

South Yorkshire Area Child
Protection Procedures

Appendix 14

**Interagency Guidelines for Gathering
Information when working with Parents
with Mental Health Problems**

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1. INTRODUCTION

These guidelines should be read in conjunction with South Yorkshire Area Child Protection Committees' Child Protection Procedures, in particular part 2.3.

They should be used by GPs, psychiatrists, CPNs, health visitors, social workers, and anyone else who works with families.

They are consistent with, and informed by, the Human Rights Act 1998, the Data Protection Act 1998, the Crime and Disorder Act 1998, the Mental Health Act 1983 and the Children Act 1989.

These guidelines are also consistent with the Joint Information Sharing Protocol, which is an agreement between the Sheffield Care Trust and Sheffield City Council.

As in all areas of child welfare, it is vitally important that workers from all disciplines work together to undertake clear assessments and implement effective plans. In the interface between adult mental health services and services for children and families this may involve new ways of working and greater understanding of each other's perspectives.

These guidelines are written with the understanding that there can be powerful tensions between those advocating on behalf of parents and those working to safeguard and promote the well being of children. They are also written in the spirit of acceptance that in the vast majority of cases, children's needs are best met, sometimes with additional support, within their families

2. CONSENT, CONFIDENTIALITY AND INFORMATION SHARING

Research and experience have shown repeatedly that keeping children safe from harm and ensuring that their needs are met requires professionals and others to share information. This information may be about a child's health and development and exposure to possible harm; about a parent who may need help to, or may not be able to, care for a child adequately and safely; or about those who may pose a risk of harm to a child.

Parts 3, 4 and 5 of South Yorkshire's Child Protection Procedures give detailed practice guidance about sharing concerns, which is consistent with all relevant legislation. **A child should never be left at risk of significant harm because of indecision about sharing, or reluctance to share, information.**

3. THE NEED FOR SUPPORT

Parental mental health problems have been identified as one of the key sources of stress, which may make the difficult task of parenting even harder ('Child Protection: Messages from Research' 1995; 'Working Together to Safeguard Children', 1999). It is estimated that 30% of mentally ill adults have dependent children ('Crossing Bridges' 1998) and that 3.8% of all parents with dependent children have mental health problems.

It is important to emphasise that many families under great stress nonetheless manage to bring up their children in a warm, loving and supportive environment in which the children's needs are met and they are safe from harm. Mental health problems in a parent or carer do not necessarily have an adverse impact on a child, but it is essential always to assess its implications for any children involved in the family.

At the most extreme, parental mental health problems have been identified as a clear factor in a significant number of child deaths (33%)(1). In many instances children's developmental needs may be inadequately met by parents or carers whose parenting capacity is limited by mental health difficulties. Recent figures show that 28% of all children whose names are included on Sheffield's Child Protection Register have at least one parent with a mental health problem.

There is a growing body of evidence, which indicates that there is a high level of mental health problems amongst children and young people growing up in a family where the parent/parents have a mental health problem. Oates (1997) found psychiatric diagnoses in 40% of children of parents with affective disorders. Recent research in Sheffield has shown that about one third of parents of children known to CAMHS (Child and Adolescent Mental Health Service) have been suffering from mental health difficulties. Despite these figures, there were no referrals from the adult mental health services, indicating the need for clearer links and more understanding of the roles of all involved.

Another reason for workers to take note of the needs and demands of the children in a family is in order to assess the impact that these may have on the mental health of the parents themselves. An adult who may be capable of maintaining a stable lifestyle and adhering to treatment programmes etc., if living without children, may find that the specific difficulties presented by their children make this almost impossible.

These guidelines are not absolute and do not replace good practice: they are an aid to professional judgement. In individual cases, consideration should be given to any additional factors thought to be relevant. The guidelines are for general application where there are parental mental health problems and should be used alongside any assessment format and procedures used by individual agencies.

The guidelines are to assist in understanding fully the family's situation, including the impact of mental health problems, whilst recognising strengths and difficulties in the family.

4. GUIDELINES FOR GATHERING INFORMATION

All professionals working with families, whether with the parents or with the child, should use this guidance in conjunction with the 'Framework for the Assessment of Children in Need and their Families' (DOH 2000). In addition, professionals working with parents who are expecting a child should use it: planning support for expected children leads to better parenting outcomes than doing so postnatally. It will be necessary to liaise with other professionals involved to ensure that all relevant information is obtained. Once information is gathered, professional judgement needs to be exercised as to whether or not the cumulative picture of concern in relation to the child warrants intervention under the child protection framework or the family support framework. In making this judgement, it will be advisable to refer to the child protection procedures (parts 1 and 2) and to consult a child protection adviser. Sheffield's Interagency Referral and Assessment form should be used when requesting services from other agencies.

