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Mothers and mental illness: Breaking the silence about child loss☆

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1. Introduction

Women have unique mental health needs that are intimately entwined with gender related roles, identities and experiences across the life span, including in women's reproductive years (Astbury, 2001; Kohen, 2010; Riecher- Rössler, 2017; Riecher-Rössler & García-Moreno, 2013; Castle & Abel, 2016; Khanlou & Beryl Pilkington, 2005; Reid, 2017). To provide women with optimal mental health care, there is a need to recognize the relationship between gender based life experiences, mental wellbeing and psycho-social distress. Engaging with the highly contextual nature of mental distress is a challenge because it marks a departure from the previous clinical focus on psychopathology associated with the peri-natal period (Murray, Cooper, & Hipwell, 2003). Emphasis on the peri-natal period is important. It has brought the welcome establishment of mother and baby units in major psychiatric hospitals around the world and driven the development of best practice peri-natal clinical guidelines such as the Australian Centre for Perinatal Excellence (Austin et al., 2017) and the National Institution of Health and Care Excellence (NICE) in the United Kingdom (NICE National Institute for Health and Care Excellence, 2018). While these initiatives can improve treatment and care options for women, many women and their clinicians continue to call for clinical expertise in women's health and women centered approaches to the delivery of mental health care (Ballou & Brown, 2002; Chesler, 1972; Kendall-Tackett & Ruglass, 2017; Morrow, Hankivsky, & Varcoe, 2008). Women centered approaches to mental health care seek to recognize and respond to the deeply contextual experiences of women with mental illness, often by documenting women's experience of mental illness. Understanding the lived reality of women's lives as a matter of personal experience is consistent with the broader movement in psychiatry to understand the complex interplay of the intrapersonal, interpersonal, familial, social, economic and environmental circumstances and their impact on everyone's mental health and wellbeing (Bywaters, Featherstone, & Morris, 2019). An important aspect of women's experience of mental health is the experience of women who are mothers.

New literature dedicated to analysis of the subjective experiences of mothers with mental illness is building a deeper understanding of the relationship between motherhood and mental illness and women's strategies for mothering successfully in the context of mental illness. In particular, the new literature highlights women's struggle to reconcile concerns about 'dangerous mothers' with the cultural expectations of ideal motherhood (Halsa, 2018). The new literature also identifies the range of issues confronting mothers with mental illness such as the experience of social stigma and prejudice, guilt, isolation and concern for their children, coupled with the practical difficulties associated with managing childcare (Dolman, Jones, & Howard, 2013). Some authors have begun to elaborate on these key themes, which has served to build a larger body of women centred knowledge about motherhood and mental illness. One key theme that has received little attention is women's experience of child custody loss. To fill this gap, this paper provides an exploratory analysis of child custody loss as it is experienced by mothers with mental illness. This analysis shows that women child custody loss, in some form, is an almost universal experience for women with acute mental illness and a common experience for many. To date, this aspect of women's experience and its impact on the health and wellbeing of mothers and their children has been marginalized. This article argues that women's fear of child removal makes them reluctant to access mental health services. Appropriate clinical, legal, and public health responses are warranted.

2. Motherhood and mental illness in context

Many women with mental illness, including those with severe mental illness, are mothers. A recent study in Austria found that 56% of female patients in an acute facility were mothers (Schrank, Rumpold, Gmeiner, Priebe, & Aigner, 2016). In a study in London 63% of women with psychotic illness were found to have at least one child, while in Australia 59% of women with serious mental illness were mothers (Diaz-Caneja & Johnson, 2004). A study in a large psychiatric institution in New York, 38.5% of female patients were mothers, many of whom were the primary carers of their children, with over half maintaining at least weekly contact with the children (Benders-Hadi, Barber, & Alexander, 2013). A recent study in America reports similar rates of parenthood amongst those with (69%) or without (71%) a serious mental illness (Kaplan, Brusilovskiy, O'Shea, et al., 2019). Whether or not women with mental illness are mothers and/or carers continues to be undocumented in many women's mental health histories (Dipple, Smith, Andrews, & Evans, 2002).

