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MONITORING REPORT

When parents are detained

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Executive Summary

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The Mental Welfare Commission is responsible for monitoring the use of the Mental Health Act. Under section 278 of the Act, there is a duty for service providers to mitigate the effects of compulsory measures on parental relations.

We found that, although there are some areas of good practice, these duties are generally unknown and neglected. Some professionals are unaware of their obligations; others struggle to meet them because of inconsistent systems and a lack of resources.

We spoke to nursing staff and mental health officers as well as looking at Mental Health Act documentation. None of the formal certificates, reports or applications authorising compulsory measures record whether people have children.

The social circumstances report (SCR) is a document which addresses the interaction of a person's mental disorder and their social circumstances. We looked at a sample of 212 SCRs from which we identified 56 people with children aged under 18.

The Commission has produced guidance on when an SCR should be completed. We think that the detention of mothers and fathers of children under 18 should trigger an SCR at the beginning of each period of detention because of the potential implications of parental mental illness for children. It is clear from our exploration that this is not standard practice.

In cases where people were subject to Compulsory Treatment Orders (CTOs) we also looked at care plans. CTO applications include proposed care plans and statutory care plans written by responsible medical officers (RMOs). Our scrutiny of these documents showed that approaches to mitigate adverse effects on parental relations were rarely mentioned. The absence of such documentation may or may not reflect the emphasis given to this important issue. It will take further contact with practitioners and patients themselves to fully explore the extent to which practitioners are mindful of their responsibilities under section 278.

When we contacted ward managers and mental health officers, we found a mixed picture. Although some professionals had a good knowledge and positive experience of using section 278, there was a lack of consistency. We were able to identify some common themes, including challenges with inter-agency working and a poor awareness of section 278. We also found that there was a lack of resources to support families: from simple things like age-appropriate information on mental illness, to child-friendly visiting spaces in hospitals and access to community support.

The nature of family life is complex. When parents are subjected to compulsory measures, it is not only the individual parent who is affected. There is an impact on children and on those people who may look after them in their parent's absence. Similarly, the presence of children can affect whether people receive support. Fear of losing one's children is a frequent obstacle to parents seeking and accepting help.

The challenges, and the solutions, must involve professionals from a range of agencies and disciplines. We also believe that those who commission services should commit more consideration to the resources required to support families where a parent is subject to compulsory measures.

This initial exploration of the implementation of section 278 has enabled us to make recommendations, but it leaves many questions unanswered. The most important of these is how the parents and children who have been through the experience of compulsory procedures feel. We hope to explore this in more depth in the future. In the meantime, when we visit patients in psychiatric facilities throughout Scotland, we will continue to be mindful of the needs of parents subject to compulsory measures under the Act.

Our recommendations:

1. Raise awareness of section 278

A key finding was that some ward staff are not aware of their responsibilities under section 278. As a minimum, staff should know that they have a duty to consider the potential adverse effect of compulsory measures on parental relations. We recommend that service managers develop and deliver training on issues for parents and children for appropriate staff.

2. Care plans that consider the impact on family life

Formal care plans rarely specifically address the needs of patients as parents or the needs of their children, even where the behaviour which precipitated the use of compulsory measures involved serious risks to the children. Mental health teams should always consider whether patients who are parents need support to maintain good relationships with their children. Access to support services should be facilitated in order to provide benefits for both parents and children.

3. Improve communication between professionals

The complexity of supporting families means that agencies must be able to work well together. Children's services do not always understand or address the impact of mental illness; mental health professionals, as well as patients, often worry that referral to children's services will lead to the removal of children. Local authorities and their NHS colleagues should audit communication between these services to ensure each service understands their respective roles, processes and procedures.

4. Access to resources

In most areas, resources to support children and families are very limited, leaving mental health teams with few options to augment their work when trying to mitigate the adverse effects of compulsion on parental relations. Those who commission services should look at opportunities to increase the range of support available. Services should advertise the availability of support to families affected by mental illness.

5. Child-friendly visitor spaces in hospitals

Provision of child-friendly spaces for children who are visiting their parents in hospital is patchy. NHS Boards should audit the availability of these facilities and ensure that arrangements are made to provide them in every psychiatric hospital.

6. Access to child-friendly information

Ward staff and mental health officers do not have access to a range of age-appropriate educational materials to enable parents and practitioners to help children understand the nature of their parent's mental illness and the need for treatment. Local authorities and their NHS colleagues should audit the availability of these materials and ensure that staff and parents are able to access them.

7. Social circumstances reports where a service-user has a child under eighteen

Where the service-user has a child under eighteen, the use of compulsory measures should prompt a social circumstances report at the beginning of each new episode. We found that the use of these reports was inconsistent. Involving mental health officers at an early stage offers an opportunity to assess the support needs of children and parents.

1. Introduction

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Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and guiding and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

Individuals with mental illness, learning disability and related conditions have the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recover and lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment

1.1 Background to the study

The Mental Health (Care and Treatment)(Scotland) Act 2003 has been in effect now for over seven years. Many of the changes it introduced have been incorporated successfully into practice. One area which has not yet been explored is how services are fulfilling their duties under section 278, "*the duty to mitigate the adverse effect of compulsory measures on parental relations*". Practice in this area remains largely hidden. We did this research to examine practice in this area as part of our duty to monitor the implementation of the Act. We also hoped to raise awareness of this largely overlooked statutory duty.

The primary focus of this study is on parents whose illness is severe enough to require compulsory measures. We are therefore considering families where there is likely to be a major impact on children. This section, however, places similar duties on those exercising functions under the Act when it is the child who is subject to compulsory measures. The parent who requires treatment and care for mental illness and other related conditions, is also likely to require support in their parental role. In addition their children may need help to understand and cope with their parents' illness.

For this study we obtained information about practice from five different sources:

- a sample of social circumstances reports (SCRs)
- individual cases which have been brought to the attention of the Mental Welfare Commission
- a survey of nurses in charge of admission wards
- a survey of mental health officers (MHOs)
- RMO (responsible medical officer) Care Plans under section 76 of the Mental Health Act.

The statutory forms authorising compulsory detentions under the Mental Health (Scotland) Act 2003 do not record whether the patient has children under 18. The only formal documents that might be expected to show this are social circumstances reports (SCRs) and formal Care Plans required under Section 76, either of which might include information on actions to mitigate the adverse effects of compulsory measures on parental relations. In practice, from the Commission's experience, RMO Care Plans mention 'family support' in very few cases, and do not show whether the need for section 278 support has been considered or provided. For the purpose of this study, the main documents we examined were SCR's.

In addition to examining SCR's, we issued two brief surveys via an email link to an online survey tool¹, one to managers of adult admission wards and another to MHOs. We were interested to find out about their views on current practice and to obtain illustrative examples. Further details are given in the following two chapters.

1.2 Supporting parental relations

Parental mental health and their children's wellbeing are closely linked. The impact on the family of a parent's mental illness can be very varied, ranging from mild and short-lived effects to devastating and long lasting effects². The Mental Health (Care and Treatment) (Scotland) Act 2003 in Section 278 includes a welcome innovation relating to how the use of the Act has an impact on parental relations³. This section broadens the responsibility of services when using compulsory treatment. It places a duty, on all who exercise functions under the Act, not just to provide treatment and care for an individual's illness, but also to respond to the needs of the individual in their family role, whether as a child or a parent. The law states that action must be taken when compulsory measures are likely to "impair the personal relations or diminish direct contact between" children and parents.

In 2007, the Scottish Government⁴ published guidance for practitioners *Getting it Right for Every Child*⁵. The guidance states:

"that no matter where they live or whatever their needs, children and families need to know where they can seek help, what help is available, that the help is appropriate to their needs and it will be delivered to the highest possible standard".⁶

1 We issued an email link to an online survey form using 'Survey Monkey'. We validated email addresses where possible but in some cases the professional had moved on from their post; in others the local Health Board may have 'blocked' the survey link. As far as possible we tried alternative methods to obtain a view from those areas. The samples obtained are therefore convenience samples.

