WPA guidance on the protection and promotion of mental health in children of persons with severe mental disorders

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This guidance details the needs of children, and the qualities of parenting that meet those needs. Parental mental disorders can damage the foetus during pregnancy through the action of drugs, prescribed or abused. Pregnancy and the puerperium can exacerbate or initiate mental illness in susceptible women. After their birth, the children may suffer from the social disadvantage associated with severe mental illness. The parents (depending on the disorder, its severity and its persistence) may have intermittent or prolonged difficulties with parenting, which may sometimes result in childhood psychological disturbance or child maltreatment. This guidance considers ways of preventing, minimizing and remedying these effects. Our recommendations include: education of psychiatrists and related professions about the effect of parental mental illness on children; revision of psychiatric training to increase awareness of patients as caregivers, and to incorporate relevant assessment and intervention into their treatment and rehabilitation; the optimum use of pharmacological treatment during pregnancy; pre-birth planning when women with severe mental illness become pregnant; development of specialist services for pregnant and puerperal women, with assessment of their efficacy; community support for parenting by mothers and fathers with severe mental disorders; standards of good practice for the management of child maltreatment when parents suffer from mental illness; the importance of multi-disciplinary teamwork when helping these families, supporting their children and ensuring child protection; the development of child and adolescent mental health services worldwide.

Key words: Parenting, severe mental illness, mother-infant relationship, substance abuse, childhood mental disorders, child maltreatment, child and adolescent mental health services

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The United Nations (UN) Convention on the Rights of the Child (1) affirmed that the child, for the full and harmonious development of his/her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding. Nations must take appropriate measures to protect the child from all forms of physical or mental violence, maltreatment or exploitation, while in the care of parents or other persons entrusted with their care. This Convention was adopted by the UN General Assembly in November 1989, and has been ratified by 192 nations. It is not only because of this authoritative pronouncement, but also because the ambition of medicine is to prevent disease, that the issue of the mental health of children of mentally ill parents is important: a promising preventive strategy is to work with high risk groups, such as these vulnerable children.

Most of these children are born and reared in low-income nations, which have a dearth of resources and also, in some cases, of essential knowledge. There is a paradoxical relationship between wealth and birth rates: nations in Europe, North America and elsewhere, with advanced health systems and strong scientific contributions, have fewer than 10 million births/year. We are concerned not only to improve practice in these nations, but also and especially to find solutions for those countries in which the other 125 million infants are born. Thus, we seek to recommend state-of-the-art services to those that can afford them, and creative interventions to less prosperous nations.

PARENTING AND THE NEEDS OF CHILDREN

The needs of children, which parenting must address, can be listed as follows:

- *Basic care* (shelter, nutrition, hygiene, clothing and medical care).
- *Safety* (protection from dangers, including unsafe people).
- *Emotional warmth*, so that the child feels unconditionally valued and secure. This will involve comforting, praise, and considerate, affectionate and loving care.
- *Encouragement of learning*. This requires quick and contingent responses to the child's language and questions, play, support to schooling, and the promotion of social opportunities. It is aided by understanding the child's world, his/her temperament, strengths and weaknesses, and may require special skills, for example in handling disabilities.
- *Guidance and setting consistent boundaries for culturally acceptable behaviour*, aiming to equip the child with consideration for others, discipline and internal moral values. This is achieved by supervision and monitoring (protecting the child from poor role models), coaching, and

rewarding good behaviour. Unacceptable actions are discouraged in a consistent way, providing a model for anger control and conflict resolution.
- *A stable family base* for engagement with the wider world.

Although there is much variation, these needs progress in phases from birth to adolescence, starting with attachment to primary caregivers in the first year. From the security thus provided, the child achieves gradually increasing autonomy, and starts to develop a sense of self, to recognize and regulate emotional states, and to discover the limits of personal power and identity. During the preschool years, an important task is peer-group integration. Towards the end of the first decade, the child begins to establish personal preferences, to take responsibility and develop a sense of right and wrong. Adolescence is marked by psychosexual development and a gradual move towards adulthood.

The term "parenting" covers the adult activities that meet these needs, and foster the child's development into a successful adult. "Caregiving" is sometimes preferred, in order to include adoptive and foster parents, and others, such as grandparents, who have a substantial role in caring for the child. Parenting may be disturbed by many factors other than mental illness, including poverty, adverse events and family violence or disruption. The neighbourhood may be violent and deprived, or, in contrast, may have strong cooperative networks. There are cultural and religious influences such as attitudes towards family privacy and cooperation, social responsibility, authority and ethnicity. Violence, war and persecution on a national scale provide the most unfavourable circumstances for caregiving.

