

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, 1997). Attempted suicide is also an important risk factor for those who go on to successfully commit 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 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
- 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; 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
- the support required for a parent to meet the needs of the children, including their safety; questioning about homicidal as well as suicidal thoughts is necessary for parents with responsibility for young children (West, 1965); alerting the children's health visitor can assist in developing appropriate plans to support children and their parents
- the mental health of parents or carers when assessing a child or young person following an episode of self-harm.

Parental hospitalisation: promoting parent–child relationships during separation

Paragraph 26.3 of the revised Mental Health Act 1983 Code of Practice states that:

'Hospitals should have written policies on the arrangements about the visiting of patients by children, which should be drawn up in consultation with local social services. A visit by a child should only take place following a decision that such a visit would be in the child's best interests. Decisions to allow such visits should be regularly reviewed'.

The crisis of parental admission will have an impact on all family members. Improved coordination between child care provision and mental health services can reduce the trauma of separation (Ekdahl *et al*, 1962). Admission provides an opportunity to review family circumstances and to consider the needs of the children and the 'patient as parent' (Oppenheimer, 1981; Shachnow, 1987; Castleberry, 1988).

Such approaches should be part of routine practice but it is important to note that parents will vary in the extent to which they welcome or block discussion about their children (Wang & Goldschmidt, 1994; Stormont *et al*, 1997). While remaining aware of and sensitive to the severity of the parent's mental state, staff should not accept parental refusal to discuss aspects of parenthood and child welfare at face value. Instead, they should endeavour to explore sensitively the reasons underlying the reluctance or resistance. If this is unsuccessful, the parent who is ill should still be kept fully informed about what is happening to their children. If, despite improvements in a parent's mental state, no discussion is possible, staff should consult with colleagues in social and child and adolescent mental health services.

The pre-discharge planning meeting is an important opportunity for all staff to exchange information and to ensure that a clear and comprehensive plan is formulated which meets the needs of both parents and their children and in which the roles and responsibilities of all team members are clearly understood and supported.

Care Programme Approach meetings and child protection case conferences are further opportunities for exchange of information, planning and implementing programmes of support and intervention which address the diverse needs of parents and their children, including the children's safety.

Practice guidelines

To meet children's needs when a parent is admitted to hospital, staff looking after a parent and those caring for the children should:

- be open and honest – children will have an awareness of changes especially the absence of their parent/carer; they may have observed all that went on or overheard conversations while in another room or when hurriedly taken to neighbours, friends or family; pretending nothing has happened may be particularly confusing – they need to be kept informed
- provide explanation – a truthful statement or description appropriate to the child's age, but without minute detail is sufficient; use of language the child can understand is important; the parent who is ill could be described as sad, confused, upset, needing a rest, stressed, mixed-up inside, etc.; describing what happens while the parent is in hospital – talking, being looked after, medication, etc. – is also helpful
- emphasise that the child is *not* to blame – the child should be told this explicitly

- help to minimise disruption and maintain daily routines for children – ‘special time’ (extra attention) is helpful
- support opportunities for contact (e.g. children visiting parents in hospital), according to parental well-being – in an appropriate and safe setting this can reduce children’s distress as well as parental anxiety; other ways of maintaining contact include the use of phone calls, letters and pictures where appropriate
- recognise changes in behaviour patterns and discuss these with relevant professionals in children’s services – children will worry, have fears/ anxieties and may be confused; this may manifest in a wide range of observable behaviours and hidden distress, such as disrupted sleep or routines, uncharacteristic quietness/inaccessibility, poor appetite, clinginess, bed-wetting, demanding or disruptive behaviour, anger, irritability, tearfulness, stomach aches, nightmares and refusal to attend school
- alert school and teachers that the child may need extra support, attention and praise
- consider whether children’s social services should be involved to assist with family support if the children are thought to be ‘children in need’, or to undertake relevant assessments if a parent appears to be struggling to meet children’s needs including ensuring their safety.

Practical approaches to supporting patients as parents and their children

All psychiatrists and members of multi-disciplinary teams should:

- (a) Be familiar with legal and policy frameworks.

In England and Wales

These include the Children Act 1989; *Working Together to Safeguard Children*; the Mental Health Act 1983; the relevant National Service Framework (NSF) (there are different NSFs in England and Wales); *Framework for the Assessment of Children in Need and their Families* (there are similar versions in England and Wales).