2 Aldridge J. (2011) *Children living with parents with mental illness*. Briefing: Scottish Child Care and Protection Network

3 Mental Health (Care and Treatment) (Scotland) Act 2003 <http://www.legislation.gov.uk/asp/2003/13/contents>

4 Now known as the Scottish Government from 2007

5 Scottish Executive (2007) *Getting it Right for Every Child: Guidance on the Child's or Young Person's Plan* <http://www.scotland.gov.uk/Publications/2007/01/22142141/0>

6 New legislation, a Children's Services Bill planned for 2013, will underpin the changes necessary to put this guidance on a statutory basis. Scottish Government legislation website <http://www.scotland.gov.uk/Topics/People/Young-People/legislation>

The impact of mental illness and other related conditions on parental relations and responsibilities through, for example, changed emotions or paranoid delusions, can have a significant impact on relationships. It is imperative that mental health professionals are aware of the important relationships in a patient's life, especially when the patient has children. Given the vulnerability and dependence of children, it is essential that professionals keep the needs of patients as parents, and the needs of their children in mind at all times when assessing and making treatment decisions. This is important for all patients, both voluntary and detained, but detained patients may face additional problems if they are subject to restrictions. For example, parents may be unable to leave the hospital or be required to reside in accommodation in the community away from their children. There may also be additional restrictions on visiting, such as closer nursing observation during family visits, potentially limiting family privacy. As well as this, there may be restrictions on periods of leave back home under suspension of detention provisions of the Act.

This exploratory study takes a preliminary look at how health services and local authorities have acted upon their responsibilities under section 278. The Mental Welfare Commission fulfils its monitoring responsibilities, in relation to children and young people who are subject to compulsory measures, both by visiting specialist units and by making enquiries into the treatment and care of any young person, under 18, who is detained in an adult ward.

1.3 Parental mental ill health and effects on the family

There is a significant body of literature exploring the effects of mental illness on the family. The Royal College of Psychiatrists report (2011) *Parents as patients* outlines the issues for parents and children⁷.

Families and their social circumstances are very varied and illnesses present in a wide variety of different ways. Children need a secure base and warm attachments to underpin their healthy growth and development⁸. Children's needs change as they grow older towards independence. The impact of their mother's or father's illness will depend not only on the nature of the illness and the family's social circumstances but on the child's age, resilience and the existence of both formal and informal support systems⁹.

A parent's interaction with their child or children may be affected by many aspects of their illness, including, for example, behavioural changes, flattened or heightened emotional responses, or specific threats from delusions or paranoia. People with mental illness may also experience social problems connected with the increased risk of unemployment, poverty, stigma and social exclusion.

7 Royal College of Psychiatrists, London (2011) *Parents as patients: supporting the needs of patients who are parents and their children*, College Report CR164, January 2011.

8 Geddes, R, Haw, S and Frank, J. (2010), *Interventions for Promoting Early Child Development for Health. An environmental scan with special reference to Scotland* (Edinburgh: Scottish Collaboration for Public Health and Policy) p.3.

9 These themes are set out in these key policy documents

The Early Years Framework, Scottish Government 2008 available at <http://www.scotland.gov.uk/Resource/Doc/257007/0076309.pdf>

Mental Health Strategy for Scotland: 2012-2015 Scottish Government 2012 available at <http://www.scotland.gov.uk/Publications/2012/08/9714>

Vignette 1: A father living apart from his partner and children

A father of two boys, aged ten and twelve, developed a paranoid illness. He thought his partner and sons were trying to undermine him and were spreading stories about him to his work colleagues. He had sufficient insight to want to spare them trauma, and he moved out of the home. Initially this was on a temporary basis but it became permanent when his wife asked him to stay away as she was afraid of his angry outbursts. When his symptoms became very severe he was admitted to the local hospital's mental health ward on a short-term detention. At this stage he presented as separated and there was no discussion or assessment of the needs of his partner and children. They had been through a very worrying time, with little previous knowledge or understanding of mental illness. The father struggled with his illness which was helped by medication. No therapy was offered to help him with the loss of his family and the feelings of guilt at what he had put them through. There is now a risk that his illness will have a more serious impact on the lives of all four family members, because of the lack of support focussing on the family.

As well as the direct consequences of their mother's or father's illness, children may experience other stress factors; for example stigma or bullying at school and neighbourhood, loss or grief due to marital separation. Older children may worry about any possible genetic implications of their parent's diagnosis for their own future health. At the very least, children with a detained parent will experience anxiety about separation and the health of their mother or father. They may also be fearful of the hospital environment. The resourcefulness of many families in coping with the practical and emotional problems helps limit adverse effects on the children. Research consistently shows that the availability of someone whom the child/ children can trust and share their fears with, is one of the most important factors to help build resilience.

Where the loss of a parent threatens the stability of family routines, practical help is important. Having an adult who is non-judgemental towards the parent and their illness and who they can trust with their fears, can make all the difference to a child's coping. Not all children, however, have someone like this in their family circle. This is where services have a responsibility and an opportunity to provide sensitive help¹⁰.

Vignette 2: A mother of three in hospital following post-natal depression

A family of three young children (girls aged seven and five and a boy aged two) lived with their mother and father in stable, albeit quite chaotic conditions. The mother had experienced post-natal depression after each birth but had been slower recovering after the birth of the youngest. Following the birth of a son, issues relating to sexual abuse she had suffered as a child were re-awakened. This affected her relations with her husband. When she was in hospital, he was only just coping with the household tasks but not managing to visit his wife. Visits home were not advised and he was unwilling to take the children in to see her. The mental health officer referred the family to the children & families team, which arranged for domiciliary support. Unfortunately, the father was alienated by the unqualified care worker's attitude. He stopped engaging with the home help service and the Mental Health team. The young children consequently had no contact with their mother for the six months that she was an in-patient. This made her re-integration back into the family much more difficult when the time came for her to return home. There were no services in the locality that could work intensively with the family as a whole on both practical and emotional issues and this adversely affected both the mother's recovery and the children's emotional development.

¹⁰ Robinson B, Scott S & Day C. (2007) Parents in hospital: *How mental health services can best promote family contact when a parent is in hospital. Final Report - July 2007* Barnardos.
http://www.barnardos.org.uk/parents_in_hospital_summary_report_july_2007.pdf

1.4 Barriers to help

The *National Guidance for Child Protection in Scotland* notes

"The stigma associated with mental health problems means that many families are reluctant to access services because of a fear about what will happen next. Parents/carers may worry about being judged and that they will be deemed incapable of caring for their children. Many will therefore view asking for services or support as a high-risk strategy".¹¹

Families often express anxiety that admitting to problems might lead to them losing their children. This can be a considerable barrier to seeking and accepting help. This fear might not reflect reality but may be: a sign of their low confidence as parents; a temporary symptom of their illness; or, related to feelings of powerlessness in the face of authorities exercising control over their lives. It means referrals need to be carefully made and actively supported in order to be successful. This can be especially true where Children and Family team workers do not themselves understand the nature of mental illness and are alarmed at the use of the Mental Health Act. The risk of alienating the family can exacerbate the family's isolation and sense of inadequacy. This in itself will increase the adverse effect of the illness on the children. It is vital that there is good communication between the Mental Health and Children and Family services and that each is aware of the roles, responsibilities and procedures of the other.

Vignette 3

Two children aged eight and six were living with their mother in temporary accommodation when she became unwell. When the stresses of her social situation escalated, she became homeless. The children were placed with foster parents when, in a crisis, she was admitted to hospital on a short-term detention order. There had been no serious concerns about the mother's ability to care for her children when well. The mental health officer and the ward team worked together with the children and family team to ensure that the foster parents were supported to understand the mother's illness so they could help the children keep in touch with their mother during her period in hospital. Unless foster parents have a good understanding of mental illness and the possibility of recovery, the task of supporting them to help the children in their care maintain contact with their mother can be daunting.

In Scotland, mainstream mental health and children's services frequently fail to offer coordinated and cohesive support. In practice, there is a lack of acknowledgement of the extent to which parental mental health and children's well being are linked. There are a few services in Scotland specifically structured to help mentally ill parents, children and other family members. On the whole, parents and carers have to struggle with a multiplicity of services, each with responsibility for a limited dimension of their problems: for example, help with transport, domiciliary help, child minding, respite care, counselling.

The *National Guidance for Child Protection in Scotland* recommends:

"Universal services must also be aware of the potential impact of adult mental illness on parenting capacity and, therefore, on children and young people."

