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Documenting of Care Arrangements for children of mothers admitted to a Psychiatric Hospital: A South African Case study

Masters of Medicine (MMed) in Psychiatry

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Declaration

DECLARATION

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Abstract

Background

Enquiring about and documenting care arrangements for children of inpatient mothers with mental illness is paramount. Failure to do so could have a negative impact on the well-being of their children. Documenting care arrangements on admission signals good practice on the part of the admitting medical staff and ensures compliance with the requirements of the South African Children's Act of 2004. This study explores the current practice at a large government run tertiary female inpatient psychiatric unit in Cape Town, regarding the enquiring and documenting practice within the first 24 hours of admission, of these care arrangements.

Methods

The study is a cross sectional study using a mixed methods approach including: i) a case note audit of 100 consecutive patient folders examining the documentation of care arrangements within the first 24 hours of admission and ii) a structured self-administered questionnaire to professional staff working on the unit.

Results

A total of 87 clinical folders were audited. Ninety nine percent of these folders had written down in them whether the women had children or not. Fifty eight percent of women had minor children and had 87 children between them. Fifteen percent of women had no care arrangements documented and 20% of women had unclear documentation of care arrangements. Fifteen completed staff questionnaires were returned. All staff agreed that it was important to ask the mothers about care arrangements.

Conclusion

Significant more women that those identified on admission may have children who may have been in unsafe care arrangements at the time of their admission. There is room for improving the clarity of documenting of care arrangements and the enquiring into the specific care arrangements.

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Abbreviations

Degree Masters of Medicine – MMed

South African National Income Dynamics Study – NIDS

United Kingdom National Health Service - NHS

University of Cape Town Human Research Ethics Committee – HREC

Unique Study Identity – ID

Chapter 1: Introduction and Literature review

The Care Arrangements for children of mothers admitted to a Psychiatric Hospital: A South African Case study

Making sure that there are safe and secure care arrangements in place for children of mothers with a mental illness and ensuring that this information is asked for and documented by doctors admitting these patients is an important issue of concern for the psychiatry inpatient clinical team[1].

This study arose out of concerns about whether this information was being effectively collected at a tertiary psychiatric hospital in Cape Town.

The concern is that the children of these mothers may be neglected or even abandoned if no specific care arrangements are in place at the time of admission. The mother's mental illness and the admission can have a significant impact on the child and on the mother-child relationship[2]. In South Africa, like in other countries, patients with serious mental illness are faced with significant and serious psychosocial stressors and disadvantage which often impacts on their children and their consequent risk of mental illness through the gene-environment interaction[3].

This exploratory study aims to establish what the current clinical practice is at a psychiatric hospital in Cape Town with regards to this issue. The results will report on several different parameters including proportion of the sample who are mothers, proportion of patients who have clear care arrangements for their children documented, and on the practice of health care professionals with respect to enquiring about child care arrangements of their patients. The findings will be made available to the hospital's senior management team.

Search strategy

A search of the published was conducted with the assistance of a librarian at Faculty of Health Sciences Library, experienced in literature searches. We developed the following MeSH terms for my search: "care arrangements" and "children" and "mothers with mental illness" and "hospitalised". The author also conducted a further search using the following keyword search: "Mental

Healthcare policy" and "South Africa" and "Children". The author searched the following databases: Google Scholar, Embase, Psych Info, Pub Med.
The author further narrowed down his search with the use of the following search terms "in South Africa", "developing countries", "in Brazil"(being a similar Low to middle income country as South Africa) so as to find relevant literature to the South African context.

Many of the studies found relevant to the topic were studies 15 to 20 years old The author tried to broaden their search beyond women hospitalised for their mental ill health and searched using following keywords: "Hospitalisation" "mothers" and "care arrangements", using a Google scholar search, but this did not yield any additional studies of relevance.

Limitations of the author's search are: that the author did not search all databases. The author did not find any South African studies published using the MeSH terms. Some of the studies found and used in this research were between 15 and 20 years old which limits the information on current clinical practices on child care arrangements. Unpublished studies on the subject matter were not searched for and hence there may have been relevant research which the author may not have accessed.

The South African policy and legal context

The South African Children's Act of 2005[4] places a statutory responsibility on health professionals to report any "who on reasonable grounds concludes that a child has been abused in a manner causing physical injury, sexually abused or deliberately neglected,(pg 160)". The Act hence encourages health care professionals to be concerned and to ask parents about the well being of their children. Thus health professionals should enquire about and document the care arrangements of children of mothers with mental illness admitted to a psychiatric hospital to ensure that there is no neglect or abuse of these children. According to Chapter 9 of South African Children's Act[4] any concerns that the clinical team may have regarding children who are not safely cared for should be identified and an urgent referral made to the nearest child protection social agency to investigate the matter further.

A review of a series of relevant government documents did not provide any guidance regarding the enquiring and recording of care arrangements of children by psychiatric doctors or other mental health professionals when mothers are hospitalised with a mental illness. These include the South African Mental Health Care Act[5], National Core Standards for Health Establishments in South Africa[6], National Mental Health Plan and Policy Framework 2013-2020[7] and the Guidelines for Good Practice in the Health Care Professions[8].

Recording of childcare arrangements in psychiatric hospitals – Current trends

Tamarit et al.[9], in their retrospective case note audit done at Goodmayes Hospital, London, United Kingdom, found that only 24% (24/100) of clinical notes indicated that the patient had children. The remaining 76% of women had no indication on whether they had children or whether they were mothers. On the other hand the study by Manderson et al.[1], also a retrospective case note audit, from a hospital in Northern Ireland, found all 100 women in their study sample had documentation in their clinical notes on whether they were mothers or not. Sixty two percent of women (62/100) in their sample were documented as being mothers with children 0-17yrs.

In the Tamarit et al.[9] sample 54% of mothers did not have any information recorded in the case notes on who was caring for their children. Manderson et al.[1], in contrast, found in their study sample that information on who was caring for their children was documented in most mothers' clinical notes.

In the Tamarit et al.[9] sample the length of inpatient stay of those women, who were mothers with minor children, varied with 33% (8/24) of the mothers admitted for less than one month and 37% (9/24) of women admitted for between one and three months. One woman was admitted for five months and in six women there was no documentation found in the clinical notes on the duration of their admission. These results highlight that many mothers in the Tamarit et al.[9] sample were separated from their children for a long time when admitted for their mental illness.

This separation may cause psychosocial stressors on the child[10]. It is important that these children are buffered from the impact of this separation on their well being[2].

The context of children in South Africa

Hall et al.[11] provide an overview profile of children in South Africa using the South African National Income Dynamics Study (NIDS) 2008 data. They reported that nearly a quarter of all children in South Africa do not live with either of their biological parents. They go on to write that "[patterns of child-parent co-residence are strikingly different for children of different races. While 70% of white children live with both their biological parents, only 53% of coloured children and 29% of African children live with both parents. And while 25% of African children do not live with either of their parents, this is true for only 4% of white children". These findings have important implications in the way we understand child care arrangements within the South African context. The strength of the NIDS findings is that they are very similar to the Statistics South Africa's General Household Survey findings for 2008[11] and continue to be relevant even in 2017.

In South African, with its high rates of social inequality and of violence against children[12], lack of safe care arrangements can place these children in situations where they are at increased risk of becoming victims of violence and or social disadvantage.

Care arrangements of children when mothers admitted to psychiatric hospitals

Cunningham et al.[2] found that 67% of children in their study sample, from admissions to a psychiatric hospital in Birmingham, United Kingdom, were cared for by their father and over 80% of children were cared for within the immediate or close family network (father, grandparent, relative). A similar result was found in a study by Hawes et al.[13] conducted in London.

Cunningham et al.[2] also found that only 4% of children in their sample were placed in foster care. They postulated that families are proficient in providing care for children of mothers who are admitted to psychiatric hospitals. The authors make the point that the children in their sample were accommodated in a secure environment whilst their mother was hospitalised. This secure placement with an attachment to an alternative care giver may buffer the children from the traumatic effects of their mother's hospitalisation and its associated psychosocial problems. They do not expand on what they mean by psychosocial problems.

