



## **Social Work with Children when Parents have Mental Health Difficulties: Acknowledging Vulnerability and Maintaining the “Rights of the Child”**

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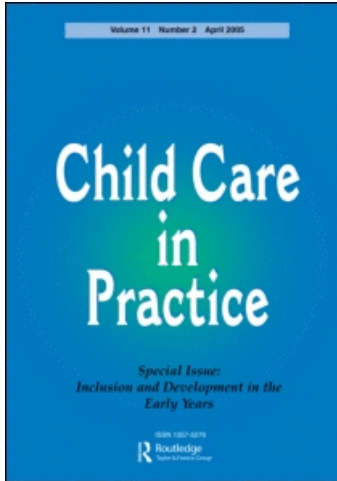
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### Social Work with Children when Parents have Mental Health Difficulties: Acknowledging Vulnerability and Maintaining the “Rights of the Child”

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# Social Work with Children when Parents have Mental Health Difficulties: Acknowledging Vulnerability and Maintaining the “Rights of the Child”

Aisling Monds-Watson, Roger Manktelow & Mary McColgan

*The 40 substantive rights contained within the United Nations Convention on the Rights of the Child (UNCRC) 1989, have applied, without discrimination, to all children in the United Kingdom since 1992. However, recurrent tragedies starkly highlight the potential vulnerability of some children when their parents experience mental health difficulties; and many children affected by parental mental illness remain a hidden population, the unique challenges they face going unaddressed. Article 3 of the UNCRC states: “All organisations concerned with children should work towards what is best for each child”. Social workers occupy a critical position in safeguarding the UN Convention rights of children, particularly in situations where mental illness is having an adverse impact on parenting, and where children are “in need” or “at risk”. However, collaboration between Mental Health and Family & Child Care services can be problematic. Poorly-integrated service provision constrained by inadequate resources and training, and complicated by a latent dichotomy between the human rights of parents and the Convention rights of children, can contribute to regrettable outcomes for these most vulnerable families. This article highlights the potential psychological vulnerability of children living in a situation where one or both parents experience mental health difficulties. Evidence regarding the scale and impact of parental mental health difficulties is explored, and discussed in the context of the UNCRC, and the key findings of recent Child Protection Inspections and*

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*Health & Social Care inquiries in Northern Ireland. The article draws on relevant literature (specifically the Western and Eastern Health and Social Services Boards Inquiry into the tragic deaths of Madeleine and Lauren O'Neill in Northern Ireland, and the preliminary findings of research being carried out by the authors within the University of Ulster) to illustrate and consider the problems associated with effective social work practice with these families. The article concludes by making recommendations to enhance effective, responsive, collaborative social care provision for children in families experiencing parental mental health difficulties.*

### **Introduction**

Ratified within the United Kingdom in 1991, the United Nations Convention on the Rights of the Child (UNCRC) 1989 places a duty on party-states to offer effective services to safeguard children's welfare. Although not legally binding, the Convention does provide agreed principles and standards that are utilised by local, national and international courts and bodies, and with which government policy and procedure is expected to comply. The UNCRC fortifies domestic legislation such as the Children (Northern Ireland) Order 1995 (and in England, The Children Act 1989) by asserting that provision of services and protection from abuse are basic rights that must be offered to all children regardless of race, culture, language, gender, disability and religion (Department of Health, Social Services and Public Safety [DHSSPS], 2005a, p. 1.6). Critically, the UNCRC requires governments to "provide children with adequate care when parents or others ... fail to discharge their duties" (DHSSPS, 2005a, p. 9).

Increasing numbers of Mental Health Service users are parents, many of whom are children's primary caregivers (Hatfield, Webster, & Mohamad, 1997; McGrath et al., 1999; White, Nicholson, & Fisher, 1995). Globally, approximately 60% of women with enduring mental health difficulties have children under 16 years of age (Reder, McClure, and Jolley, 2000, p. 175); and within the United Kingdom, research by Gillam, Crofts, Fadden, and Corbett (2003), p. 34 identified that between 25% and 49% of Community Mental Health (CMH) Team service users were parents of dependent children. In the United Kingdom, approximately 1.7 million adults and 2.5 million children live in families affected by parental mental health difficulties (Tunnard, 2004).

A total of 11,697 referrals were made to psychiatric outpatient care in Northern Ireland during the period 1 April 2006–31 March 2007, and over 6500 patients were discharged from inpatient psychiatric care during the same period (DHSSPS, 2007). However, statistical data are not available regarding the gender or parenting status of these service users. Despite the fact that the "critical need for preventative interventions with disadvantaged communities and high risk families" has been identified by the DHSSPS in the *Promoting mental health: Strategy and action plan* (DHSSPS, 2003), lack of data regarding the scale of this issue is perhaps an indication of the minimal consideration given to the specific needs of families where parental mental health difficulties exist.

*Social Situation of Families Characterised by Parental Mental Health Difficulties*

Those experiencing mental health difficulties are among the most vulnerable in our society. In addition to the psychological anguish and emotional impact of their illness, they are most likely to suffer poverty (Gould, 2006), stigma, social isolation (Manktelow, 1994; O'Doherty, Doherty, & Walsh, 2006; Office of the Deputy Prime Minister, 2004), unemployment and poor physical health (Department of Health [DoH], 2006). Research also indicates that adverse childhood experiences are related to mental health difficulties in later life (Shevlin, Dorahy, & Adamson, 2007), and are a major factor in parenting difficulties (Nicholson, Sweeney, & Geller, 1998).