Child protection services will, at times, be involved in some cases. Where they are, there must be good age-sensitive communication with the child, and there must be respect for the importance of the parental relationship in the child's experience. There must be clear avenues of support for the child, not just in providing a warm and stable environment, but also to help him or her understand the symptoms and likely course of the illness (according to age and understanding).

¹¹ National Guidance for Child Protection in Scotland | 2010
<http://www.scotland.gov.uk/Resource/Doc/334290/0109279.pdf> p119

1.5 Young carers

Children often take on household tasks when a parent is ill. Studies by organisations supporting young carers have shown that young carers' tasks can include household chores, emotional support, personal care, and help with taking medication. Caring can strengthen bonds between children and parents but only if the child can cope with what is asked of them. It is unwise for other adults such as mental health workers to make any assumptions about the child's ability to cope. Because of the reluctance to seek outside help, the child's inability to cope or psychological distress may go undiscovered. Children themselves may be fearful of disclosing the problems they are having in coping with and caring for an ill parent.

The admission of a parent to hospital will be a different experience in a single-parent family to that of a two-parent family. The presence of other close family members, grandparents or aunts and uncles who can step in to look after the children will also affect the experience.

A report by England's Department of Health in 2002 reports that:

*"There is evidence to suggest that the person with mental illness supported by a young carer is less likely to be receiving treatment and support in their own right, compared to the person supported by an adult carer."*¹²

There is no reason to believe this is not the case in Scotland too. The young carer may not know how to access help or may be reluctant to share the problem with a person outside the family. There is a risk that the needs of the ill parent and their young carer only come to light when a crisis develops.

The report continues:

"Assistance to young carers needs to avoid, however unintentionally, reinforcing the role of the child or the young person as a carer. Interventions to help support the family as a whole and promote the parenting role of adults are more likely to be helpful and ensure that a child's welfare or development is not impaired."

Increasingly treatment is being provided to people in their homes. Home treatment teams need to be aware of the different needs of children in the household.

The Australian organisation Children of Parents with Mental Illness (COPMI) has produced two useful checklists in conjunction with service providers and parents with a mental illness, their partners and children. We reproduce these in our Appendix I.¹³

One of the principles of the 2003 Mental Health Act is that the views of carers should be sought and this principle should not be abandoned merely because the carer is under 18.

¹² Department of Health (2002) Developing services for carers and families of people with mental illness.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009233

¹³ Children of Parents with a Mental Illness (COPMI) <http://www.copmi.net.au/>

1.6 Treatment and care

Admission wards

Parents receiving psychiatric treatment on a compulsory basis, and who are still actively involved in the care of their children, with regular access and contact, are most likely to be found in admission wards. However, the duties imposed on staff via section 278 apply to all units and services where parents are subject to some kind of compulsion. This will include intensive psychiatric care wards, continuing care wards and rehabilitation wards, but also supported accommodation services and home treatment teams. Assessments should address issues relating to the impact of the illness and treatment on the relationship between the parent and child. The resultant care plans required by the Mental Health Act under section 76 should reflect the services needed to remedy the adverse effects of compulsion.

Community services

If care plans were more rigorous in referring to these issues, it would alert workers to their statutory duties in respect of section 278. The principles of the Act clearly state that a range of options should be available to provide maximum benefit to the patient. Addressing this issue carefully can positively affect the wellbeing of both the patient and their children.

Mother and baby units

Section 24 of the Act requires NHS Boards to provide services and accommodation to ensure that certain mothers, of children under one year old, being treated in hospital for post-natal depression are able to care for their children in hospital if they wish to do so. Mother and baby units are designed to treat the mother's mental illness as early as possible. Wherever possible they allow for the admission of the baby so that mother and baby are not separated. They also aim to provide support to the families and carers. Health and social care professionals work together to assess and arrange treatment and care that is sensitive to the family's background. This would include support for the recovering mother to nurture her baby in a safe environment, which helps to establish a good relationship at this key early stage of maternal bonding. The ethos of mother and baby units fits closely to the principles underpinning section 278.

There is, however, a wide gap between the services provided by mother and baby units and the services available for mothers and toddlers (or, indeed, older children); although at this later stage, issues of attachment remain very important to the child's emotional and physical development.

Medium secure and forensic units

The issues on these units may be somewhat different from those on general acute admission wards and it may be useful for staff in these units to see how this has been approached by the State Hospital. While their concerns are more heavily weighted towards child protection, there will be instances in these type of units where this will be a legitimate consideration and will need to enter into the process of assessing the appropriateness of visits and the manner in which they are managed.¹⁴

¹⁴The State Hospitals Board for Scotland takes an integrated approach to Child and Adult Protection. Further details on the State Hospital procedures for child visiting and access can be found in their policy documents (2012) *Keeping Children Safe Policy and Adult Support and Protection Policy*.

2. Survey of social circumstances report

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2.1 Introduction

Mental health officers (MHOs) write social circumstances reports (SCRs) when individuals are detained beyond 72 hours under the Mental Health Act. A good SCR should bring together, in one clear document, important information concerning the individual's circumstances, their strengths and weaknesses, and the effect of the illness on their family and social situation. The purpose of the SCR is to provide the responsible medical officer (RMO) and other practitioners, with relevant information for the assessment, treatment and future care planning; including the need for the continuation of compulsory care and treatment. The SCR might also help the person receiving care and treatment, by clarifying the reasons for seeking compulsory measures and by setting out the anticipated benefits of treatment. It might also assist the individual in developing further insight into the nature and course of their illness. It can also place in context the decisions made by the RMO and others in the mental health team during an acute phase of the individual's illness.

The need for an SCR is triggered by a person being subject to one of a number of different sections of the Mental Health Act (called relevant events) unless this would serve *"little, or no, practical purpose"*. Mental Welfare Commission good practice guidance on SCRs is available on our website¹⁵. This guidance recommends that an SCR be considered a priority when the patient has caring responsibilities or there are any child protection issues. This is not only because family circumstances are an important aspect of the person's social circumstances but also because services have a duty to consider the wellbeing of children. The SCR can also serve to alert other professionals to the presence and needs of children.

The majority of people subject to detention are within the general population age groups of people likely to have children under 18. At present there is no specific place in any of the statutory MHA forms which identifies whether the individual subject to compulsory measures has children. SCRs should and mostly do note whether the individual has children, but we know that SCRs are not written for every detained patient. We are far from confident that, following a relevant event, an SCR is written for every person with children under 18.

2.2 The sample of social circumstances reports

We examined a sample of SCRs to see what, if any, information was recorded concerning the children of people subject to compulsory measures.

The sample (212) was selected from all SCRs (1729) written during the year 1 April 2010 to 31 March 2011. The sample included all reports for individuals in the following single year age groups at time of preparation of the SCR (aged 20, 25, 30, 35, 40, 45, 50 and 55).

Of the 212 reports a quarter (26%, 56) contained information indicating that the individual concerned had a child or children aged under 18. We consider that this is likely under-reporting, even taking into account reduced fertility amongst those with long-standing illness.

¹⁵ Mental Welfare Commission (2009) *Social Circumstances Reports: Good practice guidance on the preparation of Social Circumstances Reports for mental health officers and managers*.
http://www.mwscot.org.uk/media/51846/Social_Circumstances_Reports.pdf

There were slightly more men (53%) than women (47%) in the sample group, with more men than women in the two youngest age bands. In 57% of reports it was clear whether individuals did (26%) or did not (31%) have children under eighteen years. A third of women in the sample were mothers and a quarter of the men were fathers.

Table 1	Number	%
With children under 18	56	26
Without children under 18	65	31
Not clear (children mentioned but most likely over 18 years)	4	2
Not clear	2	1
Not mentioned	85	40
Total patients subject to an SCR	212	100

A number of reports for the older age groups made reference to adult children. These adult children usually played an important part in the social circumstances of their detained parent. They may well have been under 18 during earlier episodes of illness and detention.

2.3 Family circumstances and children's living arrangements

The family circumstances reported on in the SCRs varied considerably and, likewise, the degree to which the reports focussed on parental issues. Fifty SCRs recorded some information about where and with whom the children were living. Some of these children, however, did not usually live with the parent prior to their parent's hospitalisation or being subject to compulsory measures. Thirty reports included some reference to contact between the detained parent and the children. In five of these, the arrangements were well covered. In 12 the arrangements were covered to some extent. In 13 there was no further information.