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Women who are mothers experience mental illness at similar rate to the general population of women, with anxiety and depression the most common conditions (Reilly et al., 2014). Approximately 10–20% (1in 5) women experience psycho-social distress and/or mental illness during pregnancy and in the first year postpartum (Smith, Lawrence, Sadler, & Easter, 2019, 1). Approximately 1 in 7 new mothers will experience postpartum depression in the first 6 months (Hatters Friedman & Resnick, 2009). Perinatal psychiatric illness, is a leading cause of maternal death in high income countries (Humphrey et al., 2015) and is associated with increased maternal and child morbidity (Smith et al., 2019). Women with chronic mental health conditions such as bipolar disorder, affective disorder and schizophrenia are more likely to experience episodes of post-partum psychosis (Jones, Prabha, Chandra, & P, & Howard, L.M., 2014). Postpartum psychosis, is a rare (2.68 per 100,000 births) but genuine psychiatric emergency associated with increased risk of both infanticide and suicide (De Bortoli, Coles, & Dolan, 2013).

Until relatively recently, a prominent theme in the literature about motherhood and mental health had been the harmful impact of maternal mental illness on children (Halsa, 2018). Mothers with mental illness have been overwhelmingly portrayed as dangerous women who put their children at risk by being emotionally withdrawn, unpredictable, chaotic, irrational, unresponsive and uncommunicative (Dolman et al., 2013; Halsa, 2018). Studies have shown that severe mental illness in the months following birth contributes to developmental delays in motor function, language acquisition, cognitive skills, emotional self-regulation, and problematic behaviour in children (Ache et al., 2018; Verbeek et al., 2012), while other studies have shown that untreated maternal is depression is associated with a risk of poor bonding with the infant, lack of self-care, infant neglect and infanticide and ongoing mortality for women (Beckwith, Howard, Espinosa, & Tyler, 1999; Hatters Friedman & Resnick, 2009). Other scholars argue that the evidence is equivocal and more research is needed to support such conclusions (Davalos, Yadon, & Tregellas, 2012).

One in three women presenting with psychotic illness have experienced domestic violence before pregnancy and one in five have experience domestic violence during pregnancy (Taylor et al., 2015). It is widely recognised that abuse and violence, including family violence, are primary contributors to the onset of mental illness, and are secondary contributors to anxiety and depression, suicide, alcohol and drug dependency, eating disorders and complex post-traumatic stress disorder (Fernbacher, 2012; Itzin, 2006; Oram & Howard, 2017). It is estimated that 50–90% of women have experienced sexual abuse or family violence at some point in their lives, and that exposure to recent violence, violent victimisation and sexual assault are invariably associated with poor mental health outcomes. (Hiday, Swanson, Swarz, et al., 2001; Walsh et al., 2003). In a study of gender-based violence in Australia, Rees et al. found that 50% of victims exhibited mental and behavioral problems, 45% experienced anxiety, and 11% reported long term mental health problems (Rees et al., 2011). Having examined the cumulative burden of mental illness, the authors found that

- 28% of women without exposure to violence reported mental health problems
- 57.3% of women with experience of one form violence reported mental health problems
- 89.4% of those women with experience of three or four kinds of violence reported mental health problems (Rees et al., 2011).

Despite the high prevalence of violence and abuse and its connection with mental illness, mental health services have a poor record of recognising the relationship between gender based violence and trauma and deteriorating mental health for women either before, during or after pregnancy (Bateman, Henderson, & Kezelman, 2013).

3. Recovery and motherhood

Many women with mental illness, including women with severe mental illness, retain care of their children and parent successfully, although little is known about the skills and strategies that women develop to achieve good outcomes for themselves and their children (Ackerson, 2003; Awram, Hancock, & Honey, 2017; Scott, Pope, Quick, Aitken, & Parkinson, 2018). A major theme in the literature is the enormous significance of motherhood and mothering to women with mental illness (Shor & Moreh-Kremer, 2016; Blegen, Kare Hummelvoll, & Severinsson, 2012, Blegen, Eriksson, & Bondas, 2014; Halsa, 2018; Klausen, Karlsson, Haugsgjerd, & Lorem, 2016). Women with mental illness are deeply connected to the experience of being a mother (Banerjee, Desai, & Chandra, 2017; Halsa, 2018; Klausen et al., 2016; Shor & Moreh-Kremer, 2016). Many are proud of being mothers, and find in that pride a source of resilience, wellbeing and joy (Ackerson, 2003; Scott et al., 2018). Motherhood is valued in and of itself, as a vocation and as a source of social connection (Perera, Short, & Fernbacher, 2014).