The incidence of any mental health difficulty is highest amongst lone parents, three times higher in regard to major (psychotic) mental health difficulty, and twice as high for minor (neurotic) mental health difficulty (Tunnard, 2004). Social isolation and unemployment are also related to mental health difficulties, and several studies have identified that mothers with mental health difficulties are at increased risk of "exposure to multiple psychosocial risk factors", including unplanned pregnancy, poverty, inadequate social supports, poor ante-natal and post-natal care, and limited education (Graham & King, 2005, p. 2). While each of these factors are linked to parenting difficulties, the additional "mental health burden" significantly increases family vulnerability.

The interrelationship between parental mental health, social disadvantage and child welfare is illustrated by Aldridge and Becker's (2003) research examining the needs of 40 families where a parent had enduring mental health difficulties, 87% of whom were lone parents. Participants spoke of the negative impact of unemployment, poverty,<sup>1</sup> adverse housing, co-existing physical health problems and the side-effects of psychiatric medication. The research highlighted the minimal, external, informal domestic or emotional support available to lone parents with mental health difficulties, and how social isolation exacerbated the extent to which they relied on their children. Parents communicated concern and insight regarding their children undertaking age-inappropriate responsibilities, and identified the need for flexible out-of-hours support. Current formal supports were often described as "inconsistent or discontinuous" (Aldridge & Becker, 2003, p. 51).

The multiple oppressions, disadvantage, stigma and discrimination likely to be experienced by parents with mental health difficulties foreshadows the considerable vulnerability of their children. Yet the most recent inspection reports, including the recent Social Services inspection of child protection services in Northern Ireland, identify that the particular needs of children within families characterised by parental mental health difficulties are "often not fully understood"; and that there is little evidence of training for Family & Child Care (F&CC), and Mental Health Social Workers, regarding the impact of parental mental illness on children (DHSS&PSNI, 2006, pp. 45–46).

Most recently the independent inquiry into the tragic deaths of Madeleine O'Neill and her nine-year-old daughter, Lauren, drew attention to the lack of effective collaboration and communication between Mental Health and F&CC Services, and

the failure of mental health professionals to adequately assess risk. While arguments exist that the publication of public inquiry reports is intrusive, disrespectful, scapegoats professionals, and causes further suffering to families of the bereaved, this article contends that this report plays an invaluable role in highlighting the potential vulnerability of children within the somewhat hidden population of parents experiencing mental health difficulties. In light of the suffering endured by the O'Neill family and the contribution of both family members and professionals to the inquiry process, it would also be unethical and negligent not to fully utilise the inquiry's capacity to illuminate and inform practice. It is in this spirit that the O'Neill Inquiry will be referred to within this article.

### **Synopsis of Madeleine O'Neill's Journey through the "System"**

Madeleine O'Neill had been treated by her general practitioner for a fluctuating mood disorder since March 1999. In May 2005 there was a significant deterioration in her mental health, culminating in an attempted overdose and overnight admission to Belfast City Hospital on 18 May (see Table 1). The day after admission, Madeleine was asked by the specialist registrar if she had any thoughts of harming her daughter. Madeleine stated that she would never hurt Lauren; however, she admitted to having researched Internet suicide sites. The Registrar referred Madeleine to the Crisis Response Team and the Hospital Social Worker, who made a "high priority" urgent referral to the F&CC Initial Assessment Team. Madeleine was discharged from hospital later that day.

Members of the Crisis Response Team visited Madeleine at home on 20 May; they assessed that Madeleine's mental health difficulties did not constitute a high risk to either Madeleine or Lauren. Although Madeleine's parents were in the home at this time, they were not involved in this assessment. Following their visit, the Crisis Response Team made a routine referral to Knockbracken Health Park for a psychiatric outpatient appointment.

Madeleine was initially contacted by a F&CC Social Worker on 6 June, to confirm that she still required support; a visit was arranged for the following day. The social worker assessed that Lauren was not in need or at risk. Although Madeleine's father was in the house at this time, he was not involved in the F&CC assessment. However, the next day (8 June) Madeleine saw her counsellor and, in a highly distressed state, confided thoughts of taking her own and Lauren's life. On the basis of her active suicidal intent and the risk to both Madeleine's and Lauren's lives, Madeleine was admitted to Knockbracken as a voluntary patient on 9 June and transferred to Gransha Hospital on 14 June where she remained until discharge on 27 June.

While staff at Knockbracken had been aware of the risk Madeleine's mental health difficulties presented to Lauren, this information was not communicated to the staff at Gransha. On discharge from Gransha Hospital on 27 June, Madeleine was reunited with Lauren, who was being cared for by her maternal grandparents. On 29 June the F&CC Social Worker in Belfast discussed the case during supervision with a Principal Social Worker, and the case was closed. Madeleine and Lauren returned to their home