For example:

- (i) Paragraph 3.39 in *Working Together to Safeguard Children*

(Department of Health *et al*, 1999) states that: 'All professionals working in mental health services in the statutory, voluntary and independent sectors, should bear in mind the welfare of children, irrespective of whether they are primarily working with adults or with children and young people ...'.

Paragraph 3.46 states: 'Close collaboration and liaison between the adult mental health services and children's welfare services are essential in the interests of children. This will require the sharing of information where this is necessary to safeguard a child from significant harm. Child and adolescent mental health services can help in facilitating communication between adult mental health and children's welfare services, especially when there are concerns about responding appropriately to the duty of confidentiality and the protection of children'.

- (ii) The English *National Service Framework for Mental Health*

(Department of Health, 1999) provides an approach that can assist services in making better provision for patients who are parents. For example, it provides all mental health practitioners with opportunities to:

- promote mental health and engage in earlier intervention or prevention (Standard 1) – knowing which patients are parents will enable appropriate steps to be taken for the patient as parent and for her or his children
- improve links between the specialist and primary care services to which the bulk of people who have maternal depression or anxiety will present and where closer collaboration with the range of community-based children's services can occur

- support carers (Standard 6) – this should be interpreted as applicable to all carers: those who care for individuals experiencing mental illness; young carers who look after a parent or carer with mental illness; and those who are themselves experiencing mental ill health and who also care for dependent children
- The document *Adult Mental Health Services: A National Service Framework for Wales* (Welsh Assembly Government, 2002), published in May 2002, is a different document from that issued in England. It has been developed to sit alongside the strategy for mental health services published by the National Assembly for Wales (now the Welsh Assembly Government) in September 2001. Key Action 1 (within the actions related to Standard 1) relates to promoting good parenting; the aim of Standard 4 contains requirements for people caring for others, including their children; Key Action 25 (within the actions related to Standard 6) includes a requirement for access to mother-and-baby units; and Key Action 39 (within the actions related to Standard 7) deals specifically with the needs of young people in all mental health situations (i.e. whether they are patients, carers or have parents with mental health problems).
- *Framework for Assessment of Children in Need and their Families* (Department of Health *et al*, 2000) has been issued in England and there is a similar document in Wales (National Assembly for Wales & Home Office, 2001). Both provide an approach to assisting social workers in child care services to coordinate systematic assessments of the needs of the child and parental capacity to meet those needs. Other services, including the health services for children and adults, may be required to make inputs to the assessment process. These frameworks recognise the role of social adversity and mental illness among a number of influences which can adversely affect parenting. They emphasise the importance of collaboration between services and agencies at all stages of assessment and in intervention. These frameworks and experience in using them are likely to assist the responsible authorities to identify gaps in provision locally and they should also enable local people to establish better links between the child care and mental health services.

In Scotland

- (i) The legal framework which covers these issues is the *Children (Scotland) Act 1995*. The mechanism for ensuring children's welfare through legal and compulsory means is the Children's Hearing 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.

- (ii) The *Framework for Mental Health Services in Scotland* (Scottish Office, 1997) is the guidance for delivery of mental health services and this includes a small section on child and adolescent mental health. The Mental Health and Well Being Support Group, which oversees implementation, does not, however, include representation from child and adolescent mental health services and is not always aware of key issues affecting children's services.
- (iii) The **Mental Welfare Commission** has responsibility for the welfare of children and adolescents in psychiatric hospitals.

In Ireland

- (i) The *Child Care Act 1991* defines a person up to the age of 18 years as being a child. It specifically states that every health board shall 'promote the welfare of children in its area who are not receiving adequate care and protection'. It details the legislative framework for accepting a child into the care of the health boards when there is reason to suspect he or she is the subject of abuse or neglect, or is homeless. It gives in detail the procedures for obtaining supervision and care orders and regulations for the provision of children's residential services and pre-school services.
 - (ii) *Children First: National Guidelines for the Protection and Welfare of Children* (Department of Health and Children, 1999) – personnel should be aware of both the *Children First* guidelines and local health board implementation guidelines which will be based on the national document. This details child protection principles, definitions of abuse and neglect, and procedures for reporting. All personnel should be familiar with the local procedures and designated officers in their health board area.
- (b) Be aware that **young carers** can receive help from both local authorities and health services. They are entitled to an assessment of their ability to care under section 1(1) of the *Carers (Recognition and Services) Act 1995* and the local authority must take that assessment into account in deciding what community care services to provide for the parent. In addition, consideration must be given to whether a young carer is a 'child in need'

under the *Children Act 1989*. The central issue is whether a child's welfare or development might suffer if support is not provided to the child or to his or her family.