New studies exploring the resilience and success of women tend to highlight the inter-relationship between motherhood, mental illness and recovery while documenting creative responses that the balance the competing demands of motherhood and mental illness (Scott et al., 2018). For example, Awram et al. (2017) identified four interconnected balancing strategies used by women. These were prioritising in the present, looking after oneself, buffering or protecting children from the mental illness and using available supports. Recognition of the crucial interconnectedness between mothering and recovery was an essential element in women's ability to value, develop and implement these strategies (Awram et al., 2017).

It is clear from the literature that women's experience of motherhood, mental illness and recovery is mediated by a range of factors. Intrapersonal, interpersonal, social and economic factors, including family, culture and community influence women's ability to mother (Motlalepula Rampou, Havenga, & Madumo, 2015; Mowbray, Oyserman, Bybee, & MacFarlane, 2002) Supportive partners, families and communities are important in shaping women's experience of motherhood and in keeping them well (Motlalepula Rampou et al., 2015; Perera et al., 2014; Scott et al., 2018). Conversely, loneliness, lack of support, economic distress and housing insecurity have a negative impact on women's mental health (Dolman et al., 2013; Langer, 2012; Spinelli, 2008). In addition, parenting responsibilities in and of themselves create practical impediments to engaging with mental health services (Diaz-Caneja & Johnson, 2004). Women report that mental health services are rarely ‘child friendly’ (Diaz-Caneja & Johnson, 2004). If there is no-one to care for your children, attending appointments risks exposing children to the conditions that prevail in mental health services. On the other hand, missing appointments exposes women to the criticism of being disengaged or avoiding treatment. Social support, whatever its form, better enables mothers to present themselves as ‘good mothers’ and ‘good patients’ (Davies & Allen, 2007).

Many mothers with mental health illness or distress report being caught in this profound conflict between the notion of motherhood and the experience of mental illness (Blegen et al., 2014, 2012; Kantowitz-Gordon, 2013). While they invariably aspire to being good mothers who care for their children (Blegen et al., 2012), they nevertheless internalize assumptions about the dangerousness of mentally ill mothers. They express concern that they may harm their children, that their mental illness could have negative effects on their children or negatively impact on the mother–child relationship (Dolman et al., 2013). They report feelings of guilt in relation to their children and low confidence in their ability to parent (Motlalepula Rampou et al., 2015; Perera et al., 2014). They feel deviant. They feel they must constantly demonstrate their credentials as a normal or ‘good enough’ mothers (Blegen et al., 2012; Davies & Allen, 2007). Moreover, the

characterisation of mothers with mental illness as dangerous mothers conflicts with the contemporary ideology of intensive mothering that assigns to mothers a special responsibility to attend to their child's best interests at all times (Halsa, 2018). In short, many women with mental health problems experience motherhood in a hostile environment, characterised by negative and prejudicial attitudes about mothering and mental illness (Halsa, 2018). Mothers experience these identity conflicts as a personal failure, resulting in feelings of self-blame, worthlessness and loneliness (Halsa, 2018).

4. Surveillance, supervision and child loss

The profound loss of self-confidence is given expression in the almost universal fear that women will lose custody of their children (Halsa, 2018; Ackerson, 2003; Alakus, Conwell, Gilbert, Buist, & Castle, 2007; Chernomas et al., 2000; Davies & Allen, 2007; Diaz-Caneja & Johnson, 2004; Edwards & Timmons, 2005; Engqvist, Ferszt, Åhlin, & Nilsson, 2011; Nicholson, Sweeney, & Geller, 1998; Sands, 1995). Fear is underpinned by the reality that child separation, removal or custody loss in some form are extremely common experiences for mothers with mental health problems. For example, mothers in psychiatric units are often separated from their infants or children during assessment, admission or hospitalization (Savvidou, Bozikas, Hatzigeleki, & Karavatos, 2003). While this may be necessary and for a short period of time, the length of separation may be uncertain.