While there are no easily available South African data on who cares for children of mentally ill mothers admitted to hospital, the findings from the NIDS 2008 study of all children as reported by Hall et al.[11] highlight not only the racial disparities in family structures but also the high number of children who are orphaned of one or both parents (20%) and who are cared for by grandparents or other extended family members. To what extent this situation mitigates or worsens the care arrangements for mentally ill mothers' children is not clear. Part of the current study is to provide some exploratory data on these care arrangements; specifically the initial documenting of these to ensure effective management.

Impact of Maternal/Parental mental illness on their children

Cunningham et al.[13] examine the issue of attachment theory and the attachment relationship of children of mothers with mental illness. Attachment theory is an important theory in child development. It emphasises the importance and biological need of a baby and the developing child for a primary caregiver to form an attachment relationship to provide a feeling of security and protection. This attachment is manifested through behaviours that the child displays to keep the primary caregiver in close proximity. Cunningham et al.[13] describe attachment "as an affectional relationship over space and time".

Extrapolating from Bowlby[14] and Cunningham et al.[13], the issue of attachment is particularly important and needs to be especially considered when a mother, with a child younger than 2 years old, is admitted. The separation

from the mother can have a significant impact on the mother-child attachment relationship and the child's subsequent emotional development if this separation is lengthy and there is no alternative family figure who can temporarily take the place of the mother. It therefore becomes important to be sure that there are safe and secure care arrangements in place particularly for young children (<2years old) when their mother is admitted to a psychiatric hospital. In many high income countries there are now special mother and baby units (e.g. The Royal Australian and New Zealand College of Psychiatrists[15]) where mothers of new born or very young children can be admitted with their baby or child and receive care and treatment to ensure that there is no disruption in this attachment relationship.

Cunningham et al.[13] quote several studies that have associated secure attachment with social competence and insecure attachment with emotional and behavioural problems in later life, but they make an important point that insecure attachment is not a sign in itself of psychopathology in the child. Cunningham et al.[13] remind us that children of mothers with mental illness are a group at risk for experiencing higher rates of insecure attachments and of having more emotional and behavioural problems than children in the general population.

It is generally accepted that most adult psychiatric disorders have a heritable component[3]. When it comes to children's psychiatric disorders the heritability is not all that clear[16]. According to Rutter et al.[16] children of parents with a mental illness have a greater risk of developing a psychiatric disorder during childhood, compared to children in the general population. In their study Rutter and Quinton[16] found at least a third of children of parents with psychiatric illness may go on to develop a childhood psychiatric condition. In their study the effects of parental illness, through causing marital/partner relationship conflict and harsh, hostile behaviour towards the child, were considered the strongest mediator influencing the development of psychiatric condition in the child. This finding is substantiated by more recent work reviewed by Uher[3] that genetic disposition and environmental exposures are mutually dependent in giving rise to mental illness. Uher[3] further explains that children of parents with severe mental illness are susceptible to environmental stressors both pre- and postnatally.

This risk of developing childhood psychiatric disorder is thought to be higher for children of parents who have a diagnosis of a personality disorder and depression than parents who have a bipolar illness or Chronic Schizophrenia despite the fact that the latter two are considered serious mental illnesses and have more acute illness episodes and more hospital admissions[10]. This is an interesting point to bear in mind when considering mothers' diagnosis and the risk to children.

Oates[10] makes the point in her paper that patients with Chronic Schizophrenia, in most High income countries, barely cope living independently. Although the high income country studies indicated that families appear to be proficient when the female parent is admitted to a psychiatric hospital[17] there is little evidence to confirm that this is the case in middle- and lower-income countries and we cannot assume that this is so in South Africa. In South Africa there is a high chance of the child not having another parent or significant adult to step in when the child needs them. For example, Battersby[18] found that up to 50% of households were single-parent households in peri-urban areas of Cape Town.

Hawes et al.[17] in their study on disruption of children's lives by maternal psychiatric admission, in a sample of women admitted to two inner London Borough psychiatric hospitals, raise an important concern regarding the disruptive effect of the mother's psychiatric illness and admission on children. Just over 20% (12/53) of children in their interview group had to move house during their mother's admission, with two thirds of these being children of single mothers. Oates[10] states that multiple changes in care takers especially if the parent's illness is chronic and needs multiple admissions over time is a further mediator for children's psychiatric illness. It can be argued that the disruption in care causes psychosocial stress and over time can have an impact on a child if this is not buffered by other supportive adult relationships[2].

According to Oates[10], there is no evidence that patients who have a serious mental illness (i.e. Bipolar Mood Disorder or Schizophrenia) are any more likely to physically abuse their children than the general population but that mothers with a less severe mental illness, like depression or anxiety in combination with abusing drugs and being young, may be at higher risk of

physically abusing their children. This finding does raise the point of whether health care professionals in a South African context, when admitting mothers to psychiatric hospital, need to be additionally vigilant to the increased risk of physical abuse by mothers with a dual diagnosis (mental illness and substance abuse disorder) towards their children and so enquire about this too.

Mother's with mental illness and their views of parenthood

Parrott et al.[19] examined parental experiences amongst a cohort of both male and female patients admitted to a forensic hospital in the United Kingdom, using narrative interviews with a small sample of inpatients who were parents. The median stay for patients in hospital was around 24 months for men and 16.5 months for women. Despite being hospitalised, parenthood was of central importance to the emotional life and identity of these patients, which they themselves reported during interviews with the researchers. Their views were captured in the interviews under themes of loss, shame, hope, failed expectations, responsibility and joy. Two thirds of the small sample of mothers who were interviewed had contact with their children whilst in hospital whereas only a quarter of fathers had contact with their children. Some parents had photographs of when they lived with their children.

Benders-Hadi et al.[20] surveyed women at a large New York state psychiatric hospital. Their study highlights the important challenge of being a parent with a mental illness, the stigma associated with having a mental illness, the influence of the mental illness on ability to parent and the fears and concerns around this.

Dolman[21], in her systematic review and meta-synthesis of the qualitative literature on motherhood for women with severe mental illness reviews a paper by Ueno et al.[22] who interviewed 20 outpatient Japanese mothers: 13 with schizophrenia and seven who had a mood disorder. According to Dolman[21], mothers in the Ueno et al.[22] study expressed remorse that their illness affected their children and this made them sad. These mothers had less fear of custody loss, as their own mothers cared for them and their children when needed. They were less isolated as their mothers stepped in to help, but they felt socially stigmatised.

Responsibility of mental health practitioners working in adult mental Health Services in assessing child safety

Currently in the UK, a high income country, the National Health Service's Mental health service providers have policies and procedures in place for Mental Health clinicians[23] (including doctors, nurses, social workers and psychologists) with respect to adult mental illness and its impact on the mentally ill users' ability to parent. These policies are in place to ensure that frontline clinical staff knows what to do if they have any concerns for the child.

There seems to be similar levels of awareness and practice in some other European countries; for example in Denmark, there has been co-operation between adult mental health services and children's social services department on this issue for a long time[24].
An exploratory review of the published literature and existing policy documents and guidelines did not identify any similar information on South African practices or other low and middle income African countries.

So, in light of the above review and discussion, the documenting of the care arrangements of children of female in-patients with mental illness, is important and becomes a proxy marker of the awareness and importance clinicians, the health establishment and the health service broadly give to the safety, security and well being of these children. As discussed above, the children of mothers with mental illness are a group at risk of disruptions in their attachment relationship with their mothers, at risk of more emotional and behavioural problems during childhood[13] and at increased risk of developing a childhood psychiatric illness compared to children in the general population[16].

As stated at the start of this proposal, there does not appear to be any current standard of practice with regard to enquiring and documenting care arrangements when mothers are admitted to a psychiatric hospital in Cape Town or psychiatric hospital in the rest of South Africa. Neither are we clear who exactly cares for these children during their mother's admission to a psychiatric hospital in South Africa.

The research presented in this paper will address this gap in knowledge by exploring the current practice amongst clinicians working within the acute female psychiatric service at a large busy government psychiatric hospital in Cape Town, when it comes to enquiring and documenting the care arrangements of the children of mothers admitted there and to describe the care arrangements as recorded in the clinical notes of mothers.