- (c) Know the names and contact details of the **named doctor and nurse** who should be contacted for advice about child protection.
- (d) Know about local **child protection procedures**, the area child protection committee (ACPC) and contact details of local authority social services child protection services.
- (e) Find out about the availability of local services to ensure there is a range of systems to **support families** – for adults with mental health problems who have responsibilities for children; for parents with mental health problems; and for children, including young carers.
- (f) Develop **links with staff** in local services by creating and supporting opportunities for joint working and acquiring a shared understanding of each others' practice.
- (g) Develop **shared protocols** to support systematic approaches to the assessment of need in children and their parents. This must include initiatives across the various College Faculties and Sections.
- (h) Talk to each other (across College Faculties and Sections as well as across agencies) and debate competing **thresholds and eligibility criteria** involving mental illness, child protection and children 'in need' and how these barriers can be overcome.
- (i) Use *Crossing Bridges* (Falkov, 1998) to support **inter-agency training**.
- (j) Recognise that, while mental ill health does not imply automatic inability for a parent to meet a child's needs, some parents who are mentally ill will be unable to ensure the well-being and safety of their children.
- (k) Be aware of the importance of promoting the development of **good-quality attachment** between children and their parents or caregivers and of the adverse, lifelong implications for children when these early attachments are disrupted.
- (l) Remind all parents taking **medication** about the need to store potentially lethal substances safely and securely.
- (m) Be aware of the following questions which can assist routine/systematic assessment:
 - (i) Is the patient a parent? Does the patient have contact with children?
 - (ii) How many? How old? Gender? Names?
 - (iii) Where are the children? Who looks after them? Who is responsible for them (basic safety issues)?
 - (iv) Who is living in the household?
 - (v) How are the children? Does anyone have concerns (e.g. parent, partner, health visitor, general practitioner, school)? (Parental consent is usually required for this information.)
 - (vi) Are there other services or agencies involved?
 - (vii) Does the disorder influence or impair the patient's ability to look

- after the child(ren)? In what way?
- (viii) Who assists with child care (e.g. if the parent is unwell)?
 - (ix) Are there practical arrangements or sources of support, which could assist the patient and the children (e.g. extended family, grandparents)?
 - (x) Has anyone provided information and explanations for the child?
 - (xi) Is there a need to liaise with other professionals?
 - (xii) Is a child in danger or at risk of being harmed (physically and/or psychologically)?
 - (xiii) Is there a need to contact the child protection services?

Psychiatrists working with adult patients should:

- (a) Know **which patient are parents**.
- (b) **Talk with patients about their role as parents**, associated stressors, ways in which psychiatric symptoms and parenting responsibilities affect each other and how the children are getting on, including any concerns about their development, well-being or safety. This does not mean undertaking a formal assessment of parenting, which is rightly the domain of staff in various children's services.
- (c) **Observe interactions between parents and their children**, when the opportunity arises (e.g. in in-patient or day-patient settings) and, if the children are old enough, initiate conversation with them, thus recognising them as a significant part of the family. This is not being suggested as a formal assessment of the child or children's mental health needs.
- (d) **Include partners in any assessment** of the circumstances of a parent with mental illness, where appropriate. A partner is important as a potential source of:
 - (i) alternative care and support;
 - (ii) additional burden because they may also show evidence of mental illness;
 - (iii) direct harm for the children if they have been maltreated by the partner and mental illness prevents a parent from protecting the children adequately;
 - (iv) indirect harm for the children, for example if domestic violence is witnessed – a woman who is unable to adequately protect herself will struggle to ensure her children are adequately protected.
- (e) Recognise that **treating symptoms in isolation is not sufficient**. Difficulties in parent-child relationships have been shown to persist well beyond the period of a parent's mental illness. Addressing the social context of parents and children is essential. In particular, practitioners should *not* assume that resolution of the episode of illness would also mean an automatic return of good-quality and appropriate parenting. In situations where there are serious concerns about parental inability, when

unwell, to meet a child's needs, professionals will need to reassess the adequacy of parenting and the parent-child relationship once psychiatric symptoms have resolved. Good links are therefore essential between children's and adult services, across agencies.

