

Practice Guidance

Adult Mental Health and Child Protection

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1. Introduction

- 1.1 This guidance will address the issues of inter-agency working in relation to adult mental health and how this can impact on child protection. It is important that everyone has a working understanding of individuals' roles within the whole process.
- 1.2 We all have a responsibility to safeguard the welfare of children and young people. Remember 'Think Parent – Think Child – Think Family'.
- 1.3 National documents and papers were considered and their principles encompassed in our work, especially 'Working Together to Safeguard Children' and 'Crossing Bridges'. (References to all documents mentioned in the text are contained in the Key Texts section at the end of this paper).

Legal and Policy Framework

- 1.4 Children's social care has access to legal advice from their respective legal departments. Children can be protected by the use of the Children Act 1989 or occasionally by the use of Mental Health Act 1983. This would remove the mentally ill adult who poses a risk to the child from the home, rather than removing the child.
- 1.5 Working Together to Safeguard Children (2006) (page 59, 2.92) states that:
Adult mental health services – including those providing general adult and community, forensic, psychotherapy, alcohol and substance misuse and learning disability services – have a responsibility in safeguarding children when they become aware of, or identify, a child at risk of harm. This may be as a result of a service's direct work with those who may be mentally ill, parent, a parent-to-be, or a non-related abuser, or in response to a request for the assessment of an adult perceived to represent a potential or actual risk to a child or young person.

- 1.6 Para 2.93 states: 'To safeguard children of parents, mental health practitioners should routinely record details of patients' responsibilities in relation to children, and consider the support needs of patients and of their children, in all aspects of their work, using the Care Programme Approach (CPA). Mental health practitioners should refer to Royal College of Psychiatrists policy documents, including Patients as Parents and Child Abuse and Neglect: the Role of Mental Health Services.

Para 2.94 states: 'Close collaboration and liaison between adult mental health services and children's social care are essential in the interests of children. This may require sharing information to safeguard children and promote the welfare of children or to protect a child from significant harm. The expertise of substance misuse services and learning disability services may also be required. The assessment of parents with significant learning difficulties, a disability, or sensory and communication difficulties, may require the expertise of a specialist psychiatrist or clinical psychologist from a learning disability service or adult mental health service.

Where Child and Adolescent Mental Health Services are involved in a family and adults are also known to the Adult Mental Health Services, close collaboration should take place between both services.

- 1.7 The National Service Framework for Mental Health (1999) provides a framework, which can assist in 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/prevention (Standard one). Knowing which patients are parents will enable appropriate steps to be taken for the patient as parent and for her/his children
- improve links with Primary Care where the bulk of maternal depression/anxiety will present and where closer collaboration with the range of community-based children's services can occur
- support carers (Standard six). This should be interpreted as applicable to all carers: those who care for individuals experiencing mental illness; young carers who look after a mentally ill parent/carer and those who are themselves experiencing mental ill health and who also care for dependent children

- 1.8 The Framework for Assessment of Need in Children and Families (2000) provides an approach to assist children's social care to undertake systematic assessments of the needs of the child and parental capacity to meet those needs. It recognises the role of social adversity and mental illness as stress which could affect parenting. It emphasises the importance of collaboration between services and agencies at all stages of the assessment and in intervention. It will therefore help to identify gaps in provision and provide opportunities for establishing better links between childcare and mental health services.

2. Principles

- 2.1 The majority of parents who suffer mental ill-health are able to care for and safeguard their child/ren and/or unborn child. Some parents, however, will be unable to meet the needs and ensure the safety of their children.
- 2.2 The welfare of the child must be paramount.
Where professionals suspect a child and/or unborn child has suffered or is at risk of suffering significant harm as the result of commission or omission on the part of the parent/carer, the referral process must be followed. (Refer to Chapter 4 of the procedures)
- 2.3 All professionals should find out about availability of local services to ensure a range of systems to support families. These include:
 - services for adults with mental health problems who have responsibilities for children
 - services for parents with mental health problems and for children, including young carers
 - specific services for black and ethnic minority peoples' mental health
 - services for other culturally diverse groups, people from abroad, and asylum seekers