Table 2: Child living and contact arrangements recorded on SCRs		
Individuals have child/children	Child's contact with ill parent recorded	Children's living arrangements
21	21	Children living with other parent/partner in family home, where patient usually lives
9	4	Living with ex partner: patient has regular contact 3, patient is pursuing access 1, no information on contact between patient and children 5
9	5	Living with family members, grandparents, uncles or aunts: patient is usual carer (4) aunt has formal order (1) no other information (4)
1	0	Children in foster care, no information on contact
4	0	Living with other parent abroad in various circumstances
4	0	No contact with the children for a considerable time
2	0	Adopted, no contact between patient and children
6	0	No information in the report about the children's living arrangements or contact with the detained parent
56	30	Total

Of the 50 reports which mentioned the adult having a child or children for whom they usually provided care, the majority (30) noted that the children were either living with their other parent (25) or with close relatives during the current illness (five). Of the nine children living with the ex-partner of the patient, there was clear information that four were still in touch with the patient. Two patients had their children adopted many years earlier and had no current contact. In the remaining cases, there was no evidence of ongoing contact.

It was not clear whether children who did not normally live with the ill parent still had active or meaningful contact with them and whether there would be a need for support in those cases.

Preparing a social circumstances report: timing

The MHA uses the term ‘relevant event’ to denote the stage of a compulsory measure when a SCR is required. The majority of this sample of SCRs were prepared in connection with the making of a short-term detention (STD) which is usually at the start of an episode of compulsion. It might be difficult, at this early stage, to know the implications of the illness or to be certain about which treatment approaches will be most effective, unless the person is well known from previous episodes of illness. At this point it might be difficult to ascertain the family’s ability to cope or to assess what type of support for parental relationships, if any, might be necessary or helpful. However, it is a good time to pass on what is known about the relationships in the family, to highlight the existence of children and how events leading up to admission and the admission process itself appears to have affected them.

Table 3: Relevant event	All SCRs	SCRs with children
Short-term detention (STD)	175	42
Assessment order	13	5
Compulsory treatment order (CTO)	14	4
Interim (ICTO)	3	2
Treatment order	1	1
Transfer for treatment direction	3	1
Hospital direction	1	1
Total	212	56

In any intervention the manner of the initial contact is vital to its success. In the period leading up to a hospital admission, the family may have been dealing with a lot of stress. They may also have been directly affected by the person’s symptoms such as paranoia, delusional thoughts or withdrawal. Because of this, the family may be relieved the person has been admitted to hospital and is receiving treatment, whether on an informal or formal basis, and they may well be very receptive to offers of help. When the parent is admitted under a short-term detention certificate, the ward team and the MHO are in a good position to get to know the family and offer immediate support to children and carers.

In conclusion, we found that preparation of SCRs is an area where practice varies. Despite the Mental Health Act and the related forms for SCRs attempting to address this issue, it remains unclear how managers and/ or MHOs decide when a SCR would serve a useful purpose. Because of the considerable significance of parental mental illness for both parents and children, we feel the use of compulsory measures under the Act for mothers and fathers of children under 18 should prompt an SCR at the beginning of each new episode. It is clear from examining this sample of SCRs that this is not standard practice.

Whilst SCRs may capture the situation at an early stage, there are parents subject to compulsory measures for longer periods, both in hospital and the community. We looked at this by following up two groups of parents identified in SCRs; where the SCR was triggered by a Compulsory Treatment Order (CTO)(6), and, where after the expiry of the STDC the parent went on to a CTO.

Compulsory measures relating to CTOs triggered an SCR for six of the sample parents. In five of these cases, nothing was recorded about the patients' relations with their children during the illness – neither in the SCRs or in the formal section 76 care plans. In three cases it was noted that the patient normally lived with their children but only one of these SCRs mentioned the issue of support to maintain contact with the children. In this case the CTO application completed by the MHO, included an unspecified need for 'support for emotional distress' in the proposed care plan; the RMO's care plan also recorded a need for 'family support'.

Of the 50 people where short-term detention certificates triggered SCRs, 26 became informal patients after the STD; and we have no further information about the care plans or supports offered to help with their recovery. Three people were detained on CPSA orders and again we have no further information about their care. CTO applications were made in 16 cases, 14 of which were granted. Of these 14 who went on to long term orders, 11 had current relationships with their children; three had not had contact with their children for many years.

We tried to get a picture about the parental support offered for the 11 parents (eight mothers and three fathers) on long term orders. We looked at the proposed care plans for the CTO applications and the RMOs section 76 care plans to see if they addressed support for individuals in their role as parents, as well as support for their children. In 10 of the 11 cases, the need for a Compulsory Treatment Order was justified by identified risks. All the risks were likely to affect the children either directly or indirectly. Examples of risks included one case of domestic violence where the children were living at home; others included the parent's paranoid delusions, where aggressive thoughts were directed towards the other parent or children.

Proposed care plans and RMO care plans are by nature brief. However we found that there was a worrying lack of reference to treatment approaches to help families cope with the difficult experiences identified elsewhere in the CTO paperwork. The main treatment specified was medication, and in the few cases where psycho-social interventions were mentioned, this was done in a very general way. The MHO referred to psycho-social support in only two proposed care plans; one of which referred to both family support and carer support. Only one RMO's care plan included 'family support', even where risks to family relationship had been given as the reason for the necessity of compulsion.

Good practice guidance, *Parents as patients* (Royal College of Psychiatrists, 2011)¹⁶ emphasises the psychiatrist's duty to: be alert to the presence of children in patients' families; to assess their needs and to refer to other services when necessary. It may be that this is happening but it is not being recorded in RMOs' care plans. This begs the question "why leave it out?" Medication may help improve the parent's mental health but the fear and memory of the disrupted relationships will not be erased by medication alone.

¹⁶ *Parents as patients: supporting the needs of patients who are parents and their children*, Royal College of Psychiatrists Report (RCP) CR 164, January 2011, London

This mismatch between risks and the treatments does not seem to be in accord with the principles of the Act. The needs of individuals as parents are very varied and a generalised prescription cannot be given that fits each scenario, but services to support parental relations should be responsive and flexible to meet the needs of the individuals involved. The first step, however, is to recognise the importance of assessing these needs.

3. Survey of nurses in charge of admission wards

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We surveyed general adult psychiatric wards where parents of children under 18 were likely to be included in admissions. These were mostly general admission wards in psychiatric hospitals. We issued 72 questionnaires to nurses in charge of these wards using 'survey monkey'. We received 30 replies from charge nurses and ward managers, referred to in this report as 'nurses'. These results are based upon 24 completed responses. Six nurses considered the survey not applicable to them. Some questionnaires were partially completed.

The survey was anonymous. The provision of additional identifying information, for the purpose of facilitating potential additional follow-up was optional. Responses indicated that questionnaires were returned from at least seven Health Board areas.

Some questions were applicable to parental issues in respect of all patients, whether detained or not. Other questions were specifically focussed on detained patients.

3.1 Hospital policy, facilities and information for children visiting patients in hospital

We asked nurses to comment on their hospital's policy, any special facilities for children visiting patients in hospital, and the availability of age-appropriate information.

Written hospital policy

Five nurses said that there was a written policy on visits by children under 18 to patients, eight did not know if there was a policy and seven were clear there was no written policy. Nurses who commented also spoke of 'ward-based policy' and it was not clear whether the policy was hospital-wide:

"current guidelines request that the patient / family advise ward staff 24 hours prior to children visiting so that the appropriateness of the visit can be reviewed. This recognises that an individual's mental health may deteriorate or improve."

Special facilities

Twelve nurses said there were specific facilities in their hospital for visits by children. Seven were clear that there were no such facilities. In some wards special 'family rooms' are available for visiting, or a 'family' area' was mentioned. Others have designated areas away from the ward. These rooms or 'areas' were equipped with child friendly equipment such as toys, play equipment, small table, books.

In some instances patients and families were also offered a choice of another room off the ward if it seemed the on-ward room was not suitable:

Examples highlighted the need to take into account the circumstances of each family and child individually and to consider whether it was appropriate for children to visit on the ward. One example highlighted the drawback of a room away from the ward, whilst another highlighted potential 'safety' issues of a child visiting on the ward:

"Unsure if it could be called 'special' but we have an agreement that young people visit their parents in a room outside of the admission ward. It doubles up as an assessment room. However, this agreement fails when the patient is cared for in conditions under Criminal Procedures remand when they cannot leave the ward and it would not be in the interest of 'safety' to have the children visit on the ward."