- (f) Be aware of the dilemmas that may arise in terms of the time required for a parent to recover and the continuing uncertainty this generates for children, carers and professionals. **Ways need to be found to support children while parents are being rehabilitated.** However, there will be situations in which the likely duration of parental rehabilitation will pose unacceptable delays and risks to children's development. Alternative care arrangements will be necessary and, in conjunction with the local authority, permanent fostering and adoption will need to be considered.
- (g) Ensure that better links are developed with staff in various sectors of local children's services – primary care, social care and the voluntary sector. This can be done by supporting opportunities for joint working and developing a shared understanding of each other's practice. **Health visitors** are an important source of information and support for all children under 5 years of age, and for their parents. There should be routine liaison with health visitors who should be involved in care plans to ensure that the needs of the parent and the child are integrated. **School nurses** are a potentially useful source of information and support for older (school-aged) children and young people.
- (h) Ensure that particular attention is paid to concerns about **personality disorder** including:
 - (i) the presenting problems;
 - (ii) childhood history and experiences, especially of severe illness, abuse or behavioural disturbance;
 - (iii) violent outbursts or episodes and their precipitating factors;
 - (iv) risk-taking behaviour (self-harm, harm to others including children);
 - (v) relationships, their type and stability (parental discord and violence);
 - (vi) mental health of the partner (children living with two parents who have personality problems and/or mental illness);
 - (vii) comorbid physical or mental disorders including substance misuse;
 - (viii) implications for dependent children of an inability to engage with the parent.

Psychiatrists working in substance misuse services should:

- (a) Liaise with colleagues to ensure that comorbid conditions are assertively treated and to ensure good communication and collaborative working.
- (b) Consider making arrangements for consultation with local child and adolescent mental health services to ensure that parenting issues and

- children's mental health and safety needs are considered routinely.
- (c) Know who provides local children's services and where these are available.
 - (d) Ask directly about availability and storage of substances (e.g. methadone) and check that they are stored securely in tamper-proof containers kept beyond the child's reach.
 - (e) Be aware that substance dependence, especially if associated with comorbid conditions, presents serious risks to a parent's capacity to meet children's needs and ensure their safety.

Psychiatrists working in specialist forensic services should:

- (a) Ensure that account is taken of the serious risks posed to children by parents with impulsivity, high levels of aggression and unstable relationships. Exposing children to domestic violence, persistent verbal abuse and lack of warmth is associated with high risks for them developing emotional and behavioural problems.
- (b) Take expressions of homicide-suicide very seriously, especially where the parent has young children and poor social support.
- (c) Incorporate loss and separation issues into therapeutic work with parents.
- (d) Ensure that the wishes for contact with their children by parents who are patients in special hospitals are carefully considered in conjunction with the needs, wishes and safety of children.
- (e) Assist psychiatrists and others working with children and undertaking parenting assessments by providing information about the availability of local services and therapeutic facilities for parents with personality disorder.

Child and adolescent and learning disability psychiatrists should:

- (a) Ensure that the mental health of parents of referred children is considered routinely in assessment and intervention.
- (b) Ensure that appropriate arrangements are made for treatment of a parent's mental ill health.
- (c) Consider the role of the child's disorder in the mental health of the parent.
- (d) Be responsive to calls and referrals from colleagues in adult services. This could include establishing opportunities for collaboration during and beyond a crisis, for example, routine discussion about the needs of patients who are parents, consultation and joint work.
- (e) Be prepared to work flexibly so that assistance can be provided to children and families or to mental health staff during a parent's admission to hospital or through attendance at a parent's Care Programme Approach meeting.
- (f) Be aware that the assessment of parenting in complex cases, where there are concerns about parental capacity to meet a child's needs, is rightly the

domain of the child and adolescent psychiatrist and child and adolescent mental health service, in association with relevant statutory and other children's services. In cases where one or both parents has a learning disability, child and adolescent mental health and learning disability teams may need to work together.

- (g) Be aware that in making referrals to social services, some children's health or development may not be considered as being impaired sufficiently to warrant intervention. However, an assessment of the risk factors and stressors would suggest they are likely to suffer impairments in the future. The interaction of child and parental problems in a child's development and the cumulative effect of such problems over time should be emphasised through joint working. For example, a mother with mild learning disability may not reach the criteria for help from an adult service team and her child's standard of care may not be sufficiently poor to meet criteria for intervention by the children's services. The emphasis must be on the need for earlier, coordinated intervention from all relevant services to reduce the likelihood of the child's current and future development being impaired (Department of Health *et al*, 2000: p. 47, para. 3.58).