3. Importance of Inter-Agency Working

- 3.1 Adult mental health professionals and childcare social workers, school nurses, health visitors and midwives and education services and other agencies as appropriate must share information in order to be able to assess risks. **Please refer to Chapter 2: Information Sharing.**
- 3.2 Care Programme Approach (CPA) meetings about mentally ill parents must include consideration of needs and risk factors for the children concerned. In all such cases Children's Social Care must be involved in planning discharge arrangements.
- 3.3 Child Protection Strategy meetings and Child Protection Conferences must include any psychiatrist, community psychiatric nurse, psychologist and adult mental health social worker involved with the parent/carer.
- 3.4 Children's Social Care may be requested to assess whether it is in the best interests of a child to visit a parent or family member in a local mental health unit or special hospital.
Please refer to Protocol for Assessing and Managing Visits by Children to Special Hospitals, Medium Secure Units and other local Psychiatric Hospitals or Dispersed Units .

4. Assessing the impact of parental mental ill-health

- 4.1 When a parent receives mental health services in the community or is hospitalised, it is crucial to identify which patients are parents and include the following as part of the assessment:
- is the patient a parent?
 - is the patient the main carer?
 - does the patient have contact with children?
 - how many? how old? gender? names?
 - where are the children? who looks after them? who is responsible for them? (basic safety issues)
 - who is living in the household?
 - how are the children? does anyone have concerns? e.g. parent, partner, health visitor, GP, school (parental consent required)
 - are there other services or agencies involved?
 - does the disorder influence or impair the patient's ability to look after the child(ren)?
 - in what way?
 - who assists with childcare (e.g. if parent unwell)?
 - are there practical arrangements or sources of support, which could assist the patient and the children? For example, extended family, grandparents etc. identify their views on the treatment plan/medical diagnosis

(The above questions are specifically important for **Approved Social Workers** when considering the possibility of compulsory admission of a parent/carer).

- 4.2 Assessment needs to follow the Framework for Assessment of Children in Need as for any social assessment of a child. This includes an holistic assessment of the child's developmental needs as follows:
- health and physical development
 - education and cognitive development
 - emotional and behavioural development
 - family and peer relationships
 - self-care and competence
 - identity
 - social presentation

Particular issues relating to adult mental health problems are:

4.3 Child's own development and mental health

- the child's understanding and response to the mental illness

4.4 Parenthood and the parent-child relationship

- extent and nature of care provided by the ill parent
- the child's involvement in and exposure to parental symptoms
- quality of parental/family relationships and effects of any changes or separations
- previous child/parent relationship

4.5 Adult Mental Illness and its impact on Parenting Capacity

- mental state of the parent
- effect of symptoms and treatment on parenting capacity
- quality of social supports
- childhood experiences of parents/carers
- stresses involved in becoming a parent
- relationship with and mental health of partner or other significant family members

4.6 Assessing the impact of the mental illness on parenting capacity

Children may not be exposed to or involved with specific symptoms, yet parenting can still be altered. The presence of mental illness can reduce and/or change a parent's responsiveness toward their child. For example, a parent may become less emotionally involved, less interested, less decisive or more irritable with the child. This will affect the quality of the parent-child relationship, parenting capacity and the child's well being.

4.7 Then assessing the impact of parental illness on children, differentiate between:

- the nature of the child's experiences associated with their exposure to parental symptoms
- how the parent's actual parenting has changed due to the illness
- the quality of parenting skills when well

NB. This information may not always be available.

