

# REPRESENTING PARENTS WITH MENTAL HEALTH PROBLEMS

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When representing parents with mental health problems, it is important to have at least a basic knowledge of some of the terms that a practitioner may encounter. At least a basic idea of the terminology commonly used by psychiatrists in the diagnosis and treatment of those suffering with a mental health problem is required, and knowing and understanding the many principles behind the Mental Health Act 1983 is also important.

Broadly speaking, mental health problems can be subdivided into either a psychotic illness or a neurotic illness.

## PSYCHOTIC ILLNESS

This term is often applied to a person suffering from a major mental disorder in which reality is distorted or lost, ie the patient is in a mental world of his own creation. Phrases such as psychosis and psychotic are used, and the drugs used in the treatment of a psychosis are referred to as psychotropic. Types of mental illness that are of a psychotic nature include schizophrenia, which can come in a variety of forms, for example, paranoid schizophrenia where the sufferer experiences delusions and hallucinations often of a persecutory nature. The definition of a delusion is: 'false conclusions which are unreasonable and are maintained in spite of accurate evidence to the contrary', for example, a client may have a delusion that their child is the son of the devil and may cause harm to them. A hallucination is defined as: 'an apparent perception of an external object not actually present and involving any of the special senses', eg a visual hallucination where the client may see a person or thing. The client may believe

a person is following them or experience an auditory hallucination in which the patient hears people that are not present, eg voices that are heard in the brain/mind as very real and present but which in reality/objectively do not exist.

## NEUROTIC ILLNESSES

The other type of mental illness may be seen as a neurosis. It can sometimes be referred to as a psycho-neurosis and is defined as:

'a group of mental disorders less pronounced than the psychoses. They have no demonstrable organic pathology and do not result in distortion of reality or impairment of intellect, ie the patient remains in contact with the world or reality about him.' (*Terms, Test and Drugs Used in Psychiatric Practice* (Lancaster Health Authority, 1984)

Neurosis might be characterised by extreme anxiety, for example, fear of open spaces or claustrophobia. Other examples of neurosis include obsessive-compulsive disorder and depression, which is defined as: 'a persistent feeling of sadness, often accompanied by feelings of hopelessness, inadequacy and unworthiness'. It is also important not to see a mental health problem too rigidly in terms of either a neurotic or a psychotic illness. There are some clients who may suffer from a range of mental health problems that can cross over the borders.

## DEFINITION OF MENTAL DISORDER – s 1 OF THE MENTAL HEALTH ACT 1983

The definition of mental disorder under s 1 of the Mental Health Act 1983 (MHA 1983) is:

'A mental disorder means mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind and mentally disordered shall be construed accordingly.'

The sub-definitions of mental disorder are first, mental illness. This includes, for example, psychotic disorders such as schizophrenia, delusional or persecutory beliefs, alteration of mood, and impairment of intellectual functions, such as memory, comprehension and orientation (where the person does not know who they are, what time it is, who the Prime Minister is, etc). Arrested or incomplete development of mind is sometimes known as mental handicap. This term describes a significant failure to meet normal milestones of development caused by genetic factors and excludes those whose handicap derived from an accident, injury or illness occurring after the mind had reached its full development, eg a brain injury. For example, it could be a person with a severe mental handicap or severe learning disability, but for MHA 1983 purposes, particularly in relation to detention and treatment, mental handicap alone is insufficient and it must be associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

The term psychopathic disorder means a persistent disorder or disability of mind that results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned. Psychopathic disorder is of an entirely different nature to mental illnesses such as schizophrenia. The term was only introduced around 90 years ago and how it should be managed and treated has been the subject of intensive debate over the years. Important features may be an inability to relate to others and to take account of their feelings and safety, difficulty in influencing their behaviour by any social, penal or medical interventions, and commission of extreme anti-social acts. There is controversy in the profession as to whether there can be any effective treatment for psychopathic disorder. There seems to be a school of thought among some psychiatrists that it cannot be treated and

there is therefore little point in such people being sectioned for treatment under the MHA 1983 and that it would be more appropriate if they were punished for their crimes and detained in prison.

Finally, the definition in the MHA 1983 of mental disorder refers to any other order or disability of mind. It is almost a catch-all phrase to include various neuroses and personality and behaviour disorders.

This article next considers some aspects of treatment, the law and the issue of capacity and understanding, which may have an impact upon whether a client can be represented at all or whether the Official Solicitor needs to be invited to act. Finally, the Children Act 1989 will be considered and typical examples given of where a parent with a mental health problem might be represented and how the likely outcome in a case might be improved with a better understanding of mental disorder.