Aims and objectives

Aim of study

To explore the current practice at an acute female inpatient psychiatric service regarding the enquiring and documenting within the first 24 hours of admission, of the care arrangements in place for the children of mothers with mental illness admitted to Valkenberg psychiatric hospital in Cape Town.

Objectives

1. To determine the extent of documentation in the clinical notes within the first 24 hours of admission of care arrangements of children when their mothers are admitted to a tertiary psychiatric hospital in Cape Town.

2. To explore the thinking, current practice of staff and processes in places regarding the enquiring and documenting of care arrangements for the children of mothers who are admitted for treatment of their mental illness to the Female High Care Unit at Valkenberg Hospital.

3. To establish what action, if any, staff on the female High Care Unit may take if they find out within the first 24 hours of admission that any children are not safely cared for whilst their mother is in hospital.

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Chapter 2: Publication-ready Manuscript

Cover Letter

To The Editor 11th August 2017

The South African Journal of Psychiatry

I would like to submit the attached abstract and original article for consideration for publication in the South African Journal of Psychiatry. This article is Chapter 2 of my MMed in Psychiatry Mini-Thesis write up and has been submitted for examination to the University of Cape Town.

My article title is: **Documenting of Care Arrangements for children of mothers admitted to a Psychiatric Hospital: A South African Case study**

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I can confirm that my article has not been sent to another journal for publication.

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Yours Sincerely
Dr Nisaar Dawood

Documenting of Care Arrangements for children of mothers admitted to a Psychiatric Hospital: A South African Case study

Dr Nisaar A Dawood (Corresponding author),
A/Prof Marguerite Schneider, was Dr Dawood's main supervisor for this MMed research
Dr John Parker, co-supervisor for Dr Dawood's MMed research

Abstract

Background

Enquiring about and documenting care arrangements for children of mothers admitted with mental illness is paramount. Failure to do so could have a negative impact on the well-being of their children. Documenting care arrangements on admission signals good practice. It also ensures compliance with the requirements of the South African Children's Act of 2004. This study explores the practice at a large government run tertiary female inpatient psychiatric unit in Cape Town, regarding the enquiring and documenting practice within the first 24 hours of admission, of these care arrangements.

Methods

The study is a cross sectional study using a mixed methods approach including: i) a case note audit of 100 consecutive patient folders examining the documentation of care arrangements within the first 24 hours of admission and ii) a structured self-administered questionnaire to professional staff working on the unit.

Results

A total of 87 clinical folders were audited. Ninety nine percent of these folders had documentation whether the women had children or not. Fifty eight percent of women had minor children, and had 87 children between them. Fifteen percent of women had no care arrangements documented and 20%had unclear documentation of care arrangements. Fifteen completed staff questionnaires were returned. All staff indicated that it was important to ask the mothers about care arrangements.

Conclusion
There is concern that many women may have had children in unsafe care arrangements. There is room for improving the clarity of documenting and the enquiring into care arrangements.

Introduction

The psychiatric inpatient facility should make sure that there are safe and secure care arrangements in place for children when their mentally ill mothers are admitted. This is an important concern for the inpatient psychiatry clinical team[1].

The South African Children's Act of 2005[2], places statutory responsibility on health professionals to report any suspicions based on reasonable grounds, of gross neglect or abuse of children. The Act therefore encourages health care professionals to be concerned and to ask parents about the well being of their children.

Asking about and documenting of the care arrangements for children of female psychiatric inpatients may be considered a proxy marker for the awareness and importance clinicians and the health service place on the safety, security and ultimately on the well-being of these children.

In South African, with its high rates of social inequality and of violence against children[3], lack of safe care arrangements can place these children in situations where they are at increased risk of becoming victims of violence and or social disadvantage.

There are many ways that parent's mental illness can impact on children and their emotional development both directly and indirectly. The mechanisms are complex and remain at the level of theoretical hypothesis at present[4]. Some thinking suggests that this occurs through parental relationship problems[5], social adversity or multiple changes in caregivers[6].

Children of mothers with mental illness are at risk for experiencing higher rates of insecure attachments and of having more emotional and behavioural problems than children in the general population[4]. In their study Rutter et al.[5]

found at least a third of children of parents with psychiatric illness may go on to develop a childhood psychiatric condition. This highlights that inadequate care arrangements can place the children of mentally ill women under more stress when these children already are at a significantly increased risk of developing a childhood psychiatric disorder or behavioural and emotional problems.

Information on the practice of asking about and documenting care arrangements in a High Income country, for example the United Kingdom (UK), shows that this issue is given a high priority and importance amongst health care organisations (Southern Health NHS Foundation Trust, 2014). The UK has several examples of clear policies and procedures in place[7, 8].

A search of the literature for studies from South Africa and other low and middle income countries on care arrangements for children of mothers admitted to an acute psychiatric ward yielded no published studies. Similarly, we found no published research on addressing care arrangements for children when mothers (without mental illness) are admitted to a general hospital.

It is imperative to know in whose care the children are while the mother is admitted to a psychiatric unit is a further concern. Cunningham et al.[9] in their UK study on care arrangements found that 67% of children were cared for by their father and over 80% of children were cared for within the immediate or close family network (father, grandparent, relative). A similar result was found in a different study by Hawes et al.[10] in a London Psychiatric Hospital.

A review of a series of relevant South African policies and legislation did not yield any specific guidance. The documents reviewed included: the SA Mental Health Care Act[11], National Core Standards for Health Establishments in South Africa[12], National Mental Health Plan and Policy Framework 2013-2020[13] and the Guidelines for Good Practice in the Health Care Professions[14].

Hall et al.'s[15] findings have important implications in the way we understand child care arrangements within the South African context. In their paper they analyse the National Income Dynamics Study (NIDS) 2008 data and statistics from the Children's Institute, to report findings that nearly a quarter of all

children in South Africa do not live with either of their biological parents and these are primarily within historically disadvantaged communities. They found that 25% of Black children do not live with either of their parent; this is true for only 4% of white children. Care arrangements for children of mentally ill mothers add to this existing context of tough care arrangements for children and should not be ignored.

In conclusion, enquiring and documenting the care arrangements for the children of mothers who are admitted to hospital because of severe mental illness is an important component of the admission process. However, the seemingly lack of clear guidelines within the South African public health care service on this practice is a concern.

The current research will address this gap in knowledge and explore the extent to which care arrangements are addressed and documented through a combination of a case note audit and interviews with psychiatric inpatient personnel.

Study objectives

- To determine the extent of documentation in the clinical notes within the first 24 hours of admission of care arrangements of children when their mothers are admitted to the Female High Care Unit at Valkenberg Hospital, a tertiary psychiatric hospital in Cape Town.
- To explore the thinking and practice of staff and processes in places regarding the enquiring and documenting of care arrangements for the children of mothers who are admitted for treatment of their mental illness
- To establish what action, if any, staff may take if they find out within the first 24 hours of admission that any children are not safely cared for whilst their mother is in hospital.

Research Methods and Design

The study context

Valkenberg Hospital is a large, tertiary referral psychiatric Hospital in Cape Town, providing several specialist inpatient and some outpatient psychiatric services to at least 1.5 million people living within the Cape Town metropole.

It accepts referrals of adults (18 – 59 years old) with mental illness for admission to its acute inpatient psychiatric services directly from its outpatient department, one district hospital, one Central hospital and two regional hospitals and also females between ages of (18 to 59) from a community based emergency unit.