4.8 Consideration should be given to the protective factors as well as stressors and should include:

- actual symptoms and child's involvement in and exposure to parental symptoms
- pattern of the illness including nature, severity, duration and timing; first or recurrent episode, chronicity
- compliance with treatment/use of help/acceptance of support
- religious/cultural beliefs
- previous psychiatric and forensic history
- whether the symptoms and behaviours can be improved in any way
- previous history of violence, self-harm, suicide attempts
- dual diagnosis e.g. mental illness and personality disorder or mental illness and learning difficulties
- mental illness combined with misuse of drugs or alcohol
- delusions involving the child
- the especially worrying combination of mental illness of a parent and domestic violence

4.9 Changes in family structure or functioning/Young Carers

4.10 Where mothers or expectant mothers are admitted to a psychiatric unit, midwives/GPs/health visitors/school nurses should automatically be informed by the Named Nurse of the Ward.

- 4.11 Children may take on more responsibilities and/or caring roles within the family when a parent is mentally ill. This includes practical tasks such as chores, caring for siblings, shopping and emotional concerns like worrying about the ill parent. Hospitalisation of a parent may lead to changes in roles and/or living circumstances for the family. The impact on children following admission to hospital of a single, socially isolated parent will have quite different implications compared to hospitalisation of a mentally ill adult in a family where good quality alternative carers are available.
- 4.12 Be aware that young **carers** can receive help from both local and health authorities. 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 as to whether a young carer is a child in need or in need of protection and whether the child's welfare or development might suffer if support is not provided to the child or family.
- 4.13 Recognise that **treating symptoms in isolation is not sufficient**. Difficulties in parent-child relationships have been shown to persist well beyond the period of parental 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 nor should they assume that children will accept their parent back easily into the family home. In situations where there are serious concerns about parental inability to meet a child's needs when unwell, professionals will need to reassess the adequacy of parenting and the parent-child relationship once psychiatric symptoms have resolved. Good links between children's and adult services, across agencies, are therefore essential.
- 4.14 Be aware of the dilemmas, which can arise in terms of the times 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 where the likely duration of parental rehabilitation will pose unacceptable delays and risks to children's development. Alternative care arrangements may be necessary and, in conjunction with the local authority, permanent fostering and adoption will need to be considered.
- 4.15 Find out about availability of local services to ensure 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.

High Risk Indicators

4.16 **Childcare professionals should be consulted where there is evidence of:**

- psychotic beliefs particularly if involving the child
- 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
- 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. For example, delusions targeting the child, incorporation into a parent's obsessional cleaning/contamination rituals, or a child kept at home due to excessive parental anxiety or agoraphobia
- ongoing hostility, irritability and criticism of the child or adolescent, inconsistent and/or inappropriate expectations of child
- serious neglect of the child

4.17 **Other Negative Indicators**

The following factors suggest riskier situations. They do not predict abuse in individual families. When more than one of these factors below are present the risk is increased.

- combinations of depression, substance dependence and personality disorders at various points in time are the most frequently reported psychiatric conditions affecting parents who abuse their children
- mental illness or another mental disorder combined with a background of domestic violence
- both parents have a mental disorder or a lone parent with limited support has a mental disorder
- poor compliance with treatment
- lack of insight into the disorder and its likely impact on the child
- self harming behaviour and suicide attempts
- parental learning difficulties and mental illness

4.18 **Examples of mental illness and its impact are:**

- severe post natal depression, which is likely to pose a greater risk to children
- psychotic illness including puerperal psychosis. The risks to children increase if the mentally ill parent has delusional ideas involving the children e.g. if the parent thinks the child is the devil or if a severely depressed parent feels that the child should be protected from the evils of this world by killing the child
- parents with obsessive compulsive disorders may involve their children dangerously in their rituals (e.g. by scrubbing the child

constantly) and they may also become very irritable and short-tempered with a child who naturally interrupts their rituals

- adults experiencing episodes of manic behaviour are more likely to be extremely irritable and short tempered with children during these episodes
- particular attention should be paid to concerns about personality disorder. A parent with a personality disorder may have very limited ability to cope with the symptoms of relatively moderate mental health problems (e.g. mild anxiety or depression). Such parents will find it much harder to prioritise their children's need than some other parents with severe mental illnesses but without serious personality disorders. Parents with personality disorders may also be less likely to comply with treatment and may be antagonistic to Social Care and Health Professionals. The challenge for professionals is then to keep their focus firmly on the child's welfare and safety