RISK FACTORS DURING PREGNANCY

Treatment and prophylaxis of mental disorders in pregnant women

Most patients with chronic psychoses, and many with recurrent mental illness, are prescribed prophylactic or therapeutic drugs, and many women become pregnant when taking them. Although it is generally advisable to avoid medication in pregnancy, the risks of stopping it often outweigh the risks to the foetus. Pregnancy does not usually become detectable before 30-40 days gestation, so that infants conceived by women on regular drug intake are exposed to teratogenic hazards. In the case of most psychotropic drugs, this risk is controversial and slight. But valproate (possibly also carbamazepine) can cause neural tube defects and learning disability; this risk is reduced, but not eliminated by folic acid. Electroconvulsive treatment can precipitate early labour, preventable by a tocolytic drug. Neonatal toxicity and/or addiction have been reported in some babies exposed to lithium, antipsychotics, antidepressants and benzodiazepines. The risks to the breast-fed infant have been exaggerated (2).

Substance abuse

We focus on ethanol, narcotics and cocaine, which are the best researched. Exposed infants face many adverse factors: their parents often have mental disorders (such as depression and paranoid disorders); they often abuse other drugs; they suffer from multiple social problems and poverty; many do not seek antenatal care. The infants may be affected by maternal malnutrition and infections such as hepatitis, HIV or venereal diseases. The quality of care, as much as drug effects, is a strong predictor of outcome.

All three drugs are associated with an increased risk of short gestation and low birth weight. In addition, some exposed infants are small for gestational age, which carries the implication of placental insufficiency, not just early arrest of intra-uterine life. This in itself, without drug exposure, can result in neurological dysfunction, and possibly language delays and emotional disorders (3).

Selecting some salient points, *ethanol*, taken in excessive quantities, may be teratogenic, causing a general increase of congenital abnormalities. There may be microcephaly and permanent brain damage; foetal alcohol syndrome is a leading cause of mental retardation. A notable complication of *narcotic addiction* is the withdrawal syndrome, against which methadone maintenance does not protect. A specific complication of *cocaine abuse* is placental abruption. The long-term effects of both opiates and cocaine have been much studied, but without reaching a consensus on cognitive deficits or behavioural problems, when controlled for social deprivation (4).

Other harmful influences during pregnancy

There are claims that subclinical anxiety, depression or stress during pregnancy can have lasting effects on the child. They include pregnancy complications, prematurity, low birth weight or intra-uterine growth retardation, foetal or neonatal distress, and developmental delay, but there is no consensus on these effects. Perhaps the best supported claim is that mid-trimester anxiety affects mental health in mid-childhood, but such investigations are plagued by many confounding factors. Only rigorously designed cohort studies can substantiate these claims.

Domestic violence during pregnancy carries the risk of foetal injury and death. It can also severely affect maternal attitudes and morale.

Many pregnancies are unplanned, but most of these are merely mistimed, and are fully accepted. A minority remain persistently unwanted. The number of these unwelcome pregnancies is much reduced in nations that allow termination of pregnancy; even so some are carried to term. Unwanted pregnancy is a significant problem in many low-income countries (5). It is associated with an increased risk for denial of pregnancy, foetal abuse, neonaticide, depression, mother-infant relationship disorders and emotional disor-

ders in children. Cohort studies of unwanted pregnancy and its psychological outcomes are a research priority.

DISTURBANCES OF PARENTING DUE TO MENTAL DISORDERS

The complex functions of parenting may be disrupted, to a greater or less extent, by all forms of parental mental disorders. It is not so much the diagnosis that confers the risk, but the severity and chronicity of psychopathology. It is important to emphasize that investigations of parenting report statistical associations in large samples. There is much variation in psychopathology (its severity and duration), and in each patient's personality, coping and social circumstances. Many parents with severe depressive, anxiety or eating disorders, and even those suffering from psychosis, make excellent caregivers.