The study design

The study design is an exploratory study using a mixed methods approach including:

i) A case note audit, of 100 consecutive admissions to the female High Care Unit at Valkenberg Hospital between 1st August and 31st October 2015.

ii) A structured self-administered questionnaire to all the staff members working on the female High Care Unit at Valkenberg Hospital (26 in total). These included psychiatry registrars, social workers, Occupational therapist, professional nurses and medical officers. Twenty six questionnaires were distributed.

a) Clinical folder audit

i) *Inclusion Criteria*

- Female adult patients admitted during the 3 month period of review – 1 August to 31 October 2015. This sample period was chosen to make sure that patients were no longer inpatients at the time of the study.
- Every admission was treated as a separate admission in the case of a patient admitted more than once during the period of our study.
- Women with any severe mental illness.
- Information recorded within the first 24 hours of admission.

ii) *Exclusion Criteria*

- Women younger than 18 or older than 60
- Female Admissions to non acute inpatient services.
- Women who are admitted for Forensic observation

A database in the form an Excel spreadsheet was obtained from the admissions clerical supervisor. This database contained the patient details of all the admissions for our sample period.

iii) *Sample size*

No specific sample size calculation was done. As this was an exploratory study, a sample size of 100 patient records was deemed sufficient to allow for basic statistical analyses(however only 99 records sampled). This sample size choice was also based on sample size used in similar studies by Manderson et al.[1] and Tamarit et al.[16].

iv) *Data collection*

An audit tool used was designed based on information from audit tools used by Manderson et al.[1], Tamarit et al.[16], Cunningham et al.[9] and Hawes et al.[10]. The local context of the study site was also taken into account.

The audit tool was divided into three sections: basic socio-demographic information of patient (including whether they had children), illness history and care arrangements for children. Each section was made up of several questions. Demographic information and illness history data were collected for all the patients in our study.

Data on the nature of care arrangements was collected only for those patients who were documented as having children younger than 18 years old (referred to as minor children on audit tool)

Information to complete the audit tool was obtained from the following parts of the patient's clinical folder:

- Inpatient medical entries for the first 24 hours of admission, including the notes of the admitting doctor
- The first 24 hours of inpatient nursing entries
- The First call sheet. This must be completed within the first 24 hours of the patient's admission. It documents details of conversation between nursing staff and next of kin with particular focus on the patient's accommodation on discharge.
- Patient personal data sheet

Each patient record was coded with a study number, to ensure confidentiality of information.

b) Staff Questionnaire

i) *Inclusion Criteria*

Psychiatry Registrars and Medical officers, Social workers, Professional nurses and Operations manager, occupational therapist and Intern psychologist working on the Female High Care Unit at Valkenberg Hospital. Most of the above professionals are likely to be involved in the admission of female patients.

ii) *Exclusion Criteria*

Nursing assistants, security guards, cleaning and housekeeping staff and medical students were excluded because they are less likely to be involved in the patient's admission process.

iii) *Questionnaire Development*

The author developed a simple self-administered structured staff questionnaire to assess the level of awareness of and attitudes and personal beliefs of health care practitioners on the importance of safe child care arrangements and concomitant enquiring about and recording of this information. The questionnaire included both closed- and open-ended questions.

Participation was voluntary and assurance of anonymity was stressed. Participants were asked to indicate their professional group. This was to help identify potential differences and similarities in practices and attitudes amongst members of the multi-disciplinary team. All participants were asked to read and sign a consent form prior to completing the questionnaire.

All completed staff questionnaires were anonymised, with each being allocated its own unique study ID.

iv)*Recruitment of participants*

The lead investigator of this study contacted the Lead Consultant psychiatrist for the Female High Care Unit and was invited to the weekly staff meeting. The study was introduced and participation explained to staff members and questionnaires handed out. Twenty five questionnaires in total were distributed.

v) *Data Collection*

Completed questionnaires were placed in a sealed box in the nursing staff room on the female high care unit. The author made several visits to the Female High Care unit and registrar teaching sessions on different days and at different times to remind staff to complete questionnaires and to collect completed questionnaires.

Data Analysis

- Data for both the clinical folder audit and self report questionnaire were captured onto a prepared Excel spreadsheet and exported to SPSS for analysis
- Data were analysed using Microsoft Excel and SPSS Version 23 to produce descriptive statistics.
- Frequencies and basic cross tabulations were conducted on the data.
- Open ended question responses on the staff questionnaires were analysed according to the themes they reflect.

Ethical Considerations

The study was approved by the University of Cape Town Human Research Ethics Committee (HREC) (protocol ref number: 066/2016), the Western Cape Government department of Health and by the head of Valkenberg Hospital, a Western Cape Government facility.

Results

a) Clinical Folder audit

Ninety nine patient folders were sampled in the available time allocated for data collection. Eighty seven folders were audited, 11 folders were not available as they either could not be found or were being used. One patient was excluded as she did not meet study inclusion criteria.

Nurses and doctors conducted their own, separate admission interview. They recorded their notes in their respective sections of the clinical folder.

Table 1: Number of admitted women with children as recorded by admitting doctors in first 24 hours (N=87 admitted women)

What is documented	No of women (N)	Percent (%)
Minor children (<18yrs old)	46	53%
Only Adult children	12	14%
Patient refuses to disclose	2	2%
No Children	17	20%
Information given by patient deemed unreliable	9	10%
No Info recorded	1	1%
Total	**87**	**100%**

Table 1 summarises the findings of the recording of minor children. We were able to identify those patients with minor or adult children because the admitting doctors recorded the ages of the women's children in their admission notes.

According to Table 1, 86/87 women in our sample had information documented on whether they had children or not. Nine out of the 87 women were documented as having children but were deemed unreliable informants by the researcher and because of this not included as having minor children. The decision to judge these nine women as unreliable informants was made after the researchers' read through the information documented by the admitting doctor and found inconsistent and sometimes contradictory description of events and personal information documented in different parts of the admission notes. Reading the symptoms that the admitting doctor observed these patients to be experiencing at the time of admission suggested to the researchers that these patients may have been too ill to be reliable with their information. The nursing notes helped to confirm this decision. (See table 4). The admitting doctor did not comment in the admission plan that they thought the information regarding children given by these patients was unreliable.

Forty six women had a total of 87 minor children between them. Figure 1 shows the number of children each women had.

Figure 1: Number of children per mother

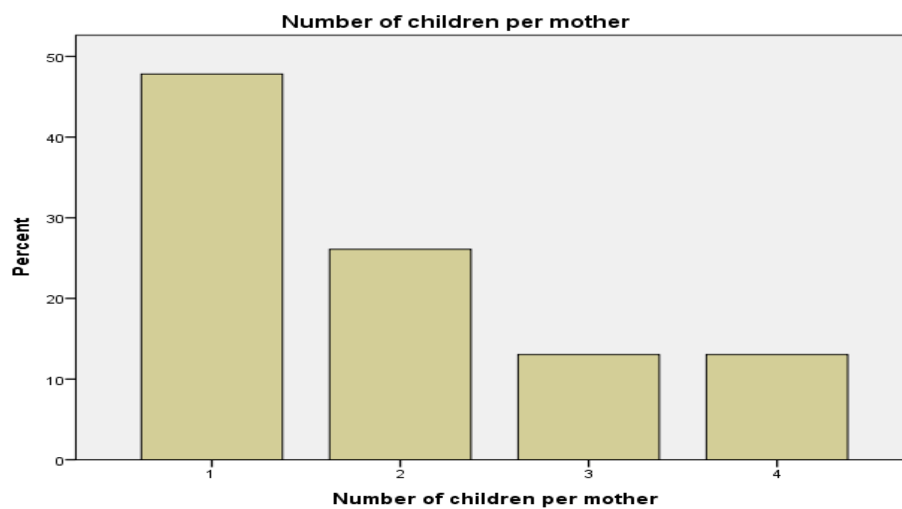


Table 2: Documentation of Caregiver arrangements (N=46 women)

What is documented	**No of women (N)**	**Percent (%)**
No arrangements recorded	7	15
Caregiver recorded - but unclear	9	20
Children cared for by same caregiver	23	50
Children living on their own	1	2
Mother does not know	1	2
Children split between 2 caregivers	2	4
Care arrangements recorded only for some children	3	6
Total	**N = 46**	**100%**

Table 2 illustrates the documentation of caregiver arrangements for the women with minor children (N=46). Of these women 29/46 women had clear documentation of care arrangements completed within 24 hours of admission. For 9/46 (20%) of women the documentation of care arrangements was completed but unclear. One patient's children were recorded as living alone without an adult caregiver and another patient was recorded as not knowing who was caring for her children. Fifteen percent of women 7/46 had no information at all recorded regarding care arrangements for their minor children.