## TREATMENT

The main approach to treatment for a mental disorder in modern psychiatry is through medication. There are a wide range of forms of medication which are used for the treatment of psychoses in particular, but they are also referred to in use in treatment for neuroses, eg obsessive compulsive disorder or where there is extreme anxiety associated with depression. The old forms of medication of some 20 or 30 years ago caused very severe side effects such as severe shaking or lockjaw. The newer anti-psychotics tend to have fewer side effects and are referred to as 'cleaner'. Types of drugs commonly used in practice are olanzapine, haloperidol and clozaril. Typical drugs used in mood disorders, such as bi-polar affective disorder, are lithium or sodium valproate. Typically, drugs will have both a brand name and an approved psychiatric term name, eg temazepan, which is often prescribed for depression and anxiety disorders, has the brand name Euhypnos. Other aspects of treatment can involve counselling and support, psychotherapy, occupational therapy, psychological support and cognitive behaviour therapy.

Where patients are in the community they are likely to have support from their

community mental health team, the community psychiatric nurse and/or an approved social worker. The kind of services differ from region to region but can include support from an intensive supportive living team (ISL) where there can be more regular and frequent visits to help with a variety of things such as budgeting, shopping, engagement in social activities, etc for those most at risk.

The term 'insight' is frequently used. If clients have good insight they understand that they have a mental disorder and, in theory, are more likely to accept that they need help and support, that they need medication and understand its nature and purpose, and are more likely to have a better chance of getting better and coping at home.

### CAPACITY

It is important to understand the concept of capacity/incapacity as this may determine whether the client can be represented directly or whether it is necessary for the Official Solicitor to be invited to act or a 'next friend' appointed. Simply because a client has a mental health problem or mental disorder does not necessarily mean that he lacks capacity. He is more likely to lack capacity if he has an illness of a psychotic nature where he is distanced from reality, particularly where he has little insight into his illness and is reluctant or unable to take medication. If a client is detained in hospital, it is likely that he does not have capacity as it means the nature and the degree of the mental disorder is more severe and that his detention for treatment is required for his own protection or for the protection of others. For him to be able to instruct a solicitor directly he will need to have a good understanding of the nature of the case, eg, social services' concerns or the question of contact between a child and a parent and the court process. He will need to give evidence and be cross-examined and have a good level of stability in their mental health throughout the whole of the case, which might go on for several months. If in doubt, the client's responsible medical officer/psychiatrist should be contacted, if he has one, and asked to clarify whether the client does have capacity to be able to instruct directly and understand the

concerns and nature of the case and the court procedure. If he does not have a consultant psychiatrist, it is possible to contact his GP, but if the Official Solicitor is to be invited to act, a psychiatrist must first complete a medical incapacity certificate. The certificate is in a specific format and has to cover particular points before the Official Solicitor will act.

It is sometimes useful in a case in which the question of incapacity and mental disorder is likely to feature to contact the Official Solicitor's office and speak to one of the case workers. They are very helpful and may give you an indication as to whether it is the type of case where they would be likely to accept instructions. The court may then be told at a directions appointment about the short conversation with the Official Solicitor and the court told of any indications the Official Solicitor might have given. If the Official Solicitor does accept instructions to act then the solicitor will not lose his role (usually) and will work alongside the Official Solicitor as if a local agent.

### CARE PROCEEDINGS

When a mental health problem has an impact upon parenting then it can result in involvement from the local authority/social services department. The best time to begin to act/represent the parent who is a patient is before care proceedings have even commenced. In that way there might just be a possibility of avoiding the issue of care proceedings at all. If a child is expected to a client with a mental disorder, it is important to ensure that the local authority call a pre-birth case conference. It is important to put some pressure on the chair of the conference to ensure that there are representatives from the adult services/mental health team and perhaps from the mental health agencies, eg community mental health team, approved social worker and possibly even the responsible medical officer/psychiatrist (although it is very unusual that consultants would attend a case conference).

There can be a problem within local authorities because of the demarcation and sometimes a lack of liaison and communication between child protection teams and adult teams. In the past, social

workers would be generic and would have some knowledge of both mental health and child protection. However, that is very unusual now and in the main a social worker may be very experienced in child protection but have little, if any, knowledge in relation to mental health.