Beyond the hospital, mothers who retain care of their children report that subsequent contact with mental health services provides parenting surveillance rather than mental health support (Boursnell, 2014; Diaz-Caneja & Johnson, 2004; Scott et al., 2018). In Australia, Diaz-Caneja and Johnson (2004) concluded that there is a widespread assumption amongst mental health services and child welfare practitioners that mothers with mentally illness are inherently poor parents. Boursnell (2014) also describes the assessment of parenting in the Australian system as dominated by risk assessment practices that rely on rigid inflexible and predetermined categorical information that creates negative expectations about parenting ability (Boursnell, 2014). In these studies, women reported that they rarely received appropriate mental health support. Rather, the surveillance resulted in 'interventions' that occurred only at crisis points and usually in the form of child removal (Diaz-Caneja & Johnson, 2004). Similarly, in New Zealand a study found that women's efforts toward recovery were limited by the attitudes and practices of social workers (Scott et al., 2018). In that study, social workers in New Zealand were found to focus solely on medication compliance while exerting what was described as 'expert oversight' of parenting (Scott et al., 2018).

Mothers with mental illness, especially mothers with severe mental illness, may be subject to child protection supervision in addition to mental health supervision. Overall approximately 30% of women with a diagnosis of schizophrenia in the United Kingdom lose custody of their children. In one study in the United Kingdom only 23% (n = 1197) of women discharged from mother and baby units were considered not to require social service supervision at discharge (Howard, Shah, Salmon, & Appleby, 2003). In another study, 50% of women with schizophrenia discharged from mother and baby units went home without their babies, while 48% were discharged under child welfare supervision (Howard, Thornicroft, Salmon & Appleby, 2004). Supervision was more likely if women had diagnoses of schizophrenia and personality disorder and more likely if women were of low social class, were single, and exhibited disturbed behaviours. Mothers with schizophrenia were at particularly high risk of being supervised as they were often perceived as having either practical problems with baby care or of otherwise posing a risk to the baby (Howard et al., 2003). While mental health diagnosis was a strong indicator of surveillance, it is a poor indicator of mothering ability. In the 2004 UK study, poor parenting outcomes were found to be strongly associated with low social class and psychiatric illness in the partner (Howard et al., 2003).

Recognising that the needs of mothers with mental illness are routinely overlooked by mental health services, several researchers have argued for the development of mental health service delivery models that better support women with mental illness in their role as mothers (Diaz-Caneja & Johnson, 2004: Dolman et al., 2013; Motlalepula Rampou et al., 2015; Scott et al., 2018, Smith et al., 2019; Hine, Maybery, & Goodyear, 2018). Some have called for broad spectrum multi-disciplinary services that are able to address trauma, strengthen social relationships and alleviate poverty (Westad & McConnell, 2012). Others call for holistic family centred approaches to care, treatment and rehabilitation (Motlalepula Rampou et al., 2015). Taking an even broader perspective, Howard et al. (2003) recommended preventative interventions addressing the socio-economic difficulties of vulnerable families in addition to programs that detect and treat psychiatric problems in the partner (Howard et al., 2003). Reflecting on the dilemma of identity, Hine et al. (2018) conclude that for mothers with mental illness the achievement of recovery from mental illness 'is more effectively facilitated through supporting mothers to build positive realistic and diverse identities that allow them to acknowledge and respond to the mental health needs without fearing the loss of a parenting role or conforming to restrictive gendered stereotypes' (Hine et al., 2018, p.16).

5. Child custody loss and removal

Child welfare systems around the world provide a process for removing children from their parent or parents on protection grounds. They operate on the presumption that a 'healthy and robust child welfare system keeps families together, protects children from harm and centers on the need of children and their parents' (Sankaran, Church, & Mitchell, 2019–19:1161). In contrast, the research shows that child removal inflicts profound and irreparable damage to children and parents. Safety interventions, while necessary in some circumstnaces, are disproportionately wielded against impoverished families (Sankaran et al., 2019–19:1165). In the United States, mothers with mental health issues are more likely to be unemployed, more likely to receive government assistance and more likely to live below the poverty line. Those who cannot provide for the immediate physical needs of their children, or more likely to experience child custody loss (Luciano, Nicholson, & Meara, 2014).