Information for children

Giving children an understandable explanation of the nature of the illness of their parent is crucial. Age-appropriate information in leaflet, pictorial or story format can be an important adjunct to talking things through with a trusted adult. We asked if such literature was available in wards. Only four nurses told us that they had access to some information. Nurses commented that they were not aware of the availability of such literature and that they thought this was a neglected issue:

"We have a copy of "one in a hundred" written by NSF¹⁷ I am unaware of any other age-appropriate literature."

3.2 Assessment and care planning

Assessing needs

We asked whether, at admission, as part of the admission assessment, patients were asked if they had parental responsibilities. Of those responding to this question, most (90%, 19), said that the assessment process, on admission, would always, or very often, identify whether patients had children under 18. One nurse said sometimes and one did not know.

It is not at all clear that the issue of parental responsibilities is raised in assessments for every patient with children under 18, especially where parents have little active involvement or very occasional contact with the children because of separation or divorce.

In the context of patients with children under 18 being admitted to the nurse's ward, we asked whether the clinical team would have discussions which focussed upon whether any action was required by the team to help the team meet their responsibilities under section 278. The majority (86%, 18) responded positively saying that they would discuss this, with over half saying they would do this always or very often. However, two said they would 'never' do this and one did not know.

Care plans and discharge planning

We know that care plans vary in detail and comprehensiveness, and that various professionals (psychiatrists, nurses, social workers) prepare separate care plans focussing on different aspects of care. The Mental Health Act requires that, for individuals on whom an application for a Compulsory Treatment Order is being made, MHOs prepare a proposed care plan and that the RMO produces a care plan (section 76) as soon as practicable after the order is granted. The plan should be reviewed and amended as necessary. The day-to-day care provided for in-patients is usually set out in a nursing care plan in-patient notes, often with additional contributions from other professionals. Care plans should therefore record what care is planned or being provided.

We asked if care plans included actions (by the team) to help patients maintain contact with their children (except where there were legal restrictions on contact). Almost three quarters (72%, 15) said that they did with nine saying they did this always or very often. However, six respondents said this happened rarely (four) or never (two) and another one did not know.

¹⁷ NSF Scotland *1 in 100 will experience a serious mental illness Annual Report 2010-2011* <http://www.supportinmindscotland.org.uk>
In October 2010 NSF (Scotland) adopted a new operational name, Support in Mind Scotland.

We also asked whether care plans actively explored how best to support parents during their illness with their parental responsibilities. Although two thirds (67%, 14) responded positively, it was clear that this was not regular practice, with eight of these saying this happened sometimes or rarely and the remaining six responses saying rarely or never:

"We always discuss with the patient during admission to check if their children are being cared for."

Patients subject to compulsory measures

As section 278 relates specifically to the duty to mitigate the adverse effects of compulsory measures on parental relations we asked if there were any particular actions triggered when a parent becomes subject to a compulsion.

	%	No.
Referral to social work	72	13
Someone in the team offers to talk with them	56	10
Refer CHILD for carer's assessment (CC&HA 2002)	6	1
Refer OTHER ADULT CARING for child for carer's assessment (CC&HA 2002)	17	3
Other	22	4
Total	100	18

Almost three quarters of teams said they would refer to social work and anticipated liaison between the MHO, social work and mental health services. The issues were discussed by the staff team and about half the nurses noted that a member of the ward team would offer to talk to children if required.

"Links will be made to any agencies already involved in the patient's / family's care. On occasions I have spoken with teenage children with the parent, at the parent's request. However, I have not spoken to any children under the age of 12 years. Where social work have an established relationship with the child / family they take the lead. Should the child be involved with CAMHS then links are established."

"Child protection assessment carried out at point of admission. Action taken, if necessary, dependent on the outcome of that assessment."

"This component is more formally managed by social work/MHO. A nurse would only speak with the child in a general sense during visits. Formal care plans are not developed with regard to visits and maintaining contact though it would always be an issue that nursing staff would include in discussions with the patient."

Only one nurse indicated that they would refer a child for a formal carer's assessment under the Community Care and Health Act (Scotland) 2002. The practice of formally assessing a child's needs in relation to their lives as young carers appears to be a neglected one.

Recording information

We also asked what information is recorded about the children when a parent is detained under the MHA. Such information would assist communication and keep the team alert to potential parental responsibilities issues. It appeared that a high proportion of wards recorded factual information about the children's situation.

Table 5: When patients are admitted under MHA, or if they become subject to the MHA, do you formally record in the case notes any of the following:		
	%	No.
The names and ages of any children?	75%	15
The nature of their parental responsibilities?	70%	14
The care arrangements for any children during the parent's stay in hospital?	80%	16
Names and contact details of the other parent and/or kinship carers?	85%	17
Arrangements for contact and visits, if appropriate?	60%	12
Any formal orders (supervision or care) in place for any of the children?	75%	15
Names and contact details of social worker involved with the children?	90%	18
Other (please elaborate)?	25%	5
Total	100%	20

"The names of the children and their ages is recorded in the initial assessment. However, there is not a specific document or page within the individual's file regarding this. You would have to read through lots of information rather than being able to go straight to a specific page."

"Arrangements for contact and visits are generally not done at admission, however, this is explored at the earliest opportunity when the patient is able to do so."

Our survey was a trigger for at least one nurse to investigate further:

"No current way of documenting all of this info and not aware of the care plan being used but intend to look at this now."

Discharge planning

Discharge planning is always an important stage in a care pathway, both for the patient and people around them. This is especially important when returning home means returning to live with and resuming care of children. Children may have many mixed feelings, ranging through relief, apprehension, happiness and dread, depending on their experiences and knowledge.

It is a time when mental health services can support other family members. They can help reassure the children by talking about the situation in an appropriate way. It is very important where the children take a caring role, or if the ill parent is a lone parent, that the children have a crisis contact, someone with whom they can readily speak without fear of reprimand or rebuff

Ninety percent (18) of nurses said that they did consider the potential impact of the discharge upon the children but half did this only sometimes/occasionally.

General comments

Comments from nurse managers indicated that this is a complex and sensitive area of practice. In most cases, it appeared that staff were gathering basic relevant information on the individual's family which, where appropriate, should trigger further therapeutic interventions with both parents and their children. Nurse managers recognised the importance and complexity of this area of work, and the need to raise its profile:

"I think that the amount of information recorded, about the arrangements for looking after any children under the age of 18 years, varies according to each case. For example, if the other parent is deemed to be highly competent and/or there is a very supportive family structure, to support the affected parent and the children, then a case like this would need much less input than one where the parent was a single parent or where the other parent was not coping for whatever reason."

"From the questions posed, it's apparent this is an area where we have a lot of work to do."

A key finding was that some ward staff were unaware of their statutory responsibilities under section 278. It follows on that in these wards the mental health team were less likely to fully assess issues for the patients who were parents, whether they were compulsorily detained or in hospital on an informal basis.

4. Survey of mental health officers

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Mental health officers (MHOs) have specific duties under the Mental Health Act. They are appointed by local authorities after specific training in mental illness and other related conditions and mental health and incapacity law.

The survey was issued to 183 mental health officers via 'survey monkey'. We received 61 responses (33%) of which 43 (23%) agreed to take part. Some questionnaires were partially completed.

The survey was anonymous; the provision of additional identifying information, for the purpose of facilitating potential additional follow-up, was optional. Responses indicated that questionnaires were returned from at least sixteen local authority areas.

Some questions were applicable to parental issues in respect of all patients, whether detained or not. Other questions were specifically focussed on detained patients.

4.1 MHO training and experience in section 278 work

Forty two percent of MHOs said that their original MHO training included work with parents and children; only 9% of MHOs had received any continuing professional development on working with parents with mental illness and their children since. Over half (58%) said they had not received any training in the subject.

Table 6: What training have you had in working with parents with mental illness and their children?		
	%	No.
My original MHO training included training on section 278	42	18
I have undertaken continuing professional development (CPD) on section 278 for MHO work	9	4
I have had no specific training on section 278	58	25
Other (please specify)	7	3
Total	100	43

"The training I received in 2004 did not have specific training regarding section 278 as the Act was not in place then. I do not remember extensive training within the five day transitional training held later."