**Table 1** Timeline for the O'Neill Inquiry

Date	Situation
16 May	General practitioner (GP) visit "clearly depressed but not suicidal": increase in medication
18 May	Suicide attempt in own home, parents visiting. Admission to Belfast City Hospital
19 May	Psychiatric assessment by Registrar. Discharge from Belfast City Hospital, referral to Crisis Response Team (CRT) and high-priority referral by Hospital Social Worker to F&CC Social Work.
20 May	Home visit: assessed "low-risk". CRT felt that overdose was reaction to marital breakdown; Madeleine appeared remorseful but "looking forward to the future" and did not want any further support from the CRT. Madeleine's mother and father present but not interviewed
24 May	Routine referral to psychiatric outpatients service by CRT
1 June	Assessment session with Relationship Counsellor; positive in outlook, realistic and forward-looking. Discussed impact of suicide on Lauren, wanted Lauren to have "perfect childhood"
2 June	GP appointment, "mood remained low and withdrawn... denied any further thoughts of self harm"
6 June	Initial contact from F&CC Social Worker to arrange visit (telephone call)
7 June	Home visit by F&CC Social Worker: assessed "low-risk". Madeleine open about difficulties, appeared to have good family support, good friends, was moving on following breakdown of marriage. Madeleine did not request any further services. Lauren in the house but not interviewed, Madeleine's father present but not interviewed
8 June	Appointment with Counsellor and GP. Madeleine "suicidal, had expressed thoughts of wanting to take her daughter with her and had accessed Internet suicide sites". Very distressed, requested hospital admission
9 June	Admitted to Knockbracken Healthcare Park as voluntary patient. Detailed psychiatric assessment (diagnosis of severe depression). Madeleine's mother spoken to as part of assessment
10 June	Discussion between Cons. Psych., SHO and Madeleine's father re transfer to Gransha Hospital. Cons. Psych. liaises with Gransha Hospital and arranges admission ASAP. Cons. Psych communicates clinical diagnosis and suicidal ideation, unsure if risk to Lauren is mentioned. Cons. Psych. states that although Madeleine was a voluntary patient at this time, if she had attempted to leave the hospital he would have detained her for assessment
13 June	Cons. Psych confirms transfer to Gransha Hospital with counterpart
14 June	Transferred from Knockbracken Healthcare Park to Gransha Hospital. Assessed and admitted as a voluntary patient (diagnosis of situational crisis). Madeleine presents to SHO as intelligent and compliant, "no immediate threat of suicide... no mention of any threat to her daughter". Knockbracken staff assert that copies of Madeleine's notes were given to Madeleine's father to pass on to staff at Gransha Hospital. This is denied by Madeleine's father
15 June	Madeleine seen briefly by the accepting Cons. Psych. Informs Madeleine she will be under the care of Cityside Cons. Psych.
16 June	Accepting Cons. Psych. goes on annual leave
19 June	Sunday: weekend leave from hospital
26 June	Sunday: weekend leave from hospital. Madeleine requests discharge
27 June	Discharged from Gransha Hospital to parents' home in Londonderry. Medical staff stated there was "no evidence available to them which would have warranted Madeleine's compulsory detention"

Table 1 (*Continued*)

Date	Situation
3 July	Discharge summary completed and forwarded from Gransha Hospital to GP
6 July	Assessment session with Relationship Counsellor. "Calm, clear and articulate", denied having any current suicidal thoughts, and that she would ever harm Lauren
10 July	Madeleine and Lauren returned to home in Carryduff
12 July	PSNI discover Madeleine's and Lauren's bodies

Source: Adapted from WHSSB & EHSSB (2008).

in Belfast on 10 July 2005. Two days later, on 12 July, Madeleine took her own life and Lauren's life.

### The Role of Inquiry Reports

The potential vulnerability of children whose parents have mental health difficulties is graphically evidenced within the O'Neill Inquiry; and while it is acknowledged that no-one could have foretold the tragic end to Madeleine and Lauren's lives, there were certainly occasions during the O'Neill family's journey through "the system" when more effective responses may have altered the outcome. The inquiry chillingly concludes that:

When the patient made clear her intention was to kill herself and take her child with her, none of the Mental Health Professionals or Family and Child Care services involved attempted to formally assess the current risk to the child. No special arrangements were made to monitor her interaction with the child . . . no attempt made to follow up on this statement to assess how real it was. (WHSSB & EHSSB, 2008, p. 60)

Reviews of mental health-related adult homicide and child death repeatedly emphasise the necessity of communication, coordination and collaboration "within and between all services and agencies to better support mentally ill parents who are struggling to meet the needs of their children" (Social Care Institute for Excellence [SCIE], 2006); so why does a lack of effective assessment and intervention for families when parents have mental health difficulties continue to be highlighted again and again, sometimes in disastrous circumstances?

Thankfully, the murder of children is, statistically, extremely uncommon. The United Kingdom has the lowest rate of child homicide in the western world (Stroud & Pritchard, 2001) and there has been little annual change regarding the incidence of violence by those experiencing mental health difficulties (Appleby et al., 1999). But these are not grounds for complacency. This article acknowledges that the terrible events that have led to investigations such as the O'Neill Report are mercifully rare, and that the mistakes that were made are not necessarily representative of service provision. Indeed, regarding many enquiries there is a valid argument that even if



optimal services had been provided, these tragedies may still have occurred. Stanley and Manthorpe (2001, p. 78) highlight the fact that inquiries reflect back on “tragic events with the bias of hindsight” and this inclines investigators to seek patterns of causality leading to tragedy, where such patterns may not exist.

Despite these limitations, various local and international cases—such as Ferris 2001 (Aston, 2001), Yates 2001 (O’Malley, 2005), O’Neill 2005 (WHSSB & EHSSB, 2008), Darry 2007 (Paterson, 2007), McElhill 2007 (DHSSPS, 2008), Mullings-Sewell 2008 (Carter, 2008) and others—intermittently highlight how intensely vulnerable some children may be when a parent has a mental health difficulty. However, the degree of publicity given to these cases, in addition to the scrutiny and pressure experienced by practitioners and service providers during inquiries and reviews, conceivably leads to a service emphasis on the physical safety of these children, at the expense of their unique emotional needs.