At present there is only fragmented information about the frequency of child custody loss or the frequency of different types of child custody loss experienced my women with mental illness. In the research that notes custody loss, for example, women mention different types of child custody loss such voluntary short-term placements, fostering, custody loss following family law proceedings or permanent removal of their children by child welfare authorities. In the United States, Park (2006) found that mothers with mental illness are many times more likely to lose custody of their children than mothers without a mental health diagnosis. Coverdale and Aruffo (1989) found that 60% of the children of women in long term psychiatric care in the United States were reared by other people. In the United Kingdom, Joseph, Shashank, Lewin, and Abrams (1999) found that only 20% of mothers with mental illness had full custody of all their children, while Howard, Goss, et al. (2004) found that approximately a third to half of women with a diagnosis of schizophrenia lose custody of their children (Howard, Goss, et al., 2004). Australian research has identified mental illness as the primary reason for limiting women's contact with their children in 31% of family court files, compared with 2% of cases concerning men (McInnes, 2014; see also Mercovich, 2008). In Canada, approximately 20% of child maltreatment investigations involved mental health issues (Westad & McConnell, 2012). Once again underscoring women's significance of violence, a study by Lewin and Abdrbo found that 62% of the mothers with mental illness who were involved in child protection services were exposed to domestic violence (Lewin & Abdrbo, 2009). In

a study in Leicester, UK, 68% (n = 58) of the women using rehabilitation services were permanently separated from at least one child before the age of 18 years (Dipple et al., 2002).

5.1. The impact of child loss

The research shows that child removal caused confusion, grief and trauma for mothers (Sankaran et al., 2019–19:1169). Studies acknowledge that women may feel considerable distress about child loss (Dipple et al., 2002) and that depression and anxiety may be triggered if one's child is being looked after by another person (Diaz-Caneja & Johnson, 2004). Fear of custody loss may be less acute in jurisdictions where the default placement for children of mothers with mental illness is with family members who are trusted by the mother (Ueno & Kamibeppu, 2008). In a recent study in Canada, Wall-Wieler et al. found that women whose children were removed had significantly higher rates of depression and anxiety than women children whose received child protection services (Wall-Wieler et al., 2018). Another study by the same group compared the mental health of women who had lost custody of a child following involvement with child protection services (n = 5792) with the mental health of women who had experienced the death of a child (n = 1143). Mothers with a child taken into care had significantly greater rates of depression, anxiety, substance use and physician visits for mental illness and psychotropic medication. The authors concluded that losing custody of a child to child protection services is associated with significantly worse maternal mental health outcomes than experiencing the death of a child (Wall-Wieler et al., 2018). Wall-Wieler et al. argued for greater acknowledgement and support for women experiencing the loss of a child through the involvement of child protection services.

5.2. Mandatory reporting

In many developed jurisdictions, welfare intervention for children at risk is articulated through mandatory reporting laws. Mandatory reporting laws require named groups of professionals, such as psychiatrists, to alert child welfare authorities, if they form the view that a child may be at risk of harm. In Australia, mandatory reporting laws have been introduced in the different states and territories over a 40 year period between 1969 and 2009).[1] Clinicians in the United Kingdom (UK) are not subject to mandatory laws but are under professional and ethical obligations to report cases of suspected abuse to child protection authorities (Rogers & Nurse, 2019). Ireland is the most recent jurisdiction to introduce mandatory reporting legislation.[2] The Children First Act, 2017 (Ireland) requires 'mandated persons', to report to authorities if they become aware, or formulate a belief or suspicion in the course of their work that a child has been harmed, is being harmed or is at risk of being harmed.