Assessment is an ongoing process. Circumstances change and so may the child's welfare. There should be a regular cycle of assessment, planning and review, which is clearly recorded in each agency case file.

4.1 Assessing black and minority ethnic parents and their children

Professionals should guard against myths and stereotypes, both positive and negative, of black and minority ethnic families. Anxiety about being accused of racist practice should not prevent the necessary action being taken to safeguard a child. However, workers need to be aware that the assessment tools commonly used by mental health services are generally from a white North American or European perspective and are not easily applicable to black communities. They may not take account of the strong spiritual or religious beliefs of many communities, for example in relation to the expression of suicidal thoughts, and can lead to some mental health problems being overlooked or mistaken for other kinds of behaviour. African Caribbean users of services are less likely, for example, to have their depression recognised or treated. Conversely, the evidence is that they are more likely to be:

- admitted to hospital on a Section of the Mental Health Act;
- re-admitted once discharged;
- assessed as violent and receive anti-psychotic drugs by injection;
- given a higher dose of medication;
- given a diagnosis of schizophrenia.

In consequence, risk to children as a result of the mental health problems suffered by black parents may well be more difficult to assess and great care should be taken to ensure all available research findings and advice are accessed. Black mental health organisations like SACMHA should be consulted. The Department of Health has published detailed guidance for those professionals making an assessment of black children and their families ('Assessing Children in Need and their Families: Practice Guidance', 2000).

There is evidence that black families are not gaining access to family support services and professionals will need to bear this in mind when considering what might assist a family. As well as considering the needs of the adult, it is important that workers strive to promote the needs of black and minority ethnic children who may also be subject to difficulties including racism within the community.

Asylum seekers and refugees, both adults and children, may suffer post traumatic stress disorder and depression, but may find it hard to access health care and support services, in addition to facing the consequences of poverty, poor accommodation and racism. Sheffield's Nurse Consultant for Asylum Seekers may be a source of helpful information and advice (tel. 2261739).

4.2 Assessing Future needs of Unborn Children

The accepted difficulties in assessing and predicting the needs of children whose parents have a mental health problem are even more evident when the child has yet to be born. It is essential that all those involved exercise professional judgement in a multi-agency arena to look at systematically the developmental needs of a child, from small baby through all developmental stages, and to assess the likely capacity of the parent to provide for those needs.

There will be indicators available, such as stability, emotional warmth, reaction to stressful situations etc. The care of previous children needs also to be taken into account, but this must also be considered in the light of the mother's current circumstances such as stability on any treatment, support networks etc. Any assessment process needs to show that the questions suggested in the main body of this guidance have been considered and reasonable judgements have been taken in the light of all available information.

In all circumstances the focus must to be the welfare of the child and professionals need to be aware of the risks involved in taking the stance that perhaps the mother has the right to be 'given the chance'. It is also important that any package of support necessary for a mother to care for her child is actually available, reasonable and not based on such high levels of input that any reduction in service is likely to jeopardise the safety of the child or place unacceptable strain on the mother.

4.3 Useful Questions

In line with the Framework for the Assessment of Children in Need and their Families, the child's developmental needs have been identified and linked with their parents' capacity to meet their needs and the family and environmental factors which may strengthen or impair both these domains.

It must be stressed that these questions are only a useful starting point to an assessment. Clear analysis of what the information means for the child/ren and their family needs to be undertaken in consultation with line manager, supervisor and the multi-agency network.

Much of the material in section has been drawn from 'Children's Needs - Parenting Capacity (Cleaver et al 1999) and 'Patients as Parents' (Royal College of Psychiatrists 2002)

a) Health

- Do any delusions include children?
- Do the delusions include thoughts that children are evil/need saving from evil, which may involve harming or killing the children?
- If the parent has indicated that they are contemplating suicide, have they also contemplated taking the life of their children?
- Is the parents medication kept safely? Do parents appreciate safety implications?
- Does behaviour/mood involve aggression/over-chastisement/domestic abuse, which could put children at physical risk?
- Are parents physically available for children, ensuring that they are given age-appropriate supervision at all times?
- What plans are made for care of children before/during emergency admissions to hospital?
- Do parents understand the need for, and are able to provide, an adequate diet?
- Is there any pattern of coercive interaction between parents with eating disorders and their children, particularly around meal times?
- Are parents able to keep children's medical/dental appointments?
- Is the family's home suitable to meet the child's needs for hygiene, safety, cleanliness, etc. (including if a child has special needs arising, for example, from a disability)?