Table 2 also illustrates that the majority of the women with clearly documented caregiver arrangements, 23/29, had the same caregiver for all their children. The children of two of the patients were split up and cared for between two different caregivers.

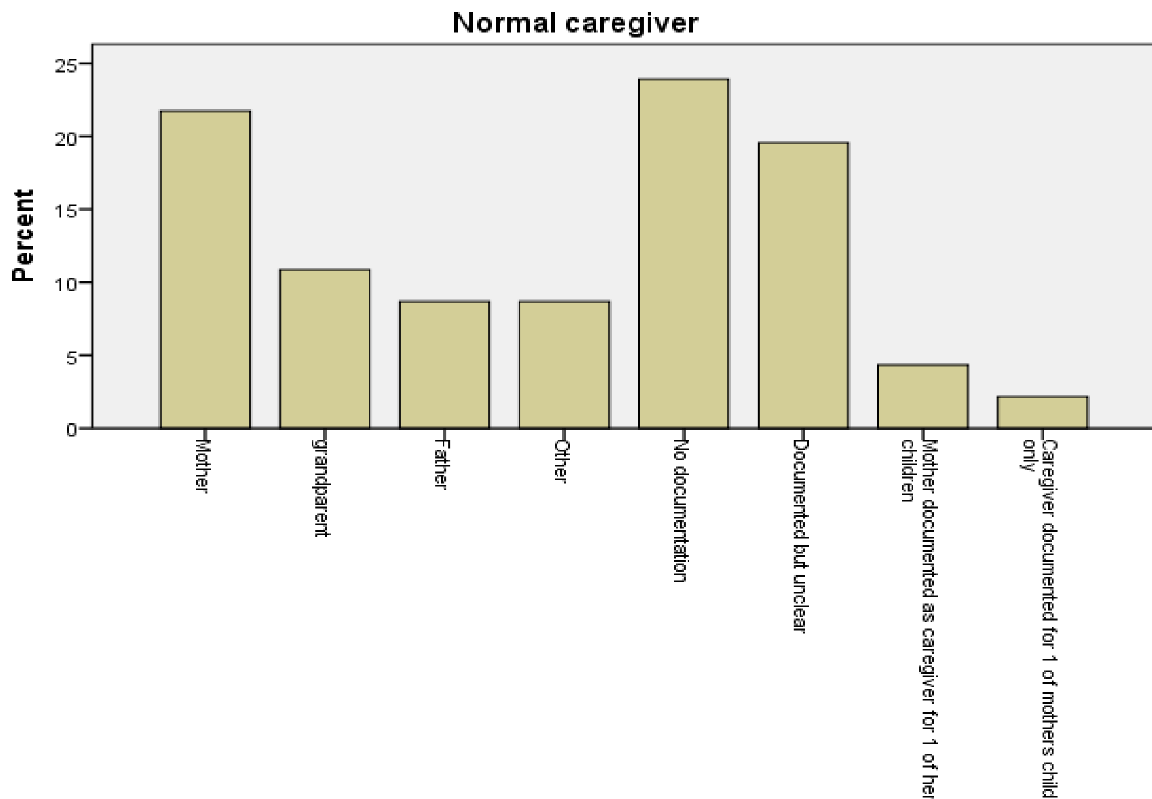
Table 3: Documented breakdown of care arrangements for children (N=87 minor children) of the 46 women documented to have minor children

Caregiver	**No of minor children (%)**
Father	12 (14%)
Grand-parents	18 (21%)
Other relative	10 (11%)
Foster care	2 (2%)
Other	6 ((7%)
Children living alone	1 (1%)
Mother did not know	1 (1%)
Not documented	17 (20%)
Documented but unclear	20 ((23%)
Total	**87**

In Table 3 is the breakdown of the caregivers of the children of the 46 women documented as having minor children. Where caregiver arrangements were clearly documented, 80% (40/50) of these children were cared for within the extended family. One mother did not know who was caring for her children.

Figure 2 illustrates the primary caregiver of the women's children. The patient was documented as the primary carer of her children for just over 20% of the children with a grandparent being the normal caregiver for 10% of patients. For 25% of the patients, the primary carer of their children was not documented and for 20% of women the documentation was unclear.

Figure 2: Primary caregiver of the women's children (N=87 children)



Of the 46 women recorded by the doctors as having *minor* children, 25 of these patient's nursing records concurred with the medical records, and 18 had no documentation in their nursing notes of having children (see table 4).

Table 4: Comparison of a *subset* of medical and nursing records on information documented (N=55 (out of the total of 87 folders sampled)

Information documented	Medical notes	Nursing notes		
		Agreed With medical notes	Different	No info about children recorded
Has minor children	46	25	2	18
Patient rated as unreliable	8	3	0	5
No documentation of children	1	1	n/a	n/a

In the medical records it was clearly documented that doctors contacted two patient's relatives only and in two further records the documentation was unclear.

One patient was documented in both the medical and nursing records as having been referred to a child protection agency prior to admission. Her one child was receiving treatment at a nearby tertiary children's hospital whilst her other children were in the care of family in the Eastern Cape.

Our study found that Valkenberg Hospital has an interesting formalised system in place called *First Clinical Call.* Its primary function is to make sure relatives or next of kin are contacted within the first 24 hours of admission by nursing staff to inform them of the patient's admission and to check if the patient has accommodation to which they can be discharged. If next of kin cannot be reached after three attempts, the clinical team is informed, usually within a few days of admission.

In 29/46 of the patients with minor children the first clinical call was successful and the next of kin reached. In only six of the 29 successful first clinical calls did we find documented evidence on the First Clinical call recording sheet confirming that the patient was a mother who had minor children. In a further eight folders information was documented to help confirm that the patient was a mother but no information was documented regarding the ages of their children.

b) Staff Questionnaire

Fifteen out of 25 completed staff questionnaires were returned. Tables 5 summarises the breakdown of the responses according to professional groups.

Table 5: Summary of Staff responses to questions regarding enquiring into care arrangements

Topic	Response	Registrar (N=3)	Medical Officer (N=3)	Nurse (N=6)	Occup Therapist (N=1)	Social Worker (N=1)	Psych Intern (N=1)	Total
1. Important to ask about care arrangements	Always	3	3	6	1	1	1	**15**
2. Ask patient if she has any children	No				1			**1**
	Always	3	2	6			1	**12**
	Sometimes		1			1		**2**
3. Ask if patient knows who is caring for her children	Always	2	1	6	1	1	1	**12**
	Sometimes	2	1					**3**
4. Would you document this in the patient's notes?	No	1						**1**
	Always	2	2	5		1	1	**11**
	Sometimes	1		1	1			**3**

All staff who responded agreed that it was important to ask the mother about care arrangements.

In our sample 80% (12/15) staff members responded that they always asked the patient if she had any children and 80% (12/15) staff members also indicated that they would always ask the patient if they knew who was caring for her children.

All the nurses (a total of six) but only half of the doctors indicated they would ask about care arrangements. Five out of six nurses responded that they would always document such a conversation whereas only half of the doctors indicated they would document this in the patient's clinical notes.

Discussion

For 86 out of the 87 folders audited the admitting doctor had enquired and written down, within the first 24 hours of admission, whether they had asked if the women had children. This rate of documentation compares favourably with that from studies in High Income countries Manderson et al.[1] and was better than that reported in the study by Tamarit et al.[16].

Forty six or 58% of women sampled were clearly documented on admission as having minor children, which was a similar percentage to the inpatient population sampled by Manderson et al.[1] in their study. These 46 women with minor children had 87 children between them, with nearly 50% of women having only 1 child.

For the 46 women who had minor children, 85% had the child care arrangements documented but 20% of these were not clearly documented. This figure was better than that found in the study by Tamarit et al.[16] but much lower than in the study by Manderson et al.[1] where most of the mother's with minor children had clearly documented information on who was caring for their children.

Where the care arrangements were clearly documented, the majority of these children were cared for within the extended family, which reflects the findings from other similar studies[1,9].