The client must be assured of all of the services that may assist him, both from the health agencies and from the social services. Clients who have previously been detained under s 3 of the MHA 1983 (long-term treatment) are entitled to services under s 117 of the MHA 1983 when they are discharged from hospital. This could involve support from the community psychiatric nurse, the community mental health team, out-patient appointments with a psychiatrist, use of a drop-in centre and support from an ISL. In addition, support could be provided in the community by the provision of medication by depo injection, which is likely to have a significant impact on a client's mental health as the use of depo injection avoids the possibility of the client not taking medication (orally), relapsing or disengaging from services. On discharge, and even if a client has not previously been sectioned under the MHA 1983, the client should be entitled to a community care assessment under s 47 of the National Health Service and Community Care Act 1990 (the social services adult team should be written to at the outset to find out whether there has been a community care assessment of the client). If there has, a copy should be obtained and if there has not been an assessment or it is out of date the matter should be dealt with urgently and a copy provided. Assessment can also include an assessment of a carer, eg if a client is living at home with a partner or elderly relative. That point is included in the model letter in the Official Solicitor's instructions to the local social services department (see also para 7.3 of the Official Solicitor's instructions). The obligation to conduct an assessment and provide services also applies to clients with mental impairments such as severe learning disability.

Where at a pre-birth case conference it is considered that there is a significant risk to the child then it might be argued that such risk could be reduced if it were accepted

that after the birth the client is subjected to an assessment in a mother and baby unit specialising in assessment and treatment of mothers with a mental disorder.

Assuming that the local authority cannot be persuaded not to issue care proceedings then the client will have to be represented at the first court hearing. The case may commence with an emergency protection order (at birth). It is usually an ex parte application but it might be possible for it to be agreed with the local authority that the application should be on notice and sometimes, if the solicitor gets wind of the application being made and turns up at court, the clerk may refuse to deal with it on an ex parte basis and be prepared to list it the following day.

There may be problems in obtaining instructions at this point and if it is clearly very difficult to obtain instructions and, if the client is quite ill, it should be conducted on a best interests basis. Solicitors should do what they think is best for a client up until the Official Solicitor becomes involved. For example, the solicitor might agree that he does not consent to an interim care order but cannot put up much opposition to it, but he might suggest that the magistrates make an order for a short period of time in order for the Official Solicitor to be invited to act.

#### ROLE OF AN EXPERT IN PROCEEDINGS

It is extremely important to get the right expert with particular knowledge of parents with mental disorders. The outcome of the assessment might significantly affect the outcome of the case. If the Official Solicitor has accepted instructions to act he should be liased with concerning the identification of the expert and the nature of any letter of instruction (see the standard instructions). Note in particular the publication by J Brophy, *Myths and Practices: National Survey of the Use of Experts in Child Care Proceedings Research Study* (British Association for Adoption and Fostering, 1999) especially at p 43:

- 'Most parents did not seek leave of the court for their experts directly to examine the child; where they did, few were successful in obtaining this type of assessment.'

- Many expert reports filed by parents focus upon the adults rather than the child in the case and many did not address the question of appropriate court orders for the relevant children.'

Types of questions to put to an expert:

- confirm the diagnosis and nature and the degree of the disorder as far as the client is concerned;
- confirm whether there are any current symptoms associated with the illness, eg experiencing delusions, hallucinations, etc;
- confirm whether the client has insight;
- confirm the nature of the treatment including the medication and any other aspects of treatment;
- confirm the history of any mental disorder;
- confirm whether the illness is likely to have caused any cognitive impairment which may have an impact upon understanding, memory, etc and if so how the social services team may better help the client to understand the nature of any concerns and to improve his ability to learn/improve his method/level of parenting;
- ask them to indicate whether there are any problems in relation to alcohol or drug misuse and any impact upon the mental disorder and/or upon parenting;
- indicate whether the illness is associated in its current form with any increased propensity to harm others, eg a child or any increased likelihood of the neglect of the parent or the child in the parent's care;
- ask them to consider the prognosis, the optimum treatment plan and extra services and support the client may receive in the community;
- ask them to consider whether the client is likely to provide good enough parenting to prevent the child from suffering neglect/significant harm; and
- ask them to consider whether the assessment might be improved by a residential assessment, eg in a mother and baby unit.

Areas where it may be more difficult to obtain assessment by the parents' psychiatric expert:

- attachment between the child and the parent;
- bonding between the parents and the child;
- any developmental disorder of the child as a result of the parenting; and
- the quality and importance of contact between the child and parent.

The following is an extract from chapter 11, by D Cassell and R Colman, of *Assessment of Parenting – Psychiatric and Psychological Contributions* (Routledge, 2000), at p 179.

'The model we suggest is for adult psychiatrists to contribute by providing information about their assessment of the ill parent, with the focus on the diagnosis and prognosis. Informing other professionals of the terminology, treatment plans, expected timescale for recovery and some indication of the effects of the illness and medication on the parent's general functions will help them formulate plans for the child. The child psychiatrist needs to assess the child's needs, impact upon the child of the parent's problems, the parent/child relationship, parenting skills or capacity, family functioning, possible risk to the child and the capacity for change in the family relationship. The child psychiatrist could help interpret the mental health problems and explain their implications for the child. In order to make a valid recommendation about the child's future to a court, the child psychologist needs to be informed by the adult psychiatrist's assessment of the parent's diagnosis and prognosis.'