Different disorders have their effect through common pathways:

- *Parental preoccupation*. Any preoccupation, whether in the form of worrying, obsessional or angry ruminations or delusions, can impair vigilance and the readiness to respond to the child; so this effect will be seen in anxiety, obsessional and querulant disorders, as well as psychoses and emotionally unstable personality disorders. Inattention is also caused by involvement in time-consuming morbid activities, such as compulsive rituals, bingeing or drug abuse. It will result from disorders affecting the faculty of attention itself, such as depression. If this withdrawal of attention is frequent and prolonged, boundary setting will be inconsistent, and the environment will be impoverished, without the stimulus to intellectual growth.
- *Emotional unavailability*. This ranges in severity from avoidance of the child due to a child-focused phobia or obsessions of infanticide, to extreme withdrawal seen in severe depression or psychosis.
- *Anger*. This is prominent in depression, acute psychosis, mania, intoxication and withdrawal from drugs or alcohol. Irritability can find an outlet in the children, who are more accessible than husbands or other relatives. Pathological anger is a manifestation of severe mother-infant relationship disorders. Hostility may be targeted on the child in delusional disorders. Explosive irritability is a problem for some people with personality disorders.
- *Disturbed behaviour*. A child may be exposed to impulsivity, extreme mood swings, bizarre utterances or behaviour based on delusions. Abnormal emotional responses may disturb the interaction. This is perplexing, sometimes frightening. The shift from institution to community treatment in some countries means that more children experience psychotic behaviour at close range.

Parenting is also affected indirectly by other factors:

- *Deprivation*. Mental illness has a general association with social adversity (6), which may contribute to its causation, or may result from illness, disability or social incompetence. For example, mothers with chronic psychosis (who have a similar number of pregnancies and births to other women) more often have to cope with single motherhood, marital discord, domestic violence, poverty and homelessness. They are vulnerable to discrimination and exploitation. More experience rape, and face consequences such as abortion or sexually transmitted diseases. More have unwanted pregnancies. More are socially isolated and lack help in child-rearing. More have partners with mental disorders. The children may have a higher genetic risk, and are more likely to have challenging behavioural problems. These associated factors, taken singly or together (without the addition of maternal psychosis) increase the risk of mental disorders in the children.
- *Separation*. The parent-child relationship may be severely interrupted by parental hospitalization. Even with optimal treatment, these parents lose contact with their children for short or long periods, and this may affect attachment. The child may be traumatized by seeing his/her parents taken away or living in hospitals. The child will often have to be transferred to relatives, or foster care, so that he/she receives multiple parenting. Where there is neither state-provided foster care nor support from the extended family, parenting will be inadequate. In addition, mentally ill women fear the forced removal of their children. Many do in fact lose them – to estranged husbands, other relatives, foster care or adoption – and this is a source of prolonged sadness (7). Fear of losing custody or access dominates interaction with mental health and social services. Women may fail to seek help, or fail to disclose that they are parents, because of this fear.
- *Stigma*. On account of the parental illness, the child may be exposed to teasing, bullying and ostracism. The parents also suffer from stigma, which may lead to social isolation that increases the adversity of the child's background.

IMPACT OF SOME SPECIFIC MENTAL DISORDERS ON PARENTING

Psychosis

In parents with *chronic psychosis*, caregiving is often erratic and intermittent, with a low quality of sensitivity and involvement (8). In parents with *recurrent and acute psychosis* (including post-partum episodes), the parental relationship is often normal after recovery (9), unless the episodes are frequent and prolonged.

Depression

Depression is the commonest mental disorder, especially in women of child-bearing age. There is much concern about

its impact on mothering, and many studies have investigated its effects on mother-infant interaction and child development, using various modalities of investigation. Infant temperament and behaviour may also affect maternal mood, creating a vicious cycle. Nevertheless, adverse effects are not universal: some depressed mothers are sustained by the interaction with their children (10).

The effects of depression on parenting include the following:

- Depressed parents communicate sadness and pessimism. They lack laughter and gaiety, and are often irritable. They may show less affection, tenderness and responsiveness. These harmful influences have most impact in infancy, when contact is close and continuous.
- Depressive anergia reduces the efforts parents can make. There may be a reduction in the quantity, quality and variety of interaction. Thinking is inefficient, and, together with brooding and morbid preoccupations, reduces attention, resourcefulness and control.
- Depression (or associated relationship disorders) may be associated with language delays and, through their pervasive influence, other educational deficits.