Only one woman was documented as having been referred to a child protection agency prior to her admission. Our concern is that there may have been many more mothers whose children were living in unsafe care arrangements who were not identified within the 1st 24hrs of admission and suitably referred to a child protection agency. For example, there was one woman whose child was living on their own at home and no action documented in the first 24 hours of admission notes regarding concerns for care arrangements of this child. The folders of nine of the 87 women patients (10%) were assessed by the author's as having provided the admitting doctor with unreliable information as set out in Table 1, were excluded from the detailed auditing for care arrangements. They form a significant portion of the

women sampled. None of these women were identified by the admitting nurse or doctor as being unreliable informants. We cannot exclude that after the first 24 hours of admission, the clinical team may have realised that the information these women gave on admission was unreliable. Our concern though remains that there may have been some of these women who had minor children, who may have been in unsafe care arrangements on admission.

In addition to the women mentioned in the paragraph above, we also found that for 9/46 women with minor children the care arrangements were not clearly documented and for 7/46 women it was not documented at all. These women had a total of 37 children between them. It is therefore possible that some of these children may too have been in unsafe or unsuitable care arrangements.

We found that the First Clinical Call at Valkenberg Hospital may be a very helpful system in place to ensure that next of kin of the patient are contacted within 24 hours of the patient's admission to verify the information given by the patient. However our results indicate that a significant number of patients' next of kin could not be reached. This information would have been reported back to the clinical team within the first few days of admission. Where family or next of kin could be reached, we found only a small number of these patients had any documentation on the First Call recording sheet about information pertaining to their children. Hence we do not know if staff routinely ask about childcare arrangements during these calls.

Our findings from our staff survey found that the clinical team reported a high level of awareness regarding the importance of enquiring if the women had children (100% of respondents) with slightly fewer indicating the importance of documenting the care arrangements for these children (80% of respondents). These findings fits with the findings of our folder review, However we also found in our folder review 20% of care arrangements not to be clearly documented. So what could be the reason for these findings?
Our findings highlight that clinical staff know the importance of asking if the women have children. When it comes to documenting care arrangements our findings may suggest that some clinical staff in question are not paying careful attention to this issue and just superficially enquiring into care

arrangements. We can further hypothesise that may be because they are busy and neglecting to document this issue carefully or that they may think it is not an important aspect of their interview or note making role. Finally, because there are no clear guidance on documenting of care arrangements, staff may be using their own personal or professional discretion in deciding on how clearly or in how much detail to enquire and document care arrangements.

Conclusion

The South African Children's Act of 2005[2] has set a national standard for ensuring the safety and protection of minor children and places an important responsibility on health care professionals with regards to this issue. We were however unable to find clear national, provincial department of health or local hospital guidance or standard to help guide the inpatient mental health teams in the job of enquiring into and documenting the care arrangements of mothers who have minor children, admitted for a mental illness.

Our concern is that because the care arrangements for the children of a significant number of women were not clearly identified or documented in the first 24 hours of their admission to hospital, there may have been many more women than the one woman actually referred to a child protection agency, whose children may have been living in a potentially unsafe care arrangement.

Our findings highlighted that within the first 24 hours of admission that there is significant room for clinicians at our sample site to improve their enquiring into care arrangements and their clarity of documenting these care arrangements when women are admitted to a psychiatric hospital.

Recommendations

We think our findings, although an initial study, does provide good evidence for the importance of this issue to be investigated further by the hospital management. A standard operating procedure with clear guidelines for clinical staff on documenting and following up child care arrangements

would seem one way to address this issue. Other hospitals in Cape Town could use our findings to help audit their own practice regarding this important issue.

Study limitations

This study was exploratory in nature and took place at only one Tertiary psychiatric unit in Cape Town and so the results should not be generalised to all tertiary psychiatric units or to district level 72- hour assessment units (particular to configuration of mental health inpatient services in South Africa).

This study only audited the first 24 hrs of clinical notes given the importance of immediate concerns for child care arrangements. We cannot comment on what the clinical team's practice was beyond this period in checking the information regarding care arrangements for children. We suggest that this should be explored in further complementary research.

Acknowledgements

The clerks at Female High Care Unit, Valkenberg Hospital.

Mr Silumko Mute for helping with finding and delivering the clinical records to me

The staff at Female High Care Unit for kindly participating in my staff survey.

Competing Interests

Nil

Author's Contribution

ND was the lead author and developed the rationale, conceptualisation and analysis of the study and was the main drafter of the paper. MS and JP assisted in the conceptualisation, analysis and drafting of the paper. All authors approved the final version submitted.

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Appendices

Appendix 1: Information sheet and consent form for staff questionnaire

Study: The Care Arrangements for children when their mothers are admitted to a Psychiatric Hospital. A South African Case study.

I am inviting you to participate in this questionnaire. Participation is voluntary and that there is no remuneration for participation.

You will not be disadvantaged if you decline to take part.

Participation is based on informed consent.

All participants will be asked to read through the information sheet and if you agree to participate, to then sign the consent form attached before completing the questionnaire.

To protect your privacy, your do not have to enter any personal information. For data collection purposes, each questionnaire has a unique study ID assigned to it.

Why is this study being done?

We wish to explore the current practice at an acute female inpatient psychiatric service regarding the enquiring and documenting within the first 24 hours of admission, of the care arrangements in place for the children of mothers with mental illness admitted to Valkenberg psychiatric hospital in Cape Town.

This study is part of the MMed study of Dr Nisaar Dawood, registrar in psychiatry, who is interested in finding out more information on this issue.

Why are you being asked to take part?

To understand what you as staff members working on the female High Care Unit at Valkenberg think about the issue of care of the children of the mothers who are admitted to your unit for treatment.

How many people will take part in the study?

We plan to interview 15 to 20 staff members from all professional disciplines who work on the female High Care Unit at Valkenberg Hospital. We also plan to audit the clinical notes of 100 patients admitted to your unit between 1st August and 31st October 2015.

How long will the study last?

For a month

What do we do to decide if you are eligible to be take part?

We would like to make sure that you belong to one of the following professional groups: a Professional nurse, doctor, occupational therapist, social worker or psychologist (including psychology interns) and work on the female high care unit at Valkenberg hospital.

What will happen if you decide to take part in the study?

We will ask you to complete a staff questionnaire that should take you between five and ten minutes to complete. We will ask you to indicate, if you wish to, your professional group to help us find out if there are differences of opinions between various professional groups on our study subject.

What are the risks and discomforts of this study?

Participants may feel uncomfortable writing about potential short comings in their practice or within the admission process. We intend to be sensitive to participants' feelings and respect participants when they do not wish to answer questions or disclose information

What other choices do you have?

You can decline to participate

What will happen when the study is over?

We hope to present our findings to the senior managers and clinicians at Valkenberg Hospital

Will the results of the research be shared with you?

We do not plan to share the results of our research with individual staff members.

Will you receive any reward (money or food vouchers) for taking part in this study?

No

Who will see the information which is collected about you during the study?

We hope to present the findings to the Unit Consultant Psychiatrists and the Director for Clinical services. If we are invited to, we will be happy to present our findings to staff members on the ward.

Who do I speak to (or contact) if I have any questions about the study?

For further information you can contact

Dr Nisaar Dawood, registrar in psychiatry on 081 277 6533.

Dr Margie Schneider, marguerite.schneider@uct.ac.za

Prof Marc Blockman, marc.blockman@uct.ac.za

Consent Form

Study ID no: _______________

Please enter your full name and surname below

I Dr/Mr/Mrs/Miss_______ _________________________________ hereby consent to participate in this structured self-administered staff questionnaire as part of the research study:

The Care Arrangements for children when their mothers are admitted to a Psychiatric Hospital: A South African Case study.

I have received and understood the study information sheet. I have weighed the risks of participating in the study and I agree to participate. I understand that the questionnaire is a self-administered one.

Date____________________________

Signature ____________________________

A copy of the information sheet and signed consent form is for you to keep.

Appendix 2: Staff Questionnaire

Please circle the Professional group you are from

(1)Doctor a)Intern; b)Registrar; c) Medical Officer ; d) Consultant (2) Nurse (3) OT 4)Social worker 5)Psychology intern

Section 1

When a female patient is admitted to your unit, within the first 24hours of her admission…

a) Do you ask the patient whether she has any children or not?