Because the O’Neill Inquiry Team has already undertaken an in-depth analysis of the circumstances surrounding the deaths of Madeleine and Lauren O’Neill, and has made multiple recommendations for subsequent policy and practice in this area, this article will not be duplicating the inquiry’s findings. Instead, this article will focus on the emotional and psychological needs of children whose parents have mental health difficulties in the context of the UNCRC. When we examine the O’Neill Inquiry Report (WHSSB & EHSSB, 2008), the critical but often overlooked rights and needs of these children are vividly illustrated.

While it cannot be emphasised enough that the tragic outcome of the O’Neill case certainly does not characterise the risk parents with mental health difficulties typically pose to their children, this particular inquiry does play an incredibly valuable role in highlighting how the day-to-day life experience of children whose parents suffer mental health difficulties can potentially be compromised by inconsistency, uncertainty, and confusion; as well as highlighting the complexity and need for specialist service provision for these families.

### **Parental Mental Health and Child Welfare**

The risks sometimes associated with parental mental health difficulties and child-rearing are well recognised (DoH, 1998; Foreman, 1998; Mayberry, Ling, Szakas, Reupert, 2005; Sheppard, 1997; Sheppard & Kelly, 2001). Not only are parental mental health difficulties a significant factor in approximately 25% of cases referred to F&CC Social Work (Tunnard, 2004, p. 6), they are also highly represented amongst those families subject to child protection or care proceedings (CSCI, 2006, p. 5; Glaser & Prior, 1997; Reder & Duncan, 1998; Sheppard 1997). Additionally, multiple medical studies present evidence of clear correlation between parental mental health difficulties and subsequent psychiatric and behavioural problems in offspring (Mowbray, Bybee, Oyserman, McFarlane, & Bowersox, 2006; Niemi, Suvisaari, Haukka, & Lonnqvist, 2005; Schubert & McNeil, 2003).

Oyserman, Mowbray, Meares, and Firminger’s (2000, p. 297) meta-analysis of research into parental mental health difficulties identified that between 32% and 56%

of children whose parents have an enduring mental illness will go on to develop a diagnosable psychiatric disorder. While the category of parental psychiatric diagnosis is of infinitely less importance in terms of child welfare, than actual parental behaviour (Reder, Duncan & Gray, 1993), the heritability estimates for mental illness offer a baseline indication of the potential vulnerability of these children.

Although referring to physical rather than psychological health issues, Robinson, Batsky, Hayes, Milap, and Mahan offer a useful definition of heritability as the “proportion of observed variation in a particular trait . . . that can be attributed to inherited genetic factors in contrast to environmental ones” (2005, p. 917). In essence a scientific response to the nature versus nurture debate, heritability estimates roughly indicate the respective influence of genetic and environmental factors on variation in individual biology, personality or behaviour (the role genetic inheritance plays versus environmental influences). However, rather than being an argument for biological determinism, it must be emphasised that this is a probability measure. Therefore the heritability estimate of 75% for schizophrenia (Rutter, 1999) does not indicate that the offspring of a parent with schizophrenia has a 75% chance of developing the illness, but rather that if they do develop the illness it is likely that genetics played a major determining role of approximately 75%.

Most mental health heritability studies rely on “twin research” and adoption studies, and while many have been criticised for lack of scientific rigour and an emphasis on biological determinism, the consistency of their findings evidences the significant influence played by our genetic inheritance. Subsequently, if we consider the heritability estimates for mental illness, the extent of a child’s genetic vulnerability becomes apparent. The heritability estimate for bipolar disorder is 80%, for depression is 34–48%, and for schizophrenia is 75% (Rutter, 1999).

It is fortunate, then, that the landmark Finnish Adoption Study (Tienari et al., 1994) identifies factors that ameliorate these risks. This 21-year follow-up study of adoptees at high genetic risk for schizophrenia examined the role of the environment in offsetting this risk, and found that adoptees of high genetic risk were significantly more sensitive to the child-rearing environment. Most importantly, the study identified that “high genetic risk” adoptees were more sensitive to both adverse and beneficial parenting. Similarly, Johnson, McGue, Gaist, Vaupel, and Christenson (2002) offer evidence that parental mental illness has less impact on a child’s subsequent psychiatric functioning than disordered parenting. Confirmation of the protective capacity of a nurturing environment, particularly for children of parents with mental health difficulties, is of particular relevance in undertaking a realistic assessment of need. However, protective factors alone do not mean a child is not vulnerable; and this incontrovertible fact will be returned to again and again within this article in a parental mental health context.

### **The Responsibilities of Community Mental Health Teams to Children**

The DoH’s “Mental Health Policy Implementation Guide” for CMH Teams acknowledges that: “Adult CMHT staff are not trained in assessing parenting ability

but can recognise when a patient's illness or problems pose a significant burden or risk for a child . . . The child's needs must take priority"; furthermore, it directs that CMH Teams undertake: "Assessment on a routine basis of the overall well-being of dependent children whose needs may be compromised by parental illness . . . (and involve) the appropriate children and families team if indicated" (DoH, 2001, p. 13).

Regrettably, preliminary findings from research currently being undertaken by the authors in the University of Ulster indicates that a significant number of CMH Social Workers do not consider the assessment of parenting capacity to be a routine responsibility. Even more concerning is the indication that when compromised child welfare is identified by CMH Social Workers and referred to F&CC for assessment, these referrals regularly do not meet the threshold for intervention from the F&CC Department. Given that CMH Social Workers generally appear to have considerable practice experience, the dichotomy between what they perceive as children "in need" or "at risk", and what F&CC Social Workers perceive as need/risk bears further, urgent, exploration.