- Are there financial implications of the parent's illness that make maintaining adequate diet and levels of hygiene and safety difficult?
- Is the child exposed to risk from other adults or visitors to the house?

b) Education

- Are school aged children regularly attending education?
- Are children kept at home to care for siblings/parents?
- If parent is emotionally unavailable to the child, is there adequate stimulation/attention from elsewhere?
- Does the child have access to other children, books and play opportunities?
- If a child is involved in delusions/altered thinking, does this affect their cognition, development and reasonable understanding of life?

c) Emotional and behavioural development

- If the parent is emotionally unavailable, is this to the extent that the child is likely to feel unloved and therefore experience poor or inappropriate attachment?
- Is the parent's behaviour violent, unpredictable or chaotic, leading to the child feeling frightened, inhibited, anxious or aggressive?
- Is the parent aware of the nature and extent of the child's emotional needs?
- Does the parent express consistent negative views about/to the child, including rejection?
- Is the parent able to respond appropriately to the requests for love and attention that the child presents?
- Does the parent demonstrate and model appropriate behaviour and control of emotions and interactions with others in order that the child is able to develop an internal model of moral values and social behaviour suitable for the society in which s/he will grow up?
- Does the parent regularly feel unable to guide the child's behaviour by instilling appropriate guidance and boundaries?
- Does the parent's anxiety or delusion entail over-protection of the child or the imposition of unreasonable routines or expectations?
- Is the child expected to take on an adult role by undertaking an inappropriate level of responsibility for self, siblings or parents?

- Is the child given appropriate explanations, by parent or others, about the parent's illness and about significant events, such as hospitalisation, visits from professionals, etc?
- Is the child's development of a stable attachment likely to be affected by inconsistent parenting?
- Is the child misusing substances, bedwetting, self-harming or displaying other problematic behaviour or emotional problems?

d) Identity

- Does the parent have a distorted sense of reality that affects the child's growing sense of self as a separate and valued person?
- Does the parent's behaviour in the community cause the child to feel different, ashamed or confused?
- Is the parent able to interact with the child in a way that enhances their self-esteem and feelings of self-worth?
- Is the parent able to help the child develop a positive sense of individuality, including issues of race, religion, gender, sexuality and disability?
- Does the child understand key issues about their parent's mental health that may affect him/her?
- Does the child have an anxiety that s/he may also become mentally ill in later life?

e) Family and social relationships

- Does the family situation provide the child with sufficient stability to enable him/her to maintain a secure attachment to the primary caregiver(s)?
- Is the child provided with a reasonably stable routine for his/her daily life, e.g. mealtimes, bedtimes, being taken to school, etc?
- Is the child encouraged to develop satisfying and healthy relationships with wider family members, friends and local community groups, appropriate to their culture?
- Does the parent's behaviour mean the child is reluctant to engage in normal friendships or invite friends to the house?
- Does the child witness or have awareness of domestic abuse of one or both parents?

f) Social presentation

- Does the parent's depressed mood or distorted thought patterns impair his/her ability to provide the child with appropriate dress, hygiene care or guidance?
- Do a parent's strange behaviour or beliefs impair the child's presentation in his/her local and wider community?
- Does the child witness bizarre or unusual social presentation by the parent, which may affect his/her understanding of their position in their society/community?
- Is the child encouraged to have confidence in his/her ability to overcome difficulties in their society and wider community that may be related to race, gender sexual orientation, disability, etc?
- Are there financial implications of the parent's illness which make maintaining an adequate standard of the child's dress and/or cleanliness difficult?

g) Self care skills

- Is the parent able to encourage age-appropriate independence?
- Does the parent's behaviour, e.g. extreme dependence, threats of abandonment or suicide, erratic outbursts, etc. lead to the child becoming anxious about separation?
- Has the child been given inappropriate responsibility for any aspects of the adult role in respect of his/her own care or that of their siblings?

Protective factors

a) The nature of the illness itself

For any illness, consider:

- Pattern – frequency of episodes, length of episodes. In general, an illness that has longer and more frequent episodes will have a greater impact than illnesses of short duration.
- Severity – the impact of an illness will not be directly related to its severity, e.g. a parent with a short severe illness may be hospitalised and substitute care provided for the child with little impact on parenting.

- Chronicity – a less severe illness that is chronic may lead to substandard care or neglect of the child, if long term medication or the illness itself lead to cognitive and/or personality changes.
- Specificity – what are the symptoms of the illness and their likely impact?

b) Factors within the child, family and wider networks

- The child is older at the onset of the parent's illness and has less exposure to, and fuller understanding of, the illness and a greater range of potential coping resources.
- The child is more sociable, or of easier temperament, and is able to form positive relationships.
- The child is of average, or above average, intelligence.
- The child has a sense of self-esteem and self-confidence, with a range of approaches for solving problems.
- There are discreet episodes of parental mental illness with a good return of skills and abilities between episodes.
- The parent understands the need for support and that there may be some difficulties in the family for which they may need help at times.
- There is alternative support from adults with whom the child has a positive, trusting relationship and who can respond to the developmental needs of the child.
- There is take-up of regular supportive help from primary health care, good quality child care and good school attendance.
- There is sufficient income and good physical standards in the home.
- There are supportive siblings, family members and friends
- The family receives practical and domestic help.
- The child receives regular medical and dental checks, including school medicals.
- The child has information on how to contact relevant professionals/others in the event of a crisis regarding the parent.
- The parent complies to a significant degree with treatment and advice.
- Care plans are in place which take account of all appropriate factors, including the needs of children and the needs of the adult as parent.
- Specialist services are accessible for the family at key times of need.