1. No 2. All the time 3. Sometimes 4. Not applicable

b) If the patient is a mother do you enquire from the patient if she knows who is caring for her children?

1. No 2 All the time. 3. Sometimes 4. Not applicable

c) If you enquired into the above issues, would you record this in the patient's clinical notes

1. No 2. All the time 3. Sometimes 4. Not applicable

Section 2

a) Do you think that it is important to know and ask about care arrangements of children of the mothers admitted to your unit?

1. No 2. Sometimes 3. All the time

b) *Please give a reason for your answer in the space provided below*

c) *Is there any policy on this issue that you are aware of?*

1) Yes 2). No

d) If yes, please list this/these:

e)Does the patient's appearance on admission affect how you document the care arrangements?

1) Yes 2) No 3) Sometimes 4) Not applicable

f) Does the impression the patient make on you on admission affect how you document the care arrangements?

1) Yes 2) No 3) Sometimes 4) Not applicable

g) If the patient's first language is not English, does this affect your enquiring and documenting of care arrangements?

1) Yes 2) No 3) Sometimes 4) Not applicable

Section 3

a) *Whose responsibility is it to ask about care arrangements for children of women admitted to the psychiatric hospital?*

1. Doctor's 2. Social worker 3. Nurses 4. OT 5. Psychologist 6. All

7. Other (specify________) 8. No one's responsibility 9. I don't know

b) *When the patient has been admitted onto the ward, which of the following would you also do within the 1st 24 hours(circle relevant numbers)*

1. Phone relatives to find out about care of children
2. call relative to inform that patient admitted
3. call relative to inform about visiting hours
4. all of the above

Section 4

a) *What would you normally do in your practice if there is no information recorded in the clinical notes regarding the care arrangements of young children of mothers admitted to your unit? (Write your answer in the space below)*

b) *What would you consider important to include in any potential hospital guidelines for enquiring about care arrangements for children of female patients admitted to Valkenberg hospital? (Write your answer in the space below)*

Appendix 3: Case Note Audit Proforma

Record no:

Medical record (1) **Nursing record (2)** **Both (3)**

Length of stay (days)

Demographic info

1. **Patient age** (1) 18 - 24/ (2) 25 - 35 / (3) 36 - 49 / (4) 50 - 59

2. **Marital status** (1) No info / (2) single/ (3) married / (4) divorced / (5) in relationship

3. **Highest level of education** (1) no education/ (2) primary school only/ (3) part of high school/ (4) completed matric / (5) tertiary qualification/ (6) No info

4. Employed (1) Yes/ (2) No/ (3) no info

4.**b** **If yes, what kind of work?** (1) Self Employed / (2) Admin/ (3) manual work / (4) professional

5. **On Disability grant** (1) Yes/ (2) No/ (3) no info

6. **Does patient have her own accommodation** (1) Yes/ (2) No/ (3) No info

6.b **If no**, (1) Homeless/ (2) lives with family member/ (3) no Info

7. **Income/month** (1) 0 / (2) <R1500 / (3) R1501- R5000 / (4) >R6000/ (5) No Info

Illness/Health of mother

8. **Reason for admission**

(1) Relapse secondary (2) non compliance/ (3) relapse on medication/ (4) use of

substances/ (5)other /(6) No info

9. **Primary Diagnosis**

(1) Major Depressive Disorder	(2)Schizophrenia	(3) Schizoaffective disorder	(4) Bipolar Mood disorder
(5) Substance induced psychosis	(6) Mental disorder secondary to an organic cause	(7) Borderline Personality disorder	(8)Anxiety Disorder
(9) Other (specify)_______________			(10) No Info

10. **a) Does patient have any other co-morbid mental illness?**

(1) No/ (2) Yes, if yes (2) please indicate from list below

10 b) (1) Depression / (2)Schizophrenia / (3) Schizoaffective do/ (4) Bipolar Mood disorder / (5) Substance Use disorder /
(6) Borderline Personality disorder / (7)Anxiety disorder / (8) Other / (9) No Info

11. **Does the patient have any co morbid medical illness/es? (1) Yes/ (2) No**

11b) If yes choose from list below

(1) Diabetes
(2) Hypertension
(3) HIV, (4) Epilepsy, (5) Heart Disease, (6) Previous stroke, (7) Asthma, (8) Tuberculosis, (9) hyperlipidaemia, (10) Other

12. **Number of psychiatric admissions in the previous 5 years (excluding current one)**

(1) 0 / (2) 1-3 / (3) 4-6/ (4) 7or more / (5) no info

13. **Mental health act status for current admission**

(1) Involuntary / (2) Assisted / (3) Voluntary / (4) No Info

14. patient admitted from

(1) Outpatients / (2) District Hospital / (3) Emergency Hub / (4) No info recorded

<u>Care arrangements for children <18yrs old</u>

15 a) (1) Medical record

15b) Admitting Doctor's Rank: (1) intern doc (2) MO doc (3) Registrar

15c) day of week patient admitted 1)Mon 2)Tues 3) Wed 4)Thurs 5)Fri 6)Sat 7) Sun

15 d) Time of day patient admitted 1)08h00 – 16h00 2) 16h00 – 20h00 3) 20h00 to 08h00

16 (a) Is there any documentation in the first 24hrs of the clinical notes that the patient has any children? (1) Yes/ (2) No

16 (b) How Many Children is the patient documented as having

(1)1 / (2) 2 / (3) 3 / (4) 4 / (5) 5 / (6) >5 / (7) not recorded

17 age of children in years and the number of children in each age category

(a) 0-5	(1) 1, (2) 2, (3) 3, (4) 4	(b) 6-11	(1) 1 (2) 2 (3) 3 (4) 4	(c) 12–17	(1) 1 (2) 2 (3) 3 (4) 4	(d) not recorded(1)

18. a) Any evidence documented in the first 24hrs of the patient's clinical notes In whose care are children during mother's admission

Child 1)

Child 2)

Child 3)

Child 4)

(1) father (2)maternal grandmother/ (3) Maternal grandparents
(4)paternal grandmother/ (5)paternal grandparents
(6)sibling (7)other relative (8)temp foster care/
(9)adopted
(10)Not recorded

18. b Any evidence documented in the first 24hrs of the patient's clinical notes on who is normally the child's primary care giver

Child 1
Child 2
Child 3
Child 4
(1)mother/ (2) grandparent/ (3) father/ (4) other -
(5) Not recorded

19. Any evidence documented in the first 24hrs of the patient's clinical notes that a child's social services agency is involved?

(1)Yes / (2)No / (3) No Info recorded

19. b) If yes to question above, state reason for involvement

20. Any evidence documented in the first 24hrs of the patient's clinical that mother was aware who was caring for her child?

(1)Yes / (2) No/ (3) No Info recorded

21. Any evidence documented in the first 24hrs of the patient's clinical notes on well being of the patient's children

(1)Yes / (2) No

21. b) If yes to question above, what info was recorded?

22. Is there any evidence in the first 24hrs of clinical notes that any member of the clinical/admin team contacted the caregiver of the patient's children to check that the patients child(dren) were safely cared for?
(1) Yes / (2) No

23. **Any evidence documented in the first 24hrs of the patient's clinical notes that patient's child(ren) was referred to a child protection social agency during the first 24hrs after admission?**

(1)Yes / (2)No
23 b) If yes, what was the reason documented?

24) Patient's level of thought disorder/severity of illness on admission as documented in Mental state examination on admission?