4.19 Positive Indicators/Protectors

The following may reduce the risk of significant harm:

- older age of the child at the time of the onset of their parent's illness (due to less opportunity for exposure to difficulties and a greater range of potential coping resources)
- the more sociable child who is able to form positive relationships (easier temperament)
- a more able child
- a parent who has discrete episodes of mental illness with a good return of parenting skills and abilities between episodes
- alternative support from adults with whom child has positive, trusting relationship
- success outside of the home, e.g. at school or in sport
- professionals can improve children's chances of avoiding significant harm by strengthening these protectors

5. Process

5.1 Those working in all agencies should be aware of the designated and named professionals for child protection who can provide advice.

5.2 Remind **all** patients taking medication about the need to store potentially lethal substances safely and securely if children are likely to visit the household. If English is not their first language, ensure information is understood by the patient in his/her own language.

5.3 **Talk with patients about their role as parents**, associated stressors, ways in which psychiatric symptoms and parenting **responsibilities affect each other and their perception of their children's health, welfare and safety.**

5.4 **Include partners in any assessment** of a mentally ill parent's circumstances. A partner is important as a potential source of:

- alternative care and support

- additional burden because they may also show evidence of mental illness
- direct harm for children if the partner has maltreated children and mental illness prevents a parent from adequately protecting children
- Indirect harm for children, for example if domestic violence is witnessed. A woman who is unable adequately to protect herself will find it difficult to ensure her children are adequately protected

Talking to the child

- 5.5 To meet children's needs when a parent is hospitalised for mental health reasons, all professionals looking after a parent and those caring **for the children should:**
- 5.6 **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 whilst in another room or whilst being hurriedly taken to neighbours, friends or family. Pretending nothing has happened may be especially confusing. They need to be kept informed.
- 5.7 **Provide explanation.** A truthful statement/description appropriate to the child's age should be provided. The use of clear language, which the child can understand, is important. The ill parent could be described as sad, confused, upset, needing a rest, stressed, mixed up inside, etc. Describing what happens while parent is in hospital – talking, being looked after, medication etc is also helpful. For a child with special educational needs who use alternative and additional communication systems, Key Workers from their educational setting should be consulted.
- 5.8 **Emphasise that the child is not to blame.** They should be told this.
- 5.9 **Negotiate** with the child and parents/carers how and how much the child should share with their friends and others about their parent's mental health problems and hospitalisation. Rehearse with the child, how they might deal with hurtful responses from their friends and classmates.
- 5.10 **Support opportunities for contact when this is in the interests of the child (refer to Assessing and Managing Visits by Children to Special Hospitals, Medium Secure Units and other local Psychiatric Hospitals or Dispersed Units).** Other ways of maintaining contact include the use of phone calls, letters and pictures where appropriate. 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. However, the needs of the child must be the paramount consideration in any decision about any form of contact.