This article argues that recognition of significant burden or risk necessitates comprehensive holistic understanding of the unique situation of the child who experiences parental mental health difficulties, and how their needs may differ from the norm. Failure to do this negates the emotional impact of parental mental health difficulties on children, and the possible benefits of appropriate psychological support. Furthermore, if social services are to effectively deliver preventative services to families where parental mental health is an issue, then focusing on the physical wellbeing of a child and intervening only when a child is at risk of significant harm is intervening too late.

### **Critical Issues relating to F&CC Social Work with Parents Experiencing Mental Health Difficulties as Illustrated by the O'Neill Inquiry**

When the F&CC Social Worker visited Madeleine O'Neill on 7 June 2005, Lauren was living at home (with her mother and maternal grandparents who had been residing there to provide support to Madeleine and Lauren for the previous three weeks) (WHSSB & EHSSB, 2008, p. 35). Despite the fact that Madeleine's mother and father were actively involved in Lauren's care, and that the referral was regarding Lauren, the social worker spoke with neither Lauren nor her grandparents. F&CC's failure to adequately assess the O'Neill's circumstances is evident and has been repeatedly highlighted. However, the context of service provision that underpins these deficiencies, and undermines effective social work practice in this arena, has been less well-examined.

F&CC Social Work Departments are generally characterised as under-resourced, over-stressed environments, where staff are likely to be recently qualified and inexperienced (Devaney, 2004), particularly in regard to parental mental health (DHSS & PSNI, 2006, pp. 45–46). Furthermore, although Lauren O'Neill's referral was marked "high priority", the referral was assumed to be for "family support" rather than "child protection". Overall, there was no historical and little current

evidence (except Madeleine's mental health difficulties) to indicate that Lauren was at risk. The inquiry team itself emphasised that they:

found nothing of concern relating to the development or parenting of Lauren O'Neill during her short life. She was obviously much loved by both her parents and the wider family circle, all of whom were keen to help out at the time of her parents' separation. (WHSSB & EHSSB, 2008, p. 35)

Madeleine O'Neill's presentation to the F&CC Social Worker also gave little cause for concern; Madeleine had conveyed the impression that she had excellent family and extended family support, and, despite her recent, serious suicide attempt, wished to move on with her life and put her difficulties behind her (WHSSB & EHSSB, 2008, p. ii). However, the next day (8 June 2005), Madeleine visited a private counsellor, whom she had seen for four sessions during the previous two months. Although less than 24 hours later, Madeleine's presentation to the counsellor was disturbingly contradictory to that witnessed by the social worker. The inquiry records that the counsellor considered Madeleine to be extremely upset and to have great difficulty focusing her thoughts; Madeleine expressed both suicidal ideation and thoughts of taking Lauren with her (WHSSB & EHSSB, 2008, p. 18).

The massive contrast between Madeleine's respective presentations to the counsellor and the F&CC Social Worker highlights three major issues relating to practice with families where there are parental mental health difficulties—issues that urgently need to be considered in the context of current service provision:

- (1) The unpredictable nature of mental health.
- (2) The psychological impact of parental mental health difficulties on children.
- (3) The stigma and fear parents with mental health difficulties often associate with interventions from F&CC Social Work.

#### *The Unpredictable Nature of Mental Health Difficulties*

Mental health problems and mental illnesses are phenomena different and distinct from physical illnesses, and it is their distinctiveness and infinite variability that limits the value of a purely medical approach. When we examine the O'Neill family tragedy we can see a mother whose wellbeing is erratic, whose suffering is masked and hidden to outsiders, whose own understanding of her feelings and behaviours as symptoms of a mental illness may be restricted (Montgomery, Tompkins, Forchuk & French, 2006), and whose emotions and behaviours have implications for family safety.

In psychiatric nosology, these features have clinical terms; fluctuating mental state, lack of insight and likelihood of harm to self and others (often close family members) are key areas for investigation when making a psychiatric assessment. Given that sufferers may have limited understanding and insight to their situation when actively unwell, caring nearest relatives play a key role as providers of information on which a sound assessment can be based. It is for this reason that a fundamental component of good mental health social work is the inclusion in the assessment process of a

“significant other” in the service user’s life, to provide corroborating or conflicting accounts, or at least insight, to the service user’s situation. However, although the F&CC Social Worker did not interview Madeline O’Neill’s parents (who were staying with their daughter throughout this period), it cannot be anticipated that they would have disagreed with the social worker’s assessment. Nor could the F&CC Social Worker have been expected to undertake a psychiatric assessment.

The referral was in Lauren’s name, it was the nine-year-old Lauren who was being referred to F&CC, and the referral was on the basis of Lauren’s “needs”—“needs” that were recognised during the Hospital Social Worker’s assessment with Madeleine and her mother on 19 May, and “needs” on which the subsequent urgent referral to F&CC was predicated. “Needs” that were, sadly, never actually addressed with Lauren.

### *The Psychological Impact of Parental Mental Health Difficulties on Children*

Children are by nature egocentric; they view and interpret the world from their singular and restricted perspective (Scherer, Melloh, Buyck, Anderson, & Foster, 1996). This unavoidable, and developmentally normal, egocentric inclination is particularly problematic for children when parents behave in an unpredictable, rejecting or inconsistent manner because it can incline children to assume a misplaced sense of responsibility for their ill parents’ behaviours, and consequently feelings of guilt, uncertainty, insecurity and rejection (Mackereth, Gopfert, Harrison, & Mahoney, 1999). These deeply disturbing and damaging emotions, especially when experienced over a protracted period of time, and particularly when combined with fluctuating parental mental health or unpredictable parental behaviour, can have enduring impact on a child’s sense of self-esteem, ontological security, interpersonal functioning, educational attainment, and ultimately their future mental health (Absler, 1999).