There may also be effects on physical health and development (11). There are conflicting reports from Brazil, India, Ethiopia, Vietnam, Pakistan and Peru on an association of maternal depression with low infant weight and malnourishment.

Mother-infant relationship (attachment) disorders

The growth of the mother-infant relationship is the key psychological process in the puerperium. It is this relationship, gradually developing during the first few weeks after the birth, which enables mothers to make sacrifices, maintain vigilance, and endure the toil of nurturing their babies. There is a pathology of this process, even before the birth. In rejected pregnancies, the foetus may be viewed as an intrusion, resulting occasionally in foetal abuse (12). After the birth, a disappointing lack of feeling for the baby (which is common in the early stages) may, in a small proportion, progress to aversion, hatred and rejection (13). Maternal hostility deprives the infant of the fundamental need for loving relationships, severely impairs interaction, and leads to emotional abuse. The infant's demands provoke aggressive impulses which, when self-control gives way, lead to verbal abuse and rough treatment. These children are at high risk of maltreatment.

Anxiety disorders

Anxiety disorders may affect parenting. Intrusion and excessive control, "catastrophizing" (predicting dire consequences of normal adventures) and overprotection, sometimes coupled with a lack of warmth and responsiveness, may deprive children of opportunities to explore and manipulate the surrounding world. These can lead to separation anxiety, school refusal and social limitations.

Eating disorders

If an expectant mother severely restricts her intake, the foetus can suffer from impaired nutrition and growth. The attitudes of some anorexic or bulimic mothers lead to mealtime conflict, and occasionally to chronic hunger and impaired growth (14).

Learning disability

Parenting by women with learning disability is becoming more important, as they are transferred from institutions to the community. They are often socially isolated, and have many other problems. Their children may be at increased risk of abuse and neglect, but there is a dearth of information on parenting by these persons.

THE HARM TO CHILDREN WHICH MAY RESULT FROM PARENTAL MENTAL DISORDERS

Childhood psychological disturbance and mental disorders

Children of persons with severe mental disorders are at increased risk of psychological disturbance, not only because of parenting problems, but also because they may share a genetic predisposition, and be exposed to a slate of background factors associated with parental mental illness. These include antecedent obstetric complications, deprivation and lack of social support, marital conflict and chaotic family life. They are more vulnerable to exploitation. There is the reciprocal effect of challenging child behaviour, provoking parental hostility. On the other hand, protective factors may be at work, such as the resilience of the child or the beneficial influence of a healthy partner or another family member.

The child's mental health and social competence is best predicted by multiple contextual risks, less by illness variables and least by categorical diagnosis. It is widely believed that parent-child relationships lacking in nurturance and marked by harsh discipline and especially maltreatment are important factors in poor cognitive, behavioural and emotional outcomes. A focus on parenting offers excellent opportunities for intervention.

Some early forms of infant disturbance can confidently be related to parenting. They include the states of fear found in severe abuse. These children have behavioural stigmata: apathy to the point of stupor, crying only *in extremis*, lack of expression and vocalization, excessive visual awareness ("frozen watchfulness") (15).

Another early manifestation is the distress noticed in infants of depressed mothers. The infant plays an important part in the developing relationship with his/her caregiver, contributing to a dialogue through gazing, smiling, laughing and babbling. He/she is distressed by the failure of these overtures.

At the end of the first year, *attachment disorders* may be recognized. Secure attachment may signify an enduring capacity to form relationships, predicting popularity and acceptance by peers, which in turn promotes other forms of social competence. Disorganized attachment may be related to neglectful and abusive parenting. *Reactive attachment disorder of infancy and early childhood* is a clinical disorder seen in the first five years, marked by persistent abnormalities in peer and other relationships. There is a disinhibited variant, with indiscriminate sociability, associated with institutional rearing.

In later childhood, there may be *"externalizing" syndromes* (hyperkinetic, conduct and oppositional/defiant disorders). Claims that parenting is implicated in attention-deficit/hyperactivity disorder (ADHD) are controversial, but children exposed to drug abuse or suffering maltreatment may be at increased risk. Conduct disorders, and disobedience in the first decade, grade into teenage delinquency, adult antisocial traits and offending. Although there are many competing aetiological factors (including genetic), much research has found an association of these disorders with parenting (16). The style most clearly related is authoritarian: rigid, harsh parenting, and an atmosphere of hostility and criticism, lead to a vicious circle of misbehaviour and punishment (17). The child's aggression is learned from the parent. It becomes part of a web of risk factors leading to further social disadvantage, provoking negative reactions, underachievement, problems in social relationships and future parenting, mood disorders and substance abuse, as well as crime.