- 5.11 **Recognise changes in behaviour patterns and discuss with relevant professionals in children's services.** Children will worry, have fears/anxieties, be confused, which can be shown in a wide range of observable behaviours and hidden distress. These could include disrupted sleep or routines, uncharacteristic quietness/inaccessibility, poor appetite, poor hygiene, clinginess, bed wetting, demanding or disruptive behaviour, anger, irritability, tearfulness, stomach aches, nightmares and refusal to attend school. This is especially important for children with communication difficulties who may have little or no expressive language. Always consult a Key Worker from their educational setting for advice.
- 5.12 **Alert school and teachers** that the child may need extra support, attention and praise. It is important that communication is ongoing and takes into consideration the issue of bullying due to the parent's ill health.
- 5.13 **Additional Issues to consider for specific Roles or Agencies**
Refer to Mother and Baby Policy, Visits of minors to Psychiatric Wards Policy and The Care Programme Approach (Leicester Partnership, NHS Trust). (See Key Texts at the end of this paper for references)
- 5.14 **Role of Child and Adolescent Mental Health Service**
Child and Adolescent Mental Health Services should: -
- ensure that the mental health of parents of referred children is routinely considered in assessment and intervention
 - ensure that appropriate arrangements are made for treatment of a parent's mental ill health
 - consider the role of the child's disorder in the mental health of parent
 - be responsive to calls and referrals from colleagues in adult services. This should include establishing opportunities for collaboration during and beyond a crisis e.g. routine discussion about the needs of patients who are parents, consultation and joint work
 - be prepared to work flexibly so that assistance can be provided to children and families or to mental health staff during a parent hospitalisation or via attendance at a parent's CPA meeting
- 5.15 **Role of Forensic Services**
Forensic mental health risk assessment of the adult (s) is provided by the Forensic Mental Health Service, Leicestershire Partnership NHS Trust, for those who have committed serious offences or are deemed at high risk of harming children.

Referral to forensic services should only be made in situations where:

- a child protection conference has reached the view that there is **sufficient risk of continuing significant harm** that a child's name

should be placed on the Child Protection Register/or would be if not looked after

- psychological assessment of an **adult directly involved** in the case of the child is seen as **necessary to inform decisions** and **assist in the development of appropriate child protection plans**
- where the subject agrees to a referral

Where there are **current** Forensic Mental Health Services provided to an adult, it is required that all professionals involved with a family will provide information to child protection conferences and assist in assessing risk.

Service Contact Point:

Service Manager
Forensic Mental Health Services
Leicestershire Partnership NHS Trust
Former Nurses Home
Towers Hospital, Gipsy Lane
Leicester, LE5 0TD
Tel: (0116) 225 6699

5.17 Mental Health Professionals attending Child Protection Case Conferences and Core Groups and Strategy Meetings

Professionals attending such meetings should familiarise themselves beforehand with the appropriate LSCB Procedures of this manual. Chapter 6 gives details of Initial Case Conferences, Chapter 7 covers Core Groups and Chapter 8 relates to Review Child Protection Conferences. Chapter 5 describes the role of Strategy Meetings.

6. Local Practice and Initiatives

6.1 Maternal and Neonatal Mental Health

Most local family health visitors and a number of other relevant professionals have been trained in the maternal and neonatal mental health approach. This training enables professionals to identify newborn babies at risk of developing mental health problems and attachment disorders and then offers a range of preventive or treatment responses. This is especially beneficial where mothers are suffering from postnatal depression.

Graded responses are organised with psychiatric referral for the most severely depressed mothers and regular listening sessions and simple bonding exercises for less severely depressed mothers.

6.2 Mother and Baby beds in local psychiatric units

There are three beds in Aston Ward at the Bradgate Unit, Glenfield General Hospital designated for mothers with babies under one year needing inpatient psychiatric care. There is no current provision at the Brandon Unit, Leicester General Hospital.

6.3 Working with Adult Survivors of Childhood Sexual Abuse

Amongst people attending psychiatric clinics records of people with experience of child sexual abuse are significant. Such experiences would have an impact on parenting. There might also be child protection implications for other children if the alleged perpetrator still has care of or close contact with other children or young people. The Leicestershire Partnership Trust has produced Guidelines for working with Adult Survivors of Child Sexual Abuse (October 2006). Reference should be made to the guidelines in any case where a patient discloses such a history.