"I am also a Tribunal member so have undertaken training on this issue with them."

We asked the MHOs if they considered parental issues at significant times. The majority (92%, 34) said that at the time of giving consent to detention, they asked 'always or very often' whether the person had children under 18. When making a CTO application most (78%, 28) said they would 'always, or very often', include parental issues in the proposed care plan.

Asking about the policy in their authority with regard to writing SCRs, only 38% of MHOs said it was policy to prepare SCRs for patients with children, 43% said it was not policy.

4.2 Social circumstances reports

MHOs indicated that they included a range of information relevant to parents and their parental responsibilities in the SCR.

	%	No.
That there are children under 18, and the nature of their parental responsibilities	91	30
Impact of the illness on the parental responsibilities (actual/potential)	88	29
Impact of the illness on the children (actual/potential)	73	24
Specific implications of the MHA measures for parental relations	55	18
Specific approaches to help mitigate adverse effects of measures	64	21
Care arrangements for the children whilst their parent is detained in hospital	88	29
Support needs of the children	58	19
Other	15	19
Total	100	33

Many of the comments show that the needs of children were considered, and practical support was arranged to help parents and children keep in touch.

"Worked closely with children & families services, including foster care arrangements, emotional support, activities, school etc. and ensured contact with mum (single) via supervised visits in family room in hospital then in community when her mental health improved."

"Where parental relationships exist, I consider all of the above, particularly where the only option for hospital detention is some 65 miles away but my SCR may not explicitly identify these areas."

"In most cases clients have already given over the care of their children to family as they have been too ill to look after their children themselves."

Other aspects mentioned included:

"Where grandparents are involved, the effects of having their grandchildren with them whilst their parent is unwell and their needs as carer."

"Risk assessment in relation to potential child protection issues. Risk assessment where parent has mental illness and child has mental illness, especially when parent has Named Person status for the child."

One response also noted that there might be nothing recorded where no difficulties had been identified:

"Frequently individuals have no immediate family but in these cases and where there are no difficulties I might not specifically record anything."

These survey responses were more reassuring than evidence found in the sample of SCRs; the responses suggested that MHO's paid attention to issues affecting parental relations as a result of the parent's admission to hospital under the Mental Health Act.

4.3 Social work and Mental Health teams' input

In the MHOs' experience of adult admission wards, just over half (56%, 20) said that that ward staff would involve social work when a patient with children was admitted, informally or formally; over a third (39%, 14) did not know. More than two thirds (70%, 25) of MHO respondents said that that in wards where they practised there were no identified linked social workers.

Detained patients

Where detained parents were part of their caseload, almost three quarters of MHOs felt the Mental Health team looking after the patient addressed the child's needs while the parent was in hospital, particularly in relation to care arrangements. The MHOs were confident of Mental Health team's practice in helping the children understand the illness, with one third of MHOs saying the team would help "very often" and another third saying the team would help "sometimes".

Three quarters of MHOs thought the team addressed issues concerning the adult and particularly the impact of the illness on parental responsibilities. They were confident that the team would address the possible adverse effects of the MHA measures on parental relations. They also believe the team would assess whether assistance was necessary to help the parents maintain contact with their children and promote positive parental relations.

Two thirds thought the team would help the other adult/carer help to understand the nature of the illness and its impact on the child and would assist in supporting the child in their relationship with their ill parent.

The practice of referring the adults caring for the children or the children themselves for formal carer assessments was less common, occurring "sometimes" "or rarely" in most cases.

It is worth noting around ten respondents (nearly a third) answered "don't know" for all these areas.

Joint working with Children and Family teams

Two thirds of MHO respondents (22) had made referrals to Children and Family Services; per year, three made over five referrals, 11 made two to five referrals, and eight made only one. Surprisingly, nine MHOs did not know if they had made a referral to Children and Family teams.

Most MHOs were positive about the culture of joint working between Mental Health and Children and Family teams but their views on the strength of this were mixed, with just under half giving a clear "yes" and a further third saying this was positive "sometimes". The comments highlight how varied MHOs' experiences are:

"Although family services are helpful in signposting you (MHO) to services available to support a child they rarely become involved."

"In specialist mother and baby unit a lot of work is done with partners, parents and forward planning for the child."

"I have, in recent years, found child care social worker to have a very poorly informed and prejudiced view of parents with mental ill health."

"I have referred families for support and unless the children require statutory support from child services, I have found that the onus is on myself to speak to the children. They are reluctant to take on any non statutory cases unless there are clear child protection issues."

MHO experience of children being safeguarded by child protection measures

Just 19 MHOs reported that they had experience of children being safeguarded by child protection measures.

"From a manager's perspective, there are often tensions between the staff focussing on the child's needs and those working with the adult. Mental Health staff often experience the demands from child protection work vis a vis reports, short timescales for meetings and attitude of child and family staff as negative towards the parent."

"I was involved in a situation where a single mum with mental health difficulties was leaving her five-year-old on own whilst she went out. Child protection and admission arrangements were done concurrently."

"Collaborative working between mental health services (both health and social work) and children & families social work services has resulted in quite positive improvements in one situation. Although my client needed to be compulsorily admitted to hospital for several months, it was possible to support her to maintain contact with her daughter who was cared for by the client's parents while she was in hospital. My client is now back home and her daughter continues to live with her and their relationship seems to have considerably improved."

"I consented to the detention of a mother whose mental illness resulted in her refusing to allow her child to attend school or go outside due to her own paranoia. Once [parent was] detained, family services were very helpful in assisting me to look at services available to support the child and family. [I] Also had good links with the school. Mum did, however, become involved with another patient on the ward who was known under MAPPa and seen to be a predator. This resulted in child protection procedures being initiated as mum was allowing him access to her son at home while on pass. It was fortunate that this was able to be resolved quickly as mum stopped access and there was good family support."

"I have made referral to Children's Panels; attended various child protection meetings; supervised access to children; charges against adults who have been accused of harming children; have provided additional support around parenting and around the needs of the child."

4.4 Resources for supporting children to visit their parents in hospital

We repeated to MHOs the question we had asked ward managers about facilities in hospitals for visiting children. There was a marked difference from their nurse colleagues in their opinion regarding the facilities available. Just four had experienced good facilities, the majority (21) were unequivocally negative and a quarter did not know. Comments included:

"I have not found this to be a positive experience for children. Normally we have to rely on the patient dining room."

"Children often have to visit a busy acute psychiatric ward, which is not always appropriate and could potentially be distressing for both children and parents."

"Our acute admissions ward and community staff will endeavour to provide support to ensure that both parent and child have a positive/safe contact."

4.5 Support for parent and child

Twenty five MHOs chose to tell us about their experience of accessing alternative care arrangements for a child during a parent's admission. Several (four) respondents did not know, were not sure or had not been involved in incidents to date. Several (at least six) said accessing support was "not easy".

Engaging family members (grandparents, second parents) to help was the usual first option and therefore it would depend upon the available family network of potential support. It was also recognised that such arrangements could put a lot of strain on the family network, particularly if the arrangement had to be longer term.

"Have never had to do this as usually either second parent or grandparents will care for child."

"It can be difficult as the option is use of family or care. While family were able to support the child, mum's admission was lengthy and this put a great deal of strain on the family (brother) relationships were very stressed and the financial demands for the brother and his family were difficult. While social work paid and provided aftercare services for the child the emotional demands for everyone were high. Social work did link in with psychology to help access support for the child."

Alternatives to family-network-based care were arranged by children & families social work services. Most comments said teams responded well. Ease of access and sustaining support was affected by a number of factors including: lack of foster placements. For older children (16+) the responsibility might be seen to fall to adult care services:

"Children & families social work services are in the main very responsive if alternative arrangements need to be made for children in this situation. In my experience there is also positive and continuing follow up work to ensure that the parent's admission has the minimum negative impact on the child and on parental/child relationships."

"This can be difficult depending on the suitability of other family members as carers. Respite would be the next option. The least favourable option for a child would be residential child care. In my view the child requires as much support, education and reassurance as the parent."

Good practice and supports identified by MHOs included:

"Networking across social work and other organisations assists process."

"Joint working – referral to children & families services."

"Attempts to secure the same carer where there are any repeat admissions."

"Befriending service linked to children & families social work services."

"Local Community Mental Health services with professionals trained in family counselling and support."