There may be also *"internalizing" syndromes*, depression and anxiety. A diagnosable syndrome of depression can be recognized in later childhood. There is much evidence of increased depression, and teenage parasuicide, in the offspring of mentally ill parents. Parental depression has many disadvantages for children, which include problems in self-esteem and peer relationships. But these may be related to "family risk factors" (such as marital and parent-child discord) in addition to, or instead of, maternal depression itself (18). There is extensive literature on the influence of parental anxiety on the development of morbid anxiety in children. The transmission of anxiety across generations is partly genetic and partly through modelling and overprotection.

In the teenage years, *substance abuse* becomes prevalent in vulnerable adolescents, more so in the children of addicts. Genetic factors may partly explain the association, but longitudinal studies have shown that parenting is also important, through ineffective discipline, lack of supervision and monitoring, low levels of support, parent-child conflict and learning by example.

Child maltreatment

Child physical abuse

Child physical abuse may be especially associated with aggressive personalities, but also with psychosis (19), alcoholism (20,21) and depression (20-22).

Child neglect

Child neglect is defined as the persistent failure to meet a child's basic needs and rights, resulting in serious impairment of health or development (23). It may complicate severe depression, psychosis (19,24) and substance abuse (20,25,26).

Neglect is a heterogeneous phenomenon with varied manifestations, including a failure to prevent suffering or seek medical or mental health care, lack of clothing, lack of supervision, leaving the child with unsafe carers, or deliberate denial of education or social opportunities. It is important to distinguish it from the unavoidable consequences of poverty: children in poor, single parent families with many social problems may be neglected despite the parents' best efforts. This applies to nutrition: "failure to thrive" should not be attributed to neglect without positive evidence. Nevertheless, extreme examples, such as severe global neglect and death from deliberate starvation, and the syndrome of "deprivation dwarfism", show that nutrition can also be involved in neglect.

Emotional neglect and abuse

Emotional maltreatment is a manifestation of severe disorders of the parent-child relationship. "Emotional neglect" means that mothers are emotionally distant and unresponsive to the child's need for comfort and help. "Emotional abuse" includes persistent belittling and humiliation – hostile, critical or sarcastic comments, conveying to children that they are worthless and unloved, scapegoating, isolating, ignoring, exploiting or "terrorizing" the child, such as by threatening suicide or abandonment (27). Exposure to domestic violence can be put under this heading. Emotional maltreatment may be a more potent risk factor for later maladjustment than other forms of abuse (28).

Munchausen's syndrome by proxy

This term covers caregivers who induce or feign illness in their children (29). The manifestations include fabrication or simulation of symptoms, and deliberate induction of illness by acts such as poisoning, smothering or infecting their infants.

Death of the child

This is usually subdivided into *neonaticide* (murder of the newborn) and *filicide* (parental killing of an older child). In neonaticide, there is usually no formal mental illness, but rather an emotional crisis marked by panic or rage, but various forms of impaired consciousness can occur during parturition (30), and can never be excluded in solitary deliveries. Filicide is very rare, but of great public concern. It is often associated with mental illness, especially suicidal depression, but also delusions involving the child, severe mother-infant relationship disorders and occasionally acute psychosis, command hallucinations, delirium, or trance states (31). Some may fear that mentioning this association of mental disorder will increase stigma, but we believe that the better strategy is to recognize the risk and take steps to minimize it.

PROMOTION OF HEALTH IN VULNERABLE CHILDREN

Clinical practice in adult psychiatry

Diagnostic classifications

Those responsible for producing the ICD-11 and the DSM-V, when formulating their multidimensional systems, should include the obligatory coding of important contextual factors. One proposed specifier is "onset of mental illness related to childbearing". We suggest that "parental context" (current care of a child under the age of 18) should be another.

Clinical assessment

The UN Convention on the Rights of the Child (1) states that nations should provide preventive health care and guidance for parents. Current practice in adult psychiatry falls far short of this requirement. The status, or even the existence, of children is often not noted. Psychiatrists must be aware that many patients are parents, and that their children are at increased risk of psychological problems. Clinicians must adapt the standard psychiatric history to include questions about parenting, marriage and family life. These must be included in mainstream training programmes for mental health professionals.