Mandatory reporting was first introduced in the United States in the 1960s as a response to the newly identified 'battered child syndrome'. The idea was to mandate staff at hospitals to report suspected incidences of child battery to welfare authorities. Typically, it was thought that children who were presented in emergency departments with unexplained injuries were likely to be victims of child battery. Child welfare laws have been adopted in many jurisdictions, taking different forms in response to evolving child protection debates. The universal rationale for mandatory reporting is the protection of children. Mandatory reporting systems have proliferated internationally with little systemic evaluation or dedicated research (McTavish, MacGregor, Wathen, & MacMillan, 2016). Recent research in Canada notes that while mandatory reporting leads to greater contact with child welfare services and authorities, there is little evidence that such interventions improve outcomes for children (Tonmyr, Mathews, Shields, Hovdestad, & Afifi, 2018).

One recent international study examines the views and experiences of psychiatrists working with the families of teenagers with eating disorders from five countries with mandatory reporting laws (Kimber et al., 2019). The clinicians involved in the study all reported negative experiences of mandatory reporting. They reported that mandatory reporting compromised therapeutic relationships, destroyed trust, prompted patients to terminate therapy and in some instances incited aggressive behaviour. The clinicians also reported feeling frustrated that the authorities who received mandatory reports seldom offered any indication of whether or not there would be a follow-up investigation, or whether or not they would inform the practitioner of the outcome should there be one (Kimber et al., 2019).

5.3. Accessing mental health services

Some of the research about motherhood and mental illness also draws a connection between mandatory reporting laws and women's reluctance to access mental health services or engage openly with mental health clinicians for fear of losing custody of their children (Diaz-Caneja & Johnson, 2004; Reilly et al., 2014). For example, Halsa concludes in her study that the identity conflict made women reluctant to express a need for help with parenting issues else they be seen as failing motherhood (Halsa, 2018). In the United Kingdom, although custody loss issues were not identified, Sambrook Smith et al. identified feelings of shame and guilt (especially in Asian communities) about motherhood and mental illness as a barrier to women accessing mental health services (Sambrook Smith et al., 2019, p. 6). Researchers in the United States have also noted that many mothers are especially fearful of engaging with mental health services because of child custody concerns (Anderson, Robins, Greeno, et al., 2006; Nicholson et al., 1998; Spreng, 2010). Moreover, some US studies report that the reluctance of mothers with mental health problems to access mental health services for fear of child removal is higher amongst women who have personal experience of the welfare system, either because their own children had been removed or the women had been themselves in foster care or removed when they were children (Fusco, 2015). This stream of US research paints a picture of intergenerational disadvantage and marginalization such that the most vulnerable mothers are the most likely to avoid service contact for fear of having their children removed by welfare services. For example, in the United States, up to 40% of Medicaid funded births of young women aged between 15 and 24 requiring mental health treatment were mothers with past contact with child welfare systems (Krohn & Matone, 2017). These young women were identified as likely to 'fall through the cracks' of a fragmented service system or actively avoid mental health services. Similar patterns are likely to apply in Australia, where it is estimated that 50% of young women leaving state care become mothers after the first year (Victoria Legal Aid, 2018).

6. Women's reluctance to access services

The survey of current literature on the question of child custody loss presented in this article draws a connection between mandatory reporting and women's reluctance to access mental health services. For

[1] South Australia 1969; Tasmania 1974; New South Wales 1977; Queensland 1980; Victoria 1993; Western Australia 2009; Australian Capital Territory 1997; Northern Territory 2007. Australian laws differ across the eight states and territories, with common elements being the mandatory nature of the obligation, confidentiality and immunity from legal liability for the reporter, provided they provide reports in good faith (Oates, 2019.)

[2] Part 3. Mandated persons 14. (1) Subject to subsections (3), (4), (5), (6) and (7), where a mandated person knows, believes or has reasonable grounds to suspect, on the basis of information that he or she has received, acquired or becomes aware of in the course of his or her employment or profession as such a mandated person, that a child— (a) has been harmed, (b) is being harmed, or (c) is at risk of being harmed, he or she shall, as soon as practicable, report that knowledge, belief or suspicion, as the case may be, to the Agency

women who are not currently accessing mental health services, shame and guilt associated with motherhood and mental illness may prevent them from disclosing concerns. The stigma associated with motherhood and mental illness underpins other barriers to appropriate care. For example, a recent systematic review of studies about access to mental health services in the UK identified:

(a) a lack of knowledge about mental health problems on the part of health care practitioners, women and families leading to poor recognition of symptoms and delayed response;
(b) inadequate resources and fragmentation of services, complicated by poor interdisciplinary communication;
(c) poor policy implementation, and
(d) significant sociocultural barriers such as language barriers and lack of interpreters (Sambrook Smith et al., 2019, p.6).