Children’s worries regarding their own future mental wellbeing must also be acknowledged as a very genuine and recurrent fear (Hall, cited in Gopfert, Webster & Seeman, 2004), especially in a culture where maxims such as “the fruit doesn’t fall far from the tree”, “chip off the old block”, “like mother like daughter” and “like father like son” are rife. Given that the child may also carry a genetic vulnerability to mental health difficulties, their feelings and concerns cannot be ignored or minimised, particularly when it has been shown that children who have such anxieties addressed, and are helped to understand that they are not personally responsible for their parents’ difficulties, have measurably improved mental health outcomes (Beardslee, Swatling, & Hoke, 1998).

Despite the loving protection of her extended family, Lauren O’Neill was witness to her mother’s mental health difficulties on a regular basis. She was almost certainly “picking up” on an atmosphere of anxiety and disquiet, she possibly felt perplexed or alarmed about her mother’s fluctuating mood, and may have been very concerned or confused. There has been repeated recognition of the vulnerability of children when parents have mental health difficulties (DoH, 1998; Mayberry et al., 2005; Mowbray et al., 2006; Niemi et al., 2005; Royal College of Psychiatrists, 2002, 2004; Schubert &

McNeil, 2003). However despite this, it appears that not a single professional spoke with Lauren about how she was experiencing or interpreting her mother's difficulties, or tried to find out what she needed.

*The Stigma and Fear Parents with Mental Health Difficulties often Associate with Interventions from F&CC Social Work*

F&CC's involvement with Madeleine O'Neill raises a number of further considerations relating to how parents with mental health difficulties perceive such interventions. The disparities between Madeleine's respective presentations to the social worker and counsellor have already been mentioned, but bear further speculative analysis to perhaps illuminate the reasons underlying the occasional failures of services to intervene successfully with these families.

Madeleine O'Neill reassured the F&CC Social Worker that there was no need for any further intervention; we must assume that she gave no indication of any underlying instability of mood, deep-seated depression or suicidal ideation that could threaten either her or her daughter's life. Yet in retrospect we can observe how rapidly Madeleine's presentation changed. It must be considered that the intervention from F&CC may in itself have been anxiety-provoking enough to instigate a "downward spiral" within Madeleine.

This article does not in any way suggest that the F&CC Social Worker did anything to instigate such a change, but rather acknowledges the stigma and trepidation parents often associate with referral to F&CC Services. The vulnerability, desperation and isolation experienced during an acute episode of mental illness can only be further compounded by the very real fear that "someone" is going to take your children away, and that you have failed as a parent, regardless of how inaccurate this perception is. Furthermore, how likely is a parent experiencing mental health difficulties to openly divulge their concerns to someone they believe can take away their child?

University of Ulster research (by the authors, currently ongoing) indicates that many CMH Workers are very aware of this issue, and subsequently reluctant to refer cases to F&CC Departments even when they have concerns regarding children's welfare. Mental Health Social Workers refer to parents' deep-seated distrust of F&CC Social Workers despite concerted efforts to allay these anxieties; and the damage done to "therapeutic alliances" between CMH Workers and service users when referral to F&CC is indicated.

Furthermore, when F&CC do intervene with these families, the combination of mistrust, rapid staff turnover, and a relative lack of mental health practice experience can result in superficial assessments that do not reflect the actual levels of need within the home. Evidence also exists that these issues do not arise solely at a regional level, but must be taken in the context of the significant fears parents have expressed elsewhere about losing their children should they highlight difficulties at home (Diaz-Caneja & Johnson, 2004; Plant et al., 2002; Stanley & Penhale, 1999).

### UNCRC Article 12: Children's Right to be Heard

Children's rights to express their desires and opinions, and be active participants in their own lives, is enshrined within Article 12 of the UNCRC. Legislative recognition of this right is reflected within The Children (Northern Ireland) Order 1995, and (in England) The Children Act 1989. Furthermore, the recommendations of Lord Laming's Inquiry into the death of Victoria Climbié (HM Government, 2003a), and the subsequent policy document *Every child matters* (HM Government, 2003b), all emphasise the principle necessity of any F&CC assessment reflecting the actively sought views and wishes of the child.

Although the individual experiences of children living with parental mental health difficulties are infinitely variable, common themes do emerge within the limited research undertaken with these families—one of which is the child's need to be heard. Productive communication is repeatedly identified as a significant area of concern, both between the parents and children themselves, and between children and professionals involved in the provision of care (Alakus, 2004; Fudge & Mason, 2004; Roberts, Bernard, Misca, & Head, 2008). The stigma, secrecy and shame associated with mental illness often prevent children sharing their home-life experience with friends, teachers or professionals; and children's desire to protect parents can also hamper communication and help-seeking behaviours (Aldridge & Becker, 2003).