#### THE LILAC BOOK

The *Lilac Book* (Department of Health, 2000) is the framework for the assessment of children in need, used by social services. It can be seen that the mental health of the parents will be a particular factor which will have an impact upon the factors in the assessment framework. Consider in particular the following:

'Particularly important to a child's health and development is the ability of parents or care givers to ensure that the child's developmental needs are being appropriately and adequately responded to and to adapt to his or her changing needs over time. Parents should provide:

- (1) Basic care.
- (2) Ensure safety.
- (3) Emotional warmth.
- (4) Stimulation.
- (5) Guidance and boundaries.
- (6) Stability.'

It should be remembered that, when representing a parent, the solicitor will be trying to establish whether the parent has a mental disorder and dependant upon the nature and degree of it, can she provide these basic levels of parenting and effectively provide adequate parenting to avoid the child having to be subject to a care order and possibly freed for adoption. When representing a parent, the question of their mental health should not be the sole factor. The assessment process is multi-faceted and there may be weaknesses in some areas but significant strengths in others. Of particular note is extended family support. Housing can be a particular problem for those suffering with a mental disorder and solicitors should try to improve the housing situation and the support available to the parent to help deal with other problems in their lives, eg debts, budgeting, social support network, etc.

Other useful publications include: *Children's Needs – Parenting Capacity; The Impact of Parental Mental Illness and Problem Alcohol and Drug Use and Domestic Violence in Children's Development* (Department of Health, 2003). In summary:

- Children do not necessarily experience behavioural or emotional problems when parents suffer mental illness, problem drinking or drug use, or domestic violence. However when these parental problems co-exist the risk to children increases considerably.
- Mental illness can seriously affect functioning. For example, the delusions and hallucinations suffered by the schizophrenic are shown to result in a

pre-occupation with a private world. Depression can result in children being neglected because of feelings of gloom, worthlessness and hopelessness, and everyday activities are can be left undone. Regardless of its cause, mental illness can blunt parents' emotions and feelings, and cause them to be behave towards their children in bizarre or violent ways.

- Parental problems can result in parents having difficulty organising their lives. This may result in inconsistent and ineffective parenting.
- Parental problems may mean parents may have difficulty controlling their emotions. Violent, irrational or withdrawn behaviour can frighten children.

As Diana Cassell and Rosalyn Colman said in *Assessment of Parents* (above):

'In general, it is evident that children can live with a parent who has a psychiatric disorder without significant suffering. However, there are particular factors that lead one to worry, including hostile and aggressive behaviour (especially if there is a previous history of aggression), repeated deliberate self-harm, threatening delusions and hallucinations, a rapidly changing mental state, when a child is involved in the parent's symptoms (especially delusional thinking), and when the symptoms (such as irritability or withdrawal) or treatment interfere with parenting tasks (particularly ensuring the child's safety or providing for the child's basic needs). From the child's perspective, professional concerns should also be raised when the child is burdened by caring for the parent, or shows significant problems with attachment, psychological differentiation, identity formation, capacity for peer relationships, self esteem, or ability to handle conflict.'

#### PRIVATE LAW CONTEXT

In many of the matters referred to above issues associated with representation of parents in care proceedings will apply equally to representing a parent in a private

law dispute. However, the competition may be between a parent without a mental health problem and parent with a mental health problem, as opposed to a competition between parents with mental health problems and social services departments. It should be noted that if a parent with a mental health problem has significant support from a co-parent who does not experience such mental health problems and provides help and support to the other 'ill' parent, then it should improve the prospects of keeping the child within the family. Again, there will probably be a need to consider: the question of capacity; whether the Official Solicitor or Next Friend should be appointed to act; the question of expert evidence and the possibility of additional evidence from a psychologist/psychiatrist in relation to attachment; and any disorder of the child.

If there is existing social services involvement with the family then it may indicate that a Children Act 1989, s 7 report should be prepared by social services rather than a Children and Family Court Advisory

and Support Service (CAFCASS) officer, and if there is a possibility of a care order being made the order for a report may be made under s 37. The court will determine the best outcome for the child based upon s 1, the child's interests and the welfare checklist. One should note in particular any harm that the child is at risk of suffering and the ability of the parent to meet the child's needs. One should never assume or conduct a case on the basis that simply because the parent has a diagnosis of a mental disorder that the other parent is automatically the most appropriate to care for the child. Prepare the case by reference to the specific welfare checklist, consider matters such as community care assessment, support available to the client in the community, the nature and degree of the parents' mental health and any impact upon parenting, and the question of attachment between the child and the parent. Even if residence passes to the other parent, the question of contact is very much a live issue, which can include potentially some staying contact.

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