We suggest, as a preliminary probe, "Are you looking after a child?", followed by "How are you managing as a parent?" or "Do you have any worries about the care you can provide for (name of child)?". In those with childcare responsibilities, there should be a brief parenting assessment, as outlined in Table 1. This takes some time, but sets the stage for family support and interventions.

Visiting facilities in hospital

During admission, facilities must be provided for visiting by the children, shielded from interaction with other patients. The sick parent may need help in explaining the illness to the children.

Discharge planning and rehabilitation

This should include educating parents about child development and the management of parenting problems. After discharge, if possible in collaboration with social services, plans should be made for long-term parenting support in the community. This could include respite for parents and leisure opportunities for children. Family status should be monitored to pre-empt a crisis demanding removal of the children. The UN Convention draws attention to the need for family planning. When this is in the best interests of the family, this advice should be a routine part of clinical practice. Schedules for brief parenting assessment, and remedial programmes, are subjects for future research. The vignette in Table 2 illustrates the management of parenting failure by an overloaded Indian service.

Pre-birth planning

When a woman with severe mental illness becomes pregnant, communication between mental health and obstetric teams, and other relevant services, is essential. If distance and resources allow, a multidisciplinary pre-birth planning meeting should be convened as soon as possible, to share information and coordinate management. The reason for urgency is that the interval between the diagnosis of pregnancy (which may be delayed) and birth (which may be premature) can be short. The meeting should include the general medical practitioner, a representative from the obstetric team, members of the mental health team, and (if possible) the expectant mother herself. It is helpful to include the patient's husband (or father of the child) and a member of the wider family. There are many issues to be

Table 1 Brief parenting assessment for patients with childcare responsibilities

A. Evidence that all the children's needs are being met.
B. If there are problems, further exploration of:
- The quality of the relationship
- Family violence
- Disrupted schooling
- Other problems, such as neglect of safety or health, overprotection or children taking on a parental role
- Children's emotional disorders or disturbed behaviour
- Sources of alternative care.

C. Available supports – the other parent, the extended family, school, neighbours, non-governmental agencies or health care services.

Table 2 A vignette illustrating parenting assessment and interventions in a case of severe mental illness in India

A 35 year old widow lived with her son and daughter, aged 7 and 9. Her elderly father-in-law lived nearby. For 2 years she seldom left the house, confined the children, neglected their hygiene and fed them on chips and fizzy drinks. Eventually, when she started screaming at imagined persecutors, neighbours helped her father-in-law to enforce her hospital admission.

Findings of the *parenting assessment*:
- The children suffered vitamin deficiencies.
- When they fell ill, their mother failed to consult a doctor.
- They had missed 6 months schooling, and had no playmates.
- Their mother was noisy and unpredictable.
- The elder child took on the parental role, and had to undertake household chores.

Available *resources*:
- The children's bond with each other and their grandfather.
- An extended family (alienated by her behaviour).
- Concerned neighbours and school teachers.

The (adult) psychiatry service was the point of delivery for all forms of care. Despite the lack of a generic social service, there was a social worker attached to the team. Together with a trainee resident, she undertook the planning of family care.

Action:
- The father-in-law was given guidance and physical help in caring for the children. He agreed to ensure school attendance.
- When the mother's mental illness was explained, her family became less critical, and agreed to visit regularly. Neighbours continued to support the grandfather.
- A teacher monitored the children's attendance and welfare.
- The children visited their mother. She was instructed in the essentials of parenting.
- Since the children were at risk from genetic loading, neglect, single parenting and unstable childhood, they were referred to the child psychiatry service for assessment and intervention.

addressed: pharmaceutical treatment, antenatal care, early signs of a relapse, the management of the puerperium and the care of the infant. It is essential that the mental health team is alerted as soon as the mother goes into labour. She will need extra support in child rearing, and the child protection team may need to be involved. Referral to a specialist psychiatric service for pregnant and puerperal women may be feasible.

Similar pre-conception planning can also be recommended when a man or woman with mental illness is considering starting a family.