7. Conclusion

- 7.1 This guidance concerns the specific Child Protection Issues relating to adults with mental health problems who have significant contact with children and young people. In particular, the guidance has concentrated on assessing the impact of parental mental health problems on children. **Remember 'Think Parent – Think Child – Think Family'.**
- 7.2 As in all areas of child protection good communication is vital between professions and agencies ensuring that what is communicated is clear in its message and the implications for the child's protection are clearly understood by all involved.
- 7.3 This guidance as with other LSCB guidelines and policies are applied across all agencies and should provide a common and safe framework for everyone to work within ensuring that the needs of the child are paramount and remove any perceived barrier to inter-agency working and the exchange of vital information in whatever form that information is held.
- 7.4 The guidance not only points out the importance of information sharing but strongly recommends joint working between agencies and professions to provide, as comprehensively as possible, risk assessments and combine child protection plans and adult care plans or care packages, to meet the needs of the whole family.
- 7.5 Often a barrier to joint working is the issue of confidentiality and who owns information. Where an issue of child protection is involved it is valid and lawful to share any relevant information in order to protect the child.
- 7.6 Staff involved in child protection issues may experience dilemmas on how best to manage information. Staff should discuss information with other team members and all areas should have access to a named child protection professional. Each agency should identify and disseminate this information.
- 7.7 Where a disagreement exists between agencies and professionals on what action to take, please refer to **Chapter 23 - Resolution of**

Professional Disagreements in Work Relating to the Safety of Children.

8. Key Texts

8.1 Relevant National Legislation and Government Guidance in relation to children (Children Act 1989)

Working Together to Safeguard Children (Department of Health 2006)

The Framework for the Assessment of children in need and their families
(Department of Health 2000)

Local Authority Circular (99) 32 Guidance on the visiting of Psychiatric Patients by Children

Guidance to Local Authority Social Services Department on Visits by Children to Special Hospitals

8.2 Relevant National Legislation and Government Guidance in relation to Adults with Mental Health Problems

The Mental Health Act 1983 and associated Code of Practice and Memorandum

The Care Programme Approach (CPA)

Supervision Registers 1994 – withdrawn since 2001

Mental Health (patients in the community) Act 1995

Health Service Circular 1999/222

Carers (Recognition and Services) Act 1995

National Service framework for Mental Health (Department of Health 1999)

Crossing Bridges, Training resources for working with mentally ill parents
(Department of Health 1998)

Working Together Part 8 Reports – Fatal Child Abuse and Parental Psychiatric Disorders
- Dr Adrian Falkov (Department of Health 1995) ACP Series, Report 1

Children's Needs – Parenting Capacity
The impact of parental mental illness, problem alcohol, drug use and domestic violence on children's development
- H.Cleaver, I.Unell & J.Aldgate – HMSO 1999

8.3 Local Protocols & Practice

Identification and Assessment of Children in Need, Interagency Protocols produced by Leicester City Council, Leicestershire County Council and Rutland County Council in June 2001

The Care Programme Approach – Collaborative Practice in Action

Lamp Directory 2002

- Also Lamp Website at www.lampdirect.org.uk

Maternal and Neonatal Mental Health

Nursing Policy and Procedure for the Admission of Mothers and Babies

- Leicestershire partnership NHS

- NHS Trust

- Reviewed June 2002

- For review June 2003

Protocol for Assessing and managing visits by children to special hospitals, medium secure units and other local psychiatric hospitals or dispersed units - produced by Leicester City Council, Leicestershire County Council and Rutland County Council in December 2003.

8.4 Books, Articles etc

Reder P, Duncan S + Gray M.

Beyond Blame – Child Abuse Tragedies Revisited
(1993) Routledge

Weir A and Douglas A (Ed)

Child Protection and Adult Mental Health – Conflict of Interest?
(1999)

Reder P + Lucey C (Ed)

Assessment of Parenting – psychological Contributions
(1995) Routledge

Reder P + Duncan S

Lost Innocents – A follow up study of fatal child abuse
(1991) Routledge

Sheppard M

Child and Family Work (1997)

The link between child abuse and maternal depression.

There are also some useful guidelines and practice aids in the Crossing Bridges pack for talking to children and working with parents with mental health problems.

e.g.

Handout 54 – Answering children’s questions

Handout 55 - Talking with Families, Role play

Chapter 8 of the reader Preventive Approaches

Appendix IV - What's wrong with mum?
Appendix VI – Children have feelings