Please note: whilst it is important to recognise and develop strengths within the family and their network, workers must be careful that they are remaining objective about risks to the children.

5. THE IMPACT OF MENTAL ILLNESS ON PARENTING: a summary of research findings

Please note that most research undertaken in this field has looked at the relationship between the child and the mother. In many of these circumstances it would be reasonable to infer that findings also relate to fathers or other adults with a mental health problem.

a) parenting outcomes for SCHIZOPHRENIA

- increased incidence of pre-term birth and intrauterine growth retardation in babies born to women with schizophrenia (2)
- touch and play are less(3), there is misinterpretation of the child's cues(4), less social interaction(5) and more anxious attachment(6).
- mothers are more remote, insensitive, intrusive and self-absorbed(7)
- mothers with a primary diagnosis of schizophrenia are 2 to 3 times more likely to experience problems with child care, emotional responsiveness and being at risk of harming their child, than mothers with a primary diagnosis of depression(8).
- pregnancy referrals are associated with better outcomes for parenting assessments
- 50% of children with a schizophrenic mother are at some point looked after by local authorities(9).

b) parenting outcomes for DEPRESSION

- postnatal depression affects a mother's attachment to her child (10,11,12)
- the quality of a child's early attachment plays a powerful role influencing the child's subsequent social and emotional development (13)
- children of depressed mothers show increased levels of behavioural disturbance, poor cognitive function, insecure attachment, and poor adjustment to school (14)
- a depressed parent is 3.5 times more likely to physically abuse their child than a non-depressed parent and more likely to neglect (15)
- suicide is the most common cause of maternal death after childbirth and 5% of those committing suicide also commit infanticide (16)

- the incidence of Sudden Infant Death Syndrome is 3 times greater for mothers with depression (17,18); between 10% and 20% of child deaths registered as SIDS are the result of parental action (19). Boys are more likely to be affected than girls, though it is not known why.

c) parenting outcomes for BIPOLAR DISORDER

- pregnancy and the postnatal period are times of increased risk (20)
- relapse rates of 50% where medication discontinued (21)
- depression in bipolar women is associated with inadequate prenatal care, poor nutrition & obstetric complications (22; 23; 24)
- manic episodes are less frequent in pregnancy (25)
- postpartum psychosis may develop in women with a history of bipolar disorder (20 – 50%) or may demarcate the onset of bipolar disorder (26; 27)
- postpartum psychosis carries a risk of suicide and infanticide (28)
- puerperal psychosis has been associated with rates of infanticide as high as 4% (29; 30)

d) parenting outcomes for PERSONALITY DISORDER

- of those parents who killed their children and had previously known to psychiatric services, 6% were diagnosed with personality disorder (1)
- personality disorder is associated with significant failure of interpersonal function which is necessary for 'good enough' parenting (32)
- personality disorder is associated with poor affect and arousal regulation, so that parents are unlikely to be able to manage many of the distressing feelings that the care of young children may generate (33)
- such parents may not be able to negotiate with their children and have unreasonably high expectations of them in terms of behaviour (33)
- some personality disorders are associated with an increased risk of violence to others (34) although deliberate self-harm is probably the most common type of physical violence, especially among women (33)
- currently services have limited approaches to those with personality disorders, and in particular, those who are parents (33)

e) impact of specific symptoms of illness on parenting

inability to sleep sleeping too much	irritability may lead to child being insufficiently stimulated or lack of supervision
introspection	may lead to inability to consider the needs of the child
neglect of own physical needs	may neglect child's physical needs
inadequacy, low self-esteem	if long-term can project onto child
withdrawal	may lead to child's social and recreational opportunities being reduced; or to lack of support
acute anxiety	may lead to irrational and risky behaviour
compulsive behaviour	may lead to inability to prioritise the child's needs appropriately
psychosis	impaired competence and behaviour which could pose a serious risk to the child
mania, unstable mood	impaired judgment
suicidal thoughts	may include killing children too
hopelessness/despair:	killing the child may seem like a positive 'solution'

Dual diagnoses – it is important to acknowledge that in many cases there may be more than one condition e.g. schizophrenia and depression and some conditions may also be affected by parental drug or alcohol misuse. It is vital that the implications for children of these factors and their inter-relation are explored when undertaking assessments of families

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