Specialist services

Mother-infant psychiatry

The UN Convention stipulates that nations should ensure appropriate prenatal and postnatal health care. Mother-infant (perinatal) services, either as a branch of child psychiatry or a subspecialty of adult psychiatry, have developed in a few high-income countries, and also in India and Sri Lanka. They can serve a population, handling severe and intractable illness, training staff, developing services, and conducting research. Their resources may include outpatient clinics, day hospitals, inpatient facilities, community outreach, obstetric liaison, links with other services and voluntary agencies, and medico-legal expertise. The core of the service is a multidisciplinary specialist team, providing care for the mentally ill mother and her child – a key resource whatever the cultural background and the resources available. There is a need for research into the cost-effectiveness of these expensive "state-of-the-art" services.

The assessment and management of disordered mother-infant relationships is one of the skills exercised by these teams. In all newly delivered mothers who present with symptoms, it is essential to explore this relationship, bearing in mind that shame, or fear that disclosure of problems will lead to the involvement of child protection agencies, often leads to concealment. Certain tactful probes should be used: "Have you felt disappointed in your feelings for (name of child)?" or "How long did it take for you to feel close to your baby?". If there is any indication of negative feelings toward the child, these are explored, together with manifestations of anger: "What is the worst thing you felt an impulse to do?", "Have you ever lost control?", "What were the worst things you did to your baby?". For mothers whose aversion is strong enough to threaten the health and safety of the infant, intervention is essential. Skillful treatment often achieves a normal relationship.

Services for pregnant women with substance abuse

All members of society should understand that drinking alcohol, and abusing drugs, can have hazardous consequences, particularly during pregnancy. Practitioners and midwives should counsel women who are planning pregnancy, or are already pregnant, advising them to abstain; they should be trained to assess abuse in pregnancy. In alcoholism an issue is the recognition of foetal alcohol effects. In narcotic addiction, reducing the exposure of the foetus is the aim. Other drugs of abuse should gradually be withdrawn. Complete withdrawal from opiates, or using an antagonist such as naloxone, can precipitate a foetal abstinence syndrome. For many, replacing heroin by moderate doses of methadone or buprenorphine is the best option, with less intra-uterine growth retardation and perinatal complications.

Pregnant addicts require intensive case management. After delivery, unsuspected abuse can be detected by markers in blood, hair, urine, meconium or umbilical tissues. The infants should be kept in hospital for long enough to manage intoxication or withdrawal symptoms. Early intervention can alleviate secondary effects, and improve literacy and behaviour. There are a few specialist multidisciplinary diagnostic and treatment services (32); their efficacy and worldwide deployment should be explored.

Child protection

The UN Convention states that child protection should include programmes to support the child and his/her caregivers, as well as to identify, report, investigate, treat, follow-up and prevent child maltreatment. In all actions concerning children, whether undertaken by administrative authorities or legislative bodies, the best interests of the child should be paramount. This, rather than family preservation, is the primary consideration, and the child's welfare trumps parental rights, even when his/her removal aggravates parental mental illness. Nations must pass laws, assigning responsibility, and setting out the procedures for investigation and remedial action, including emergency protection. Mental health professionals need to understand the law and the procedures in the country where they are working.

Child protection requires the alliance of many social institutions:

- *The extended family*. The Convention asserts the fundamental role of the family, as the natural environment for the growth and well-being of children. The father's active involvement is of great value. Siblings, in-laws and grandmothers are often the main sources of support – indeed, in some countries, the only resource.
- *Multidisciplinary child protection teams* are the mainstay in high-income nations.
- In alliance with these teams, or as an alternative, *neighbourhoods*, *schools*, *voluntary agencies and religious organizations* can support families, reporting maltreatment and promoting social opportunities and informal networks.
- *Alternative placements* are the refuge of children who cannot safely be reared by their biological parents. They include adoption, foster-parenting and various forms of institutional care.

Management of maltreatment

The early diagnosis, assessment and management of suspected maltreatment has been summarized elsewhere (33). When it is associated with severe mental disorder, this introduces a further element of complexity. We take Munchausen-by-proxy as an example. In this case the parent's severe psychopathology brings the child's right to protection into conflict with the family's right to privacy, normal doctor-patient relations and medical confidentiality. The investigation may involve reviewing the parent's medical history (with the general practitioner's help), an unscheduled home visit, covert surveillance (after wide consultation), and excluding the parent from child care. When the diagnosis is established, the meeting with the parents is critical: the physician should make it clear that he/she knows what has been happening, explain the harm to the child, and assure them that he/she is going to help them and the child.