Rather than acknowledging these factors and offering children the channels of communication they need, research indicates that practitioners are resistant to talking to children about the issues affecting their parents. When Bibiou-Nikou (2004) specifically explored how practitioners' value and belief systems influenced their communication with these families, they found that practitioners tended to inadvertently protect children from the implications and prognosis associated with their parent's mental health, and were resistant to openly addressing the challenges/issues of their day-to-day experience of parental mental health difficulties. While the study conjectured that this may be related to the practitioners' instinctual reluctance to address issues of mental health and suffering in a culture where health is viewed as a "moral virtue" (Bibiou-Nikou, 2004, p. 311), the outcome remains that rather than offering these children the much-needed opportunity for communication and emotional support, the professionals were guilty of an "adult-centric" approach that neglected children's capacity to reflect on their home environment. The study emphasised that:

It is essential in the context of parental illness that someone provides the space to reflect on children's verbal and nonverbal messages and to address the frightening questions that children may have . . . reluctance to let the child be informed can be abusive as it leaves the child in a situation of confusion and unexplained loss. (Bibiou-Nikou, 2004, p. 311)

This need is again highlighted in the research undertaken by Stallard, Norman, Huline-Dickens, Salter, and Cribb (2004). Nearly one-half of both parents and children clearly communicated the need for children to be offered opportunities to

ask questions and develop understanding of their parents' mental health difficulties. In particular, children wanted to know if their behaviour was responsible for their parents' difficulties, why their affected parent sometimes behaved the way he or she did, and the type of medical treatment their parent was receiving. The children also described bullying and discrimination related to their parents' difficulties, and subsequent secrecy and reluctance in confiding their personal and family needs. Twelve out of the 40 children interviewed said they actively concealed their parents' illness (also identified by Centre for Research on Families and Relationships & ChildLine Scotland, 2005), and highlighted that they often knew of issues affecting their parent/s of which professionals were unaware.

Participating parents echoed their children's anxieties by communicating concern that their children felt responsible for the symptoms and behaviours associated with their particular difficulties. However, this need for more communication and information was countered by a fear amongst some participants that "too much" information would unnecessarily burden their child, again highlighting the need for information and communication that is sensitive, age-appropriate and provided in response to the family's self-identified needs (Stallard et al., 2004). Indeed, research carried out by Beardslee et al. (1998), with 100 families where at least one parent suffered from a severe affective disorder, identified that the provision of appropriate support led to significantly improved relations within the home, with children reporting an increase in coping skills and an improved ability to make sense of their internal and external environments.

#### *The Current Context of Service Delivery to Children affected by Parental Mental Health Difficulties*

The O'Neill Inquiry evidences a disturbing lack of practice knowledge relating to the needs and potential vulnerability of children whose parents have mental health difficulties. However, of even greater concern is the fact that although the Inquiry Report (WHSSB & EHSSB, 2008) makes many valid observations and recommendations, what is glaringly absent is explicit, authoritative recognition that Lauren O'Neill's "right to be heard" was not acknowledged by the professionals involved. Nor is the O'Neill Inquiry alone in this regard. While the comprehensive and far-reaching Bamford Review of Mental Health and Learning Disability (DHSSPS, 2005b) makes significant reference to children affected by parental mental health difficulties, and highlights the link between childhood disorders and adult mental health problems, "Delivering the Bamford vision: The response of the Northern Ireland Executive" (Northern Ireland Executive, 2008) to the Review virtually ignores the specific issues affecting this vulnerable population.

Given the overwhelming evidence of a clear correlation between children affected by parental mental health difficulties and subsequent adult psychopathology (Mayberry et al., 2005; Mowbray et al., 2006; Niemi et al., 2005; Schubert & McNeil, 2003), surely any effort to improve the mental health of the province must target services at this most vulnerable and often unacknowledged population. However the



failure to recognise the vulnerability of these children is not just limited to Northern Ireland; Children and Young People in Mind (DoH, 2008), the final report of the national review of Child and Adolescent Mental Health Services in England, does not even mention children of parents with mental health difficulties in its list of groups of children known to be vulnerable (DoH, 2008, p. 116). In fact, unless categorised as “carers”, a vital role frequently undertaken by these children but often unacknowledged (Aldridge & Becker, 2003), children affected by parental mental health difficulties are generally not identified in current policy documents.

Since the election of the Labour government in 1997 there has been substantially increased spending on family support interventions in the United Kingdom, such as “Sure Start”, “The Children’s Fund” and “New Pin”. Underpinned by policy documents such as *Supporting families* in 1998 and *Every child matters* in 2003, these services specifically addressed the need for preventative interventions with at-risk populations such as lone-parent families and those living in areas of socio-economic deprivation. Although a venerable intention, the generic nature of these services and the fact that they do not address specific parental circumstances means that families affected by parental mental health difficulties do not necessarily benefit from these initiatives (Weir, cited in Gopfert, Webster & Seeman, 2004).

Others have long identified the need for sensitive support mechanisms for families affected by parental mental health difficulties, which are neither dominated by child protection or mental health programmes of care, but rather respond to this population’s needs in a balanced, preventative manner (Hugman & Philips, 1993). To facilitate this necessitates awareness amongst CMH and F&CC practitioners that while many children with parents experiencing mental health difficulties do not suffer any easily identifiable, significant harm, they are likely to be coping with additional concerns: concerns that, if unaddressed, may impact on their own future mental health and wellbeing. To meet the convention rights of these children, there needs to be service provision that is available without triggering unnecessary risk assessments or statutory investigations (Hugman & Philips, 1993, cited in Cowling, McGorry & Hay, 1995).

Despite the O’Neill Inquiry highlighting the unarguable need for collaborative assessment and intervention, effective statutory service provision for children affected by parental mental health difficulties in Northern Ireland does not appear to be close at hand. Valiant efforts have been made by each of the Northern Ireland Health and Social Care Trusts to establish protocols and initiate procedures to improve communication and collaboration between CMH and F&CC Services, including extensive training programmes, the creation of “Children’s Champions” within Mental Health Teams, and Senior Mental Health Practitioner Posts within Child Care Teams. However, alleviating the stigma and fear associated with referral to F&CC social work may not ever be viable or realistic, and while these issues continue to place an additional burden on families already stigmatised by mental health issues, the potential benefits of F&CC interventions with these families will be severely limited.