Inequality in provision of mental health services also influences access to appropriate mental health care for mothers. For example, a longitudinal study in Australia found that women in private maternity care are three times more likely than those in public care to be screened for mental illness (Reilly et al., 2013). In the United Kingdom, Sambrook Smith et al. reported that 60% of women in the United Kingdom had no access to perinatal mental health services and a further 38% wait over a month to be referred (Sambroook Smith et al., 2019, p.2). Delayed access to mental health services limits opportunities to provide social supports and interventions that will decrease the incidence of acute social and mental health crises. The later the intervention, the more likely the cycle of child surveillance and removal will be triggered. The fear of surveillance and intervention, and consequent services avoidance, appear to be most acute for women who have personal experience of the child welfare system, either through loss of other children or through personal experience as a welfare child (Fusco, 2015).

Perhaps most striking feature of this survey of the literature is the apparent reluctance of clinicians and services to recognize and discuss what is reported by women as the most important issue - acceptance and support of their role as potential or actual mothers. For example, the Australian Longitudinal Study on Women's Health observed a marked reluctance amongst peri-natal and mental health clinicians to speak openly about perinatal depression and anxiety with women (Reilly et al., 2014). Similarly, two recent articles implied a reluctance to speak frankly about treatment options, including discussion of risks and benefits of treatment during pregnancy and possible damage to the developing foetus (Bellantuono, Martellini, & Orsolini, 2019; Stevens et al., 2019). The Centre of Perinatal Excellence (COPE) and NICE guidelines make it clear that sodium valproate should not be prescribed for women of child bearing age because of its strong association with foetal abnormality, and that if sodium valproate is being used, it is recommended that clinicians have clear discussions with their patients about the need for effective contraception. In a recent study of a mental health service in Queensland, Australia, however, Perera et al. found that 20% of women of child bearing years (n = 98), some who were teenagers, were prescribed sodium valproate. Only 40% of the files of those women contained evidence that the serious side effects of the medication had been discussed, and that the need for effective contraception had been considered (Perera, Patterson, & Bruxner, 2019). The Queensland study indicates an urgent need for improved communication and clinical management skills with respect to perinatal care. A similar reluctance seems to apply to the question of motherhood. In the UK Dipple et al. (2002) noted that details of past custody loss are rarely recorded in the medical notes. Similarly, there is little evidence that there are open discussions with women about the need for parenting surveillance. There is little evidence that mothers with mental illness are informed about child protection processes or how they might respond to them. Also missing from the discussion is recognition of the mental health burden of gender based violence. As Oram and Howard (2017) argue in the context to the United Kingdom, while violence against women is a prominent public mental health problem, mental health professionals and mental health services fail to identify instances or patterns of violence, and are poorly equipped to identify or treat victims and offenders. The failure to address violence also results in disengagement from services.

The failure to recognize intergenerational family violence and trauma is also problematic. In many jurisdictions children are placed with family members, either informally as a stop gap measure, or formally when kinship is the first response of the child welfare system, as is the case in the United States. Mothers concern for the safety of children placed with adults how they form experience may harm them is likely add to their distress.

Despite the recognition that child removal causes significant trauma for children and mothers there is little guidance for health professionals or the courts on how to reduce child removal, or when child removal is necessary, how to conduct the process within a trauma informed framework (Sankaran et al., 2019–19:1170).

7. Suggestions for a way forward

Some authors have made suggestions for a way forward. Spreng (2010) argues that identifying the positive aspects of motherhood and mental illness is an important first step in countering past assumptions about the deviance, danger and harm while developing new strategies to improve the care and treatment of women by recognising and incorporate their situation as mothers (Smith et al., 2019). Spreng (2010) summarises the following the key points as a framework for such communications:

1. Motherhood is an increasingly central life experience for mentally ill women.
2. Many are fine parents, and their children adjust well.
3. Others have difficulties related to their health, with negative outcomes for their children.
4. Most mentally ill women who raise their children themselves do so in the context of marital discord, single-parent status, social isolation and sometimes extreme poverty.
5. Mentally ill mothers are not more likely to abuse or neglect their children;
6. Whatever one's parenting deficiencies, less than optimal parenting does not by definition fall below society's minimum standards.
7. Nevertheless, mothers with mental illness lose custody of their children disproportionately more often than do healthy mothers, often *via* the child welfare system, and they also experience greater difficulty regaining custody.
8. Some experts worry that too often diagnosis alone drives custody and termination of parental rights decisions.
9. Only when mental illness creates a direct and serious risk to the child is state interfere warranted.