Often the only safe remedy is to remove maltreated children. Coercive relinquishment is one of the most traumatic events a mother can experience, and even more so if this results from a treatable mental illness. It may also be distressing for the child. Alternative placements also have hazards: the loneliness and misery of children in orphanages and hospitals ("hospitalism") was noted long ago. Foster placements, often of great benefit, sometimes fail, leading to further disruption.

Much research has been undertaken on the prevention of maltreatment, through public education and proactive intervention in high risk groups (34,35). Except in so far as some severe mental disorders (and especially the social environment associated with them) are risk factors, this is outside the remit of these Guidelines.

Resources available worldwide

We sought information about resources for child protection in the nations that contribute most of the world's children. We had the benefit of a series of reports, obtained by one of us, from 19 countries. We supplemented this by letters sent to colleagues, asking about laws, public and political support, national records, reporting, child protection teams, training, social services and other agencies devoted to child protection. We obtained answers from six nations in Africa (Ethiopia, Kenya, Mozambique, Nigeria, Tanzania and Uganda), three in South-East Asia (India, Pakistan and the Philippines), two in the Middle East (Egypt and Turkey) and three in South and Central America (Argentina, Brazil and Mexico), as well as many high-income nations. A pattern of four broad groups emerged:

- Group 1 consists of prosperous nations, with different styles and legal arrangements, but everything available – for example Canada, which has made major contributions to research on child maltreatment.
- Group 2 consists of nations like Turkey and Taiwan, which may have begun later, but are already making strides towards an effective service. Turkey, for example, has at least 14 child protection teams.
- Group 3 consists of countries like India and Uganda, overwhelmed with children, resourceful but destitute of resources, struggling to establish pioneering units.
- Group 4 consists of nations, of which Pakistan is an example, where the problem of child maltreatment is at an earlier stage of resolution (36). A Child Protection Bill is still awaiting parliamentary action. An obstacle is the strong culture of family privacy.

We also asked our correspondents what, given their financial constraints, would improve child protection in their countries. We only have space for a selection of their responses, and have omitted the obvious need for more staff and funding. The first priority was education – "to raise public awareness of this very taboo topic" (Pakistan), educating

the populace, school teachers, families of psychiatric patients and even indigenous healers. The second was improving professional training, especially of paediatricians, primary care teams, midwives and home visitors, who often lack mental health training. The third was lobbying governments to recognize these children as a high risk group and take action.

Child and adolescent mental health services

Child and adolescent mental health services are essential for the promotion of mental health in vulnerable children. They provide treatment for all the disorders previously summarized. They have a role in teaching and training, assessment, liaison with other agencies, research and prevention, and developing guidelines. In clinical practice, multidisciplinary teamwork is optimal, with a focus on the parent, on the child and on the social and family context of the child's life. Many specific forms of psychotherapeutic and psychological intervention have been developed, including family therapies, mother and infant psychotherapies, and brief cognitive therapy appropriate to the age and stage of child development.

In the course of our enquiries, it became clear that these services hardly exist in many low-income nations. In 2005, the World Health Organization published an atlas of child and adolescent mental health resources, based on responses from 66 countries. The atlas does not give details of individual nations, but it is clear that most countries with high birth rates have limited child and adolescent services. For example, Uganda (where 1.5 million children are born each year) has two outpatient clinics in Kampala, and only one qualified child psychiatrist, dealing mainly with epilepsy and mental retardation. In 37 nations, care is provided by paediatricians, often with no training in mental health. Even the United States of America is short of child psychiatrists.

One of the research priorities is to investigate best practice interventions for mentally ill parents and their children, which are feasible, fundable and culturally acceptable in low-income nations. This could include the role of extended families in supporting vulnerable children and their families.

The way forward is long and difficult. It should perhaps start with the training of a few specialists working alone, but available for consultation. They can take a lead in public education and lobbying politicians. They can build up demonstration units and start training programmes. Training can be directed not only towards future specialists, but also towards professional people who have contact with children – for example nurses, paramedical staff and teachers – and other trusted figures in the community, who can be recruited to assist children in need.

Addressing the needs of children of persons with severe mental illness requires (in addition to improvements in the practice of adult psychiatry, community support for the families and collaboration with child protection agencies) a worldwide increment of services for child and adolescent mental health.

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Well over 1,000 works were consulted in the preparation of this guidance. A list of 200 representative references can be obtained from the first author at i.f.brockington@bham.ac.uk.