"Childcare. Practical support to support parent. Local group for young carers."

"Psychological services to the child and carers."

"The school can be very helpful in supporting the child and keeping in close communication (with me)."

We asked the MHOs what services they could access for supporting families. The results were generally fairly positive, but there were clearly gaps in some areas. It was not possible to know how many families take up offers of practical support and given the responses, it is perhaps surprising that so few supports are recorded in care plans.

Table 8: What supports can you access to help with parental relationships?		
	%	No.
Voluntary agencies offering family support	68	19
Practical support for household tasks	82	23
Help with taking children to school	68	19
Emotional support for children to help understand the impact of illness	50	14
Groups for young carers	75	21
Activity groups for children	39	11
Other	21	6
Total		28

4.6 Additional comments/improvements wanted

The majority of MHOs (27) thought that this area, section 278 MHA, required greater attention.

"I would absolutely agree that section 278 requires more attention for everyone involved in social work and not just the MHO. Children are often forgotten in the mental health process and in the general care planning, support and monitoring of the family."

There was a call for more training in the area:

"Social workers (from both mental health and children & families teams) and also mental health workers would benefit from further training in how to work effectively with children and their parents who are affected by mental health problems."

"I believe there should be a section 278 training event open to MHOs as part of their ongoing training. I also believe that the training should be promoted to colleagues in children & families teams and that joint working should be encouraged."

MHOs also commented that mental health and children & families services should work more closely together:

"There is possibly a need for Mental Health and children & families social work services to improve collaborative working arrangements to ensure we are complying fully with our duties under section 278."

"In Adult services there is a general lack of understanding of the needs of the child both as users of services and dependants of users of services. 14 - 18 year olds are particularly difficult for adult workers to manage due to the capacity and developmental challenges they throw up."

Other issues the responding MHOs felt needed to be addressed included the child's emotional needs:

"Work often focuses on practical care. Greater consideration needs to be given to emotional needs."

"Although I am very aware of the need to consider the child in the actions of the Act, I have paid little attention to the need to assist the children with understanding about the illness and I believe this is the experience of my colleagues."

There were calls for hospital facilities to be improved:

"There is a need to improve facilities to enable children to visit parents in hospital."

Some MHOs felt there was little call in their work to use this section of the MHA.

"I seldom use this section in my MHO work due to individual patient's personal circumstances."

"Section 278 is worthwhile and may sometimes require more attention than we actually give to address the issues. As MHOs, our focus on the adult should not eclipse the concomitant needs of the adult's children."

MHOs did appear to recognise the importance of their duties under section 278. They reported that they do consider issues for parents' roles at key times of compulsory interventions, for example, when giving consent and applying for CTOs. It was less clear, given the lack of mention in care plans, how many parents were offered and able to use practical and emotional support to help maintain good relationships with their children. The responses in the table above regarding supports available gave a relatively positive picture.

A number of comments throughout the questionnaires, however, showed that in most localities, the MHOs feel that the range of resources available to support parents and children is limited. MHOs feel that more work needs to be done in this field and that there is a need for focussed training involving both mental health and children and families workers together.

5. Conclusion

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This exploratory exercise aimed to find out about section 278 practice in the field. It looked at Mental Health Act documentation and conducted brief surveys to gather the views of managers of admission wards and mental health officers. It leaves many unanswered questions.

Further research in Scotland is required to explore the views of parents who have been detained and their children concerning the response of the care team in relation to the impact of the illness and admission to hospital under compulsory measures on the parent-child relationship. In addition further focussed investigation might explore how section 278 is observed when children are the subject of compulsory measures under the Act. It would also be beneficial to explore the practice and views of workers in other areas of the mental health services in relation to section 278.

References and Resources

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<http://www.rcpsych.ac.uk/mentalhealthinfo/youngpeople/caringforyoungcarers/emotionalsupport.aspx>

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<http://www.rcpsych.ac.uk/publications/collegereports/cr/cr164.aspx>

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<http://www.rcpsych.ac.uk/mentalhealthinfo/mentalhealthandgrowingup/parentalmentalillness.aspx>

Royal College of Psychiatrists (2012) *Post natal Depression, (RCP leaflet)* <http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/postnatalmentalhealth/postnataldepression.aspx>

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Scottish Government (2012) *Mental Health Strategy for Scotland: 2012-2015*

<http://www.scotland.gov.uk/Publications/2012/08/9714>

Mental Health (Care and Treatment) (Scotland) Act 2003

<http://www.legislation.gov.uk/asp/2003/13/contents>

Other Resources

Child and Maternal Health Observatory PIMH: Impact of parental mental health on children

http://www.chimat.org.uk/default.aspx?QN=PIMH_PARENTALMH

The Children's Society's <http://www.childrenssociety.org.uk/>

Children of Parents with a Mental Illness (COPMI), <http://www.copmi.net.au/>

Family Action's produces assorted materials, including a film on *Caring for a parent with a mental health problem:* <http://www.family-action.org.uk/section.aspx?id=780>

HandsOn Scotland. A Toolkit of helpful responses to encourage children and young people's emotional wellbeing, <http://www.handsonscotland.co.uk/index.html>

Parental Mental Health and Child Welfare Network, www.pmhcnw.org.uk

Royal College of Psychiatrists *Being seen and being heard* (training pack with CD ROM)

<http://www.rcpsych.ac.uk/campaigns/partnersincare/beingseenandheard.aspx>

Social Care Institute for Excellence SCIE (2012) *eLearning: Parental mental health and families*

<http://www.scie.org.uk/publications/elearning/parentalmentalhealthandfamilies/index.asp>

Support in Mind (booklets for parents and children), *It's About You Too! A guide for children who have a parent with a mental illness* and *Making Time to Talk – Advice for Parents with Mental Illness*.

<http://www.supportinmindscotland.org.uk/information-and-support/publications>

Appendix A Checklists

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Inpatient Checklist

Is your inpatient mental health service family-friendly?



- Do staff routinely ask clients/consumers if they are a parent or pregnant? Do genograms include children?
- Are relevant assessment tools in place? (eg. Family Focused Assessment NSW Health)
- Do you have a separate area where families can visit together with a degree of privacy?
- Are there comfortable sofas where children can sit next to their parent and/or each other?
- Is there easy access from this room to toilets, water, tea, coffee and healthy snack making facilities?
- Is it decorated with children/young people in mind (eg. with colourful posters, curtains)?
- Do you have a secure outdoor area where parent/s and their children can spend time together?
- Does it have play equipment in it?
- Do you have play activities for different age groups (eg. coloured pencils, books, interactive toys and games, craft activities that parents and children can do together)?
- Can children easily telephone/email their parents and can the parent communicate by telephone/email with some privacy?
- Is there a baby changing facility?
- Do you have age appropriate information/booklets/videos about mental illness available for parents to share with their children?
- Do you provide opportunities for children/young people to talk with staff/have their questions answered (given parental permission to do so)?
- Do staff make children feel welcome when they visit the facility (eg. do they address the children directly and at their level rather than simply speaking to the accompanying adult/s)?
- Do you encourage consumer parents to talk about their children?
- Do you encourage parents to have their children's photos by their beds?
- Can babies and/or toddlers 'room-in' with their parent if the parent is well enough?
- Are parents encouraged to provide the Kids Helpline number for children should they become anxious or feel frightened? (Kids Helpline:1800 55 1800)
- Are discussions held with the family and consumer about the discharge planning process and are they included in the process?
- Where a young person is assuming care giving responsibilities for a parent on discharge, is written information provided (eg. contact numbers)?
- Is a case manager/social worker specialising in COPMI available for the children and/or family?
- Are staff aware of local psychoeducation and/or counselling services family can be referred to (eg. carers groups, respite services, PHAMS, programs for children/young people, supported playgroups, transport services, aboriginal support services, CALD services)?

www.copmi.net.au

Developed from information provided by parents with a mental illness, their partners, support people and children [December 2010]

Community Checklist

Is your community mental health service family-friendly?