A second important step is to encourage services to assess the status and capabilities of mothers with mental illness rather than assume there are problems and a need for intervention (Spreng, 2010). A third is to promote ‘wrap around’ services, encouraging collaboration across sectors to address the need of the whole family. Services and support should be accessible without posing a risk of custody loss, and service providers should be trained and supported to consider parental roles and the parenting goals of service recipients (Powell and Nicholson, 2019). A fourth step the provision of employment and housing support to assist women to secure the necessary physical conditions that will satisfy child welfare evaluators.

Social workers, health and mental health care professionals, psychologist and psychiatrists will benefit from training that increases awareness about the profoundly complex issues faced by mothers with mental illness. All will benefit from specific training that would enable

them to manage child welfare questions more carefully. Those who are charged with the actual task of evaluating child welfare matters, should be able to demonstrate that they are aware of the full context and able to consider a wide range of relevant factors unimpeded by bias or misapprehension (Deutsch and Clyman 2016). Trauma informed service provers and service- systems are essential.

Once a child protection matter is elevated to the courts, judges, lawyers and attorneys, should also be encouraged toward trauma informed care an invited to consider a full suite of relevant factors. Judges, in particular, would benefit from mental health training. This would improve their ability to make appropriate decisions when child custody case involve mothers with mental health issues (Geva, 2012). Research in the United States has shown that while judges do not see parental mental illness as an *a priori* reason to deny custody, they overestimate their own understanding of relevant psychological factors and tend to accept, often without question, the evidence, opinions and conclusion of child welfare evaluators (Geva, 2012). Powell similarly reports that lawyers and judges in the United States sometimes harbour biases against parents with serious mental illness, presuming they are unfit to safely raise children (Powell 2019: 209). Beyond individual understanding, the legal mechanisms available to the court to respond to child custody case could also be expanded. For example, in the United States the termination of parental rights has been interpreted as a allowing a complete severance of the parent child relationship. An alternative approach is to provide an array of legal mechanisms and supports that allow mothers with mental illness to remain connected with their children.

Ultimately, the proper implementation of these strategies accords with human rights principles. All of the nations mentioned in this article have ratified major international conventions, adopted human rights charters and/or robust anti-discrimination laws. Although rarely tested in the courts, the failure to provide support to women with mental illness who are mothers, in the ways outlined in this article, may amount to discrimination in the basis of disability.

8. Conclusion

The new literature on the capability of mothers with mental illness may indicate that there is a trend toward greater acceptance of mothers with mental illness and recognition of their parenting abilities, with a consequent reduction in child custody loss. However, in the absence of targeted research or appropriate data collection it is very difficult to draw conclusions about the rates of child separation or custody loss, or describe the different types of loss and separation.

This paper argues that mothers with mental illness are acutely aware of the censure surrounding motherhood and mental illness and the possibility of child custody loss. As a consequence, mothers or soon to be mothers avoid disclosing mental health problems to clinicians, or avoid services altogether. The preliminary analysis in this paper is necessarily tentative, but it suggests that fear is an almost universal experience for women and avoidance is very common. Moreover, fear and avoidance are stronger amongst women in countries with mandatory reporting legislation, stronger amongst marginalized groups, and stronger amongst women with actual experience of child welfare intervention. Given the prevalence of mental health disorders amongst mothers and the possibility of serious consequences if appropriate support is not provided, the spectre of mothers with mental illness being too afraid to access mental health service warrants an open conversation about whether and how the negative public health consequences of mandatory reporting can be reduced. Evidence based research will make an important contribution to the design appropriate clinical, legal, and public health responses.

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