Given that support to children affected by parental mental health difficulties is gravely needed but also needs to be delivered in a context that is supportive, non-threatening and trusted, its source must be seriously considered. A potential

contradiction exists between acknowledging a child's UNCRC right to be heard while respecting their parent's human right to privacy and respect for family life. Parental mental health difficulties in themselves should never be the sole grounds for referral to F&CC; however, given the specialisation of services, how are children affected by parental mental health difficulties to be acknowledged and offered appropriate support?

This article conjectures that F&CC services are not best placed to offer interventions with this already stigmatised population and this specialist service should be coordinated from within the CMH Programme of Care, ideally from the parent's CMH social worker if they have one or possibly within restructured and adequately resourced Child and Adolescent Mental Health Teams. Alternatively, appropriately trained Educational Welfare Officers are ideally placed to offer support to children whose parent/s are not known to CMH services, but where schools are aware of parental mental health difficulties.

In April 2007, Northern Ireland began using Understanding the Needs of Children in Northern Ireland (UNOCINI)—a multi-agency assessment tool that aims to facilitate holistic, early and accurate identification and assessment of children in need or at risk. The structure now exists for CMH Teams to actively collaborate with F&CC Social Work Departments in undertaking sensitive and realistic assessments of the needs of families affected by parental mental health difficulties. However, for this to occur, CMH Teams need to routinely consider the needs of the child alongside the needs of the parent, and be particularly conscious of a child's potential psychological vulnerability. The authors welcome the recommendations of the recently published SCIE guidance *Think child, think parent, think family* (SCIE, 2009), which offers practical directives to develop and provide high-quality, acceptable, non-stigmatising services, by adopting a whole-family approach. CMH Services should adopt these proposals as a matter of urgency; however, this will necessitate a cultural and strategic shift amongst policy-makers and senior management to bridge the divide between Adult Social Care and F&CC Social Work.

## Conclusion

A conservative estimate indicates that at least 25% of CMH service users have children (Gillam et al., 2003, p. 34). Analysis of relevant research indicates that significant numbers of these children are at high risk of developing psychiatric and behavioural problems (Mowbray et al., 2006; Niemi et al., 2005; Oyserman et al., 2000; Schubert & McNeil, 2003). This article highlights three major areas of concern regarding service provision to children and families affected by parental mental health difficulties.

First, that current service provision for families with parental mental health difficulties often contravenes the UNCRC, particularly in respect of a child's right to be heard. Regardless of the benevolence of their home environment, children in families where parental mental health difficulties exist are at increased vulnerability due to numerous factors. Assumptions should not be made about the health and wellbeing of these children based on standard assessment models. An over-emphasis on physical

wellbeing should not displace consideration of their potential psychological vulnerability and unique emotional needs. These children need to be listened to and have their concerns addressed in a consistent, insightful and age appropriate way.

Second, CMH and F&CC interventions are often undertaken in a culture of practice that does not fully recognise the needs of these children and families. Despite a commitment to preventative interventions with vulnerable populations, current policy and service planning has failed to acknowledge the potential vulnerability and specific needs of children when parents have mental health difficulties. Evidence indicates that these families urgently require flexible, responsive, sensitive, non-stigmatising support services that actively address the needs of children and parenting issues.

Third, the context of service provision to these children and families needs to be carefully considered. Current interventions are generally undertaken by F&CC Departments. Given the stigma associated with both mental health difficulties and intervention from F&CC Social Work, this support should preferably be located within adequately resourced and trained CMH, Child and Adolescent Mental Health or Educational Welfare Services as a preventative intervention. This would avoid these children and their families being additionally stressed and stigmatised by the “double-whammy” of child protection and mental illness. Children whose parents experience mental health difficulties should be offered this support on a regular basis as they grow up, as an established component of preventative practice within CMH care. CMH Teams should adopt and implement the recommendations of the SCIE guidance: “Think child, think parent, think family” (SCIE, 2009).

Finally, above all else we need to speak with these children and be mindful of what they say.

## Note

[1] All of the lone-parent families were subsisting on benefits.

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### Appendix: Defining Terms of Reference used within the Article

Numerous issues are associated with the definition and diagnosis of mental health difficulties; the most fundamental being that mental illness exists within a continuum of human behaviour and experience that offers no unambiguous delineation between normal and abnormal, pathology and personality (Phelan, Link, Stueve, and Pescosolido, 2000). The term “mental illness” also implies a medical or biological cause that excludes the impact of additional factors such as psychology, socialisation, or cultural location.

Subsequently, what constitutes mental illness is infinitely variable according to culture, social grouping and situation, in addition to the subjective views of both the individual and the observer. Currently there is no all inclusive definition of the term “mental illness”, and inconsistency exists between narrow diagnostic definitions (such as diagnosed schizophrenia), and broader definitions, which consider the impact of diagnosed mental illness on social functioning, care needs, duration of illness and associated disability (Horwitz, 2002). Furthermore, evidence relating to the potential impact of different types of parental mental health difficulties (such as neurosis or psychosis) on offspring is contested and complex (Cassell & Coleman, 1995; Dore, 1993).

Given the complexities associated with diagnosing mental illness, the authors feel it is important not to restrict the scope of this article to a narrow clinical definition, therefore the term “mental health difficulties” is used, to describe psychological difficulties of a nature severe or sustained enough to warrant ongoing or intermittent intervention from Community Mental Health Services.