- Do staff routinely ask clients/consumers if they are a parent and/or if they are pregnant? Do genograms include children? Are relevant assessment tools in place (eg. Family Focused Assessment NSW Health)?
- Is there a safe play area with age appropriate resources in waiting areas and consultation rooms?
- Are parents supported in regularly communicating with their children (eg. email, phone)?
- Is there a baby changing facility in your service?
- Do you have age appropriate information/booklets/videos about mental illness available for parents to share with their children?
- Do you provide opportunities for children/young people to talk with staff/have their questions answered (given parental permission to do so)?
- Do staff make children feel welcome when they visit the facility (eg. do they address the children directly and at their level rather than simply speaking to the accompanying adult/s)?
- Do you encourage parents to talk about their children?
- Are there family friendly appointments (eg. if the parent has school aged children can the appointment be made during school hours)?
- Is the parent encouraged to discuss with their child's school how the child could best be supported during the parent's recovery?
- Are children included in the parent's care plan or do they have their own? (see www.copmi.net.au for care plan examples)
- Are parents encouraged to provide the Kids Helpline number for children should they become anxious or feel frightened? (Kids Helpline:1800 55 1800)
- Where a young person is assuming care giving responsibilities for a parent, is written information provided (eg. contact numbers)?
- Are discussions held with the family and consumer about the discharge planning process and are they included in the process?
- Is a case manager/social worker specialising in COPMI available for the children and/or family?
- Are staff aware of local services to which family members may be referred for support, psychoeducation and/or counselling (e.g. carers groups, respite services, PHAMS, programs for children/young people, supported playgroups, transport services, aboriginal support services, CALD services)?

www.copmi.net.au

Developed from information provided by parents with a mental illness, their partners, support people and children [December 2010]

Appendix B

Messages from Children and Young People

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Messages from children and Young People¹⁹

Messages from children and young people

Children and young people have told us what they would like from you when visiting their parents in hospital:

- 1 Introduce yourself. Tell us who you are. What your job is.
- 2 Give us as much information as you can.
- 3 Tell us what is wrong with our Mum or Dad.
- 4 Tell us what is going to happen next.
- 5 Talk to us and listen to us. Remember it is not hard to speak to us. We are not aliens.
- 6 Ask us what we know, and what we think. We live with our Mum or Dad. We know how they have been behaving.
- 7 Tell us it is not our fault. We can feel really guilty if our Mum or Dad is ill. We need to know we are not to blame.
- 8 Please don't ignore us. Remember we are part of the family and we live there too!
- 9 Keep on talking to us and keeping us informed. We need to know what is happening.
- 10 Tell us if there is anyone we can talk to. **MAYBE IT COULD BE YOU.**



¹⁹ Reproduced here with permission from Barnardo's. Children gave these messages to Barnardo's researchers. The messages set out what children would like from mental health workers when they visit their parents in hospital.
http://www.barnardos.org.uk/parents_in_hospital_july_2007.pdf

Appendix C

Suggested Reading and Resources

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1. 'Parents as patients: supporting the needs of patients who are parents and their children', Royal College of Psychiatrists Report (RCP) CR 164, January 2011, London <http://www.rcpsych.ac.uk/publications/collegereports/cr/cr164.aspx>
2. 'Parents in Hospital: How mental health services can best promote family contact when a parent is in hospital', Barnardo's, 2007, http://www.barnardos.org.uk/parents_in_hospital_summary_report_july_2007.pdf
3. 'Mental Health and Growing up', RCP factsheet: <http://www.rcpsych.ac.uk/mentalhealthinfo/mentalhealthandgrowingup/parentalmentalillness.aspx>
4. 'Post natal Depression', RCP leaflet <http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/postnatalmentalhealth/postnataldepression.aspx>
5. 'My Care - caring for a parent with a mental health problem' Mental Health Foundation, 2010 http://www.mentalhealth.org.uk/content/assets/PDF/publications/MyCare_Booklet.pdf?view=Standard
6. 'Think child, think parent, think family: a guide to parental mental health and child welfare' Social Care Institute for Excellence (scie) 2009
7. 'Stress and resilience factors in parents with mental health problems and their children' - scie research briefing 23
8. 'Working together to support disabled parents', scie Guide 19
9. 'Research review on prevalence, detection and interventions in parental mental health and child welfare', Prof G Parker, Dr B Beresford, Ms S Clarke, Social Policy Research Unit, University of York
10. Mental Health Act Code of Practice Guidance on the visiting of psychiatric patients by children, Health Service circular & Local Authority Circular, Department of Health, October 1999
11. 'Keeping the family in mind: a briefing on young carers whose parents have mental health problems', Barnardo's Report, 2008
12. "Emotional Support for Young Carers" A report prepared by the Children's Society Young Carers Initiative and the Princess Royal Trust for Carers for the RCP
13. 'Parental psychiatric disorder: distressed parents and their families' 1998, by Michael Göpfert, Jeni Webster and Mary Seeman
14. The Children Society's materials and information <http://www.childrenssociety.org.uk/>
15. Family Action's produces assorted materials, including a film on 'Caring for a parent with a mental health problem: <http://www.family-action.org.uk/9365>
16. 'Crossing Bridges' - by K Mayes, M Diggins and A Falkov. A training manual for working with mentally ill parents and their children, Pavilion Publications 1998. Department of Health.
17. RCP 'Being seen and being heard' training pack with video

Appendix D

Mental Health Act

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Mental Health Act section 278, Code of Practice and Principles

a. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003 SECTION 278:

Duty to mitigate adverse effect of compulsory measures on parental relations

This section has no associated Explanatory Notes

(1) Subsection (2) below applies—

(a) where—

(i) a child is subject to any measures authorised by virtue of this Act or authorised, in consequence of the child's mental disorder, by virtue of the 1995 Act; and

(ii) the measures will or will be likely to impair the personal relations or diminish direct contact between the child and any person with parental responsibilities in relation to the child; or

(b) where—

(i) a person with parental responsibilities in relation to a child is subject to any measures authorised by virtue of this Act or authorised, in consequence of the person's mental disorder, by virtue of the 1995 Act; and

(ii) the measures will or will be likely to impair the personal relations or diminish direct contact between that person and the child.

(2) Every person having functions by virtue of this Act which include responsibility for the administration of any of the measures mentioned in subsection (1) above shall take such steps as are practicable and appropriate to mitigate the impairment or diminution referred to in that subsection or, as the case may be, the likelihood of that impairment or diminution.

(3) In this section, "child" and "parental responsibilities" have the same meanings as they have in Part I of the Children (Scotland) Act 1995 (c. 36). <http://www.legislation.gov.uk/asp/2003/13/contents>

b. THE CODE OF PRACTICE VOLUME 1, PARAGRAPH 47 STATES

"Persons discharging functions under the Act must be aware of the duties placed on them by section 278 of the Act. This section applies where a child or a person with parental responsibilities is subject to any provisions of the Act or the Criminal Procedure (Scotland) Act 1995. Persons discharging functions under these Acts must take all practicable and appropriate steps to mitigate any effects of the measures authorised by the Acts which might impair the personal relations or diminish direct contact between a child and a person with parental responsibilities. The patient's designated MHO will play an important role in this process, particularly in relation to liaising closely with colleagues in the social work children & families teams." <http://www.scotland.gov.uk/Publications/2005/08/29100428/04289>

c. ABOUT MENTAL HEALTH LAW – PRINCIPLES

If you are providing or receiving care and treatment under the Mental Health (Care & Treatment) (Scotland) Act, the law sets out principles that should shape decisions about that care and treatment.

The principles of the Act are there to help people understand how the law should work in practice. They came out of consultation about what people thought was important to them, when they were being treated for a mental illness. The principles are also a set of guidelines for professionals, to help them make decisions that are in the spirit of the law.

The principles don't provide a person with legal rights in the same way as other parts of the Act, but you can use the principles as a guide for what a person should expect from the people providing care and treatment.

The principles say that whenever a professional involved is making a care and treatment decision he or she should:

- take the past and present wishes of the individual into account
- make sure the person gets the information and support he or she needs to take part in decisions
- take the views of the person's carer, named person, guardian or welfare attorney into account
- look at the full range of care and treatment options that a person may need
- give treatment that provides maximum benefit to the individual
- take account of the person's background, beliefs and abilities
- make sure that any restrictions on an individual's freedom should be the minimum necessary in the circumstances
- make sure that individuals receiving care and treatment under the Act are not treated less favourably than other people
- take the needs of carers into account and ensure that carers get the information and support they need
- take special care of your welfare if you are under 18 years of age

The Scottish Government's booklet [Putting Principles into Practice](#) (.pdf) provides more information for service users and carers.



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