Opportunities to improve services

Prevention

Psychiatrists are well placed to initiate and facilitate preventive interventions (Oates, 2000; Royal College of Psychiatrists, 2002). For example:

- systematic identification of the 'hidden' children of patients who are parents will enable earlier referral for support or specialist intervention
- systematic recognition of the mental health needs of parents will assist with earlier treatment which, in turn, can reduce parental burden and promote parenting capacity
- compelling evidence about the role of early adversity (e.g. child maltreatment, discontinuities in care or carers) in later susceptibility to psychiatric disorder and difficulties in the transition to parenthood means that psychiatrists have the opportunity to improve individual functioning and reduce current psychosocial morbidity and psychiatric disorder. This can, in turn, positively influence the quality of life and the proportion of individuals who continue to experience difficulties into adulthood and parenthood.

Working together to promote family relationships and positive contact between children and parents

Psychiatric services should have designated 'child and family' areas in which parents attending for assessment or follow-up clinics may wait to be seen. Wards should have a child-friendly area to facilitate opportunities for parents and children to spend positive time together. Such an area should allow observation of the contact to ensure that children are not exposed to harmful experiences and that, if parents need support or assistance, this can be provided. Judgements will need to be made about the timing of visits in relation to the mental state of the parent, taking into account relevant background information regarding the relationship between parent and child and the levels of concern by staff, key family members and relevant professionals from various children's services.

Child and adolescent psychiatrists and members of child and adolescent mental health teams could assist in the planning of such facilities and with assessments of the appropriateness of visits and contacts which, if successful, would bring important opportunities to enhance family relationships and reduce parents' and children's distress.

Audit

In order to improve risk management and address clinical governance issues, various aspects of services could be audited to ascertain the nature and extent of local need and service provision. For example:

- what proportion of adult patients are parents?
- how many parents of referred children experience mental ill health?
- are there visiting procedures for in-patients who have dependent children?
- how frequently is the named doctor consulted?
- is information provided routinely for children and young people about their parent's condition and treatment?
- are clinic appointments and home visits scheduled at times which do not conflict with child care arrangements?
- do side-effects of medication interfere with parenting tasks?
- is there a prescribing policy for mothers who are pregnant or breastfeeding?

Liaison

Services can be improved by establishing formal and informal arrangements for collaboration between adult mental health and child and adolescent mental health services and across agencies, for example, by using designated sessions to create liaison posts or using reciprocal secondment arrangements.

Education and training

The College should ensure that the issues highlighted in this document are covered in the membership examination and that all trainees have experience in child and adolescent mental health services.

Prior to obtaining the MRCPsych qualification, trainees should have combined academic/clinical training on the link between adult and child and adolescent psychiatric disorder, with particular reference to parenting and family influences on psychiatric disorder. They should acquire skills relevant to the assessment of the impact of adult disorders on children and of disorders in children on parents. This should include family histories and the use of family trees in a routine and systematic manner. They should also acquire skills in communicating with children. Training rotations should include experience in meeting the families of patients in the care of the trainee to assess their needs. All case recording of referrals to general adult, substance misuse, forensic and adult learning disability services should include information about the children and their needs. Trainees should participate in home visits with members of the mental health teams.

At specialist registrar level, trainees should share a joint academic/clinical curriculum which includes the impact of disorders on children and parenting,

information on assessment and intervention and aspects of child development and maltreatment. Skills enhancement should occur through interviews with family members and children. Specialist registrars in child and adolescent psychiatry should have a placement with a community mental health team and specialist registrars in adult psychiatry should have a placement in child and adolescent psychiatry and/or experience in a family therapy centre. Work with the families of patients should be supervised by a suitably qualified and experienced child and adolescent mental health professional.

More specific training could be provided through the use of materials from *Crossing Bridges* (Falkov, 1988) with incentives generated through inclusion in personal development plans for continuing professional development. This should include options and opportunities for consultants.

Joint training initiatives with other medical Royal Colleges (the Royal Colleges of Paediatrics and Child Health, of Nursing and of General Practitioners) and relevant organisations should be organised.

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