1) unable to interview, patient poorly co-operative 2) calm and co operative but floridly psychotic

3) agitated or restless and floridly psychotic 4) calm and co-operative – some psychotic symptoms

5) calm and co operative no psychotic symptoms 6) calm, quiet, mood depressed
7) patient with manic symptoms 8) other

Case note Audit:
15 a) (1) Nursing record

16 (a) Is there any documentation in the first 24hrs of the clinical notes that the patient has any children? (1) Yes/ (2) No

16 (b) How Many Children is the patient documented as having

(1)1 / (2) 2 / (3) 3 / (4) 4 / (5) 5 / (6) >5 / (7) not recorded

17 age of children in years and the number of children in each age category

	(1) 1		(1) 1		(1) 1	
	(2) 2		(2) 2		(2) 2	
	(3) 3	(b)	(3) 3		(3) 3	(d) not
(a) 0- 5	(4) 4	6- 11	(4) 4	(c) 12–17	(4) 4	recorded(1)

18 a) Any evidence documented in the first 24hrs of the patient's clinical notes In whose care are children during mother's admission

Child 1)

Child 2)

Child 3)

Child 4)

(1) father (2)maternal grandmother/ (3) Maternal grandparents
(4)paternal grandmother/ (5)paternal grandparents
(6)sibling (7)other relative (8)temp foster care/
(9)adopted
(10)Not recorded

18. b Any evidence documented in the first 24hrs of the patient's clinical notes on who is normally the child's primary care giver

Child 1
Child 2
Child 3
Child 4
(1)mother/ (2) grandparent/ (3) father/
(4) other -
(5) Not recorded

19. a)Any evidence documented in the first 24hrs of the patient's clinical

notes that a child's social services agency is involved?

(1)Yes / (2)No / (3) No Info recorded

19. b) If yes to question above, state reason for involvement

20. Any evidence documented in the first 24hrs of the patient's clinical that mother was aware who was caring for her child?

(1)Yes / (2) No/ (3) No Info recorded

21. Any evidence documented in the first 24hrs of the patient's clinical notes on well being of the patient's children

(1)Yes / (2) No

21. b) If yes to question above, what info was recorded?

22. Is there any evidence in the first 24hrs of clinical notes that any member of the clinical/admin team contacted the caregiver of the patient's children to check that the patients child(ren) were safely cared for?

(1) Yes / (2) No

23, Any evidence documented in the first 24hrs of the patient's clinical notes that patient's child(ren) was referred to a child protection social agency during the first 24hrs after admission?

(1)Yes / (2)No

23 b) If yes, what was the reason documented?

Appendix 4: Summary Budget

Summary Budget	**R8000.00**

- Research assistant
- Statistician
- Stationary

Appendix 5: HREC approval letter

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6626
Email: shuretta.thomas@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

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18 May 2016

HREC REF: 066/2016

Dr M Schneider
Alan Flisher Centre for Public Mental Health
Children's Centre, SCAH
46 Sawkins Rd, Rondebosch

Dear Dr Schneider

PROJECT TITLE: *THE CARE ARRANGEMENTS FOR CHILDREN OF MOTHERS ADMITTED TO A PSYCHIATRIC HOSPITAL: A SOUTH AFRICAN CASE STUDY (MMed-candidate-Dr N Dawood)*

Thank you for your response to the Faculty of Health Sciences Human Research Ethics Committee dated 25 April 2016.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30th May 2017.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval before the research may occur.

The HREC acknowledge that the student, Dr Nisaar Dawood will also be involved in this study.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

HREC REF 066/2016

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH 2006), based on the Association of the British Pharmaceutical Industry Guidelines (ABPI),and Declaration of Helsinki (2013) guidelines.
The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

HREC REF 066/2016

Appendix 6: Provincial Institutional approval letter

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857: fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_2016RP43_647
ENQUIRIES: Ms Charlene Roderick

University of Cape Town
Rondebossch
Cape Town
7700

For attention: Dr Nisaar Dawood, Dr Marguerite Schneider

Re: The Care Arrangements of the children of mothers who are admitted to a psychiatric hospital. A South African case study.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

Valkenberg Hospital	**Carol Dean**	**021 440 3160**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.

2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

A S HAWKRIDGE.

DR A HAWKRIDGE

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 27/5/2016.

Appendix 7: South African Journal of Psychiatry – Author's Guidelines Jan 2016

Introduction

Authors must submit their manuscript online, in a format defined by these author guidelines. Each manuscript is pre-screened by plagiarism detection software, both before and after its review. The review process, copy editing, layout editing and proofing of manuscripts are also all managed online, with authors contributing to both the copy editing and proofing parts of the process. The manuscript may not be with another journal for consideration.

Learn more about:

- The **publication procedure**
- How to **submit online**

Submission checklist

Journal scope

Make sure your manuscript is suitable for the journal by reviewing the page stipulating its focus and scope, publication frequency and article processing charges.

Type of articles published

Does the journal publish the **type of article** that you wish to submit?

Licensing agreement

You must be comfortable with publishing in an **open access** journal. You must be duly authorised and grant the publisher unlimited rights to publish the work in any format and/or medium, whether for gain or any other purpose. This will be one of the agreements that you must sign on behalf of all the authors.

Manuscript formatting

The entire manuscript must be neatly prepared, spell-checked, and adhere to the following formatting requirements:

- Those of the **type of article** you are submitting
- The **AOSIS house style guide**
- The **Vancouver referencing style**

Legal documents

It is compulsory to download, complete and upload the **publication, copyright and usage licence agreements** together with your manuscript.

The article may not contain any unlawful statements and must not infringe any existing copyright.
You must have obtained the necessary permission from the copyright holder(s) to reproduce in the article, in all media in all countries, and transmit via all reputable third parties, any materials including tables, diagrams and photographs not owned by you.
Author list
Anyone that has made a significant contribution to the research and the paper must be listed as an author. Your authors will be added to your **cover letter**. Contributions that fall short of meeting the criteria as stipulated in our policy should rather be mentioned in the 'Acknowledgements' section of the manuscript. Read our **authorship** guidelines and contribution statement policies.

Cover letter
Review the **cover letter** requirements which are compulsory with submission. This must be the first page of your manuscript.

Policies
Read through our **publication policies** and **privacy policy**.
Blind peer review
Ensure that your manuscript is formatted correctly to ensure the integrity of the blind peer-review process. **Learn how to do it here**.

Conflict of interest
You must declare any potential conflict of interest in the research and any support from a third party must be noted in the acknowledgements. Read our policy on **competing interests**.

ORCID iD
ORCID iDs can only be assigned by the **ORCID Registry**. You must conform to their standards for expressing ORCID iDs, and will have the opportunity to include the full URL (e.g. **http://orcid.org/0000-0002-1825-0097**) during the submission process, that will link to your name when the manuscript is published.
Human/animal rights

All research involving human participants must have been approved by the authors' institutional review board or equivalent committee(s). All animal work must have been conducted according to relevant national and international guidelines. Read how to comply with our **human and animal rights** policy.

Online manuscript submission

Register and **login** on the journal website and follow the online new submission process. Ensure that you have all the documentation in place before submitting.

Revised submission

Revisions may be requested from time to time. You will receive an email with instructions on how to proceed with creating and uploading your revised submission on the journal website. Read our **resubmission process** and how to **prepare your revised manuscript** before resubmission.

Overview

Focus and scope

The journal is the leading psychiatric journal of Africa. It provides open-access scholarly reading for psychiatrists, clinical psychologists and all with an interest in mental health. It carries empirical and conceptual research articles, reviews, editorials, and scientific letters related to psychiatry. It publishes work from various places in the world, and makes special provision for the interests of Africa. It seeks to serve its readership and researchers with the most topical content in psychiatry for clinical practice and academic pursuits, including work in the subspecialty areas of psychiatry. Submissions in English (full article) will be considered for publication.

Publication frequency

The journal publishes four issues per year. Individual articles are published as soon as they are ready for publication by adding them to the table of contents of the 'current' volume and issue. In this way, the journal aims to speed up the process of manuscript publication from submission to becoming available on the website. Special issues may be added on an ad hoc basis to the journal throughout a particular year and will form part of consecutive issues thereafter.

Authors will be able to check the progress of their manuscript via the submission system at any time by logging into the journal website's personalised section.

Review process

The journal has a double-blinded peer review process. Manuscripts are initially examined by editorial staff and are sent by the Editor-in-Chief to two expert independent reviewers, either directly or by a Section Editor. Read.

Historic data

The journal was launched in 1995 as an initiative of the **South African Society of Psychiatrists** (SASOP) and has since been the official scientific journal of SASOP. Prof Cliff Allwood (formerly form Wits) and Prof Robin Emsley (Stellenbosch University) served as editors during its first decade and since 2006, Prof Werdie van Staden (University of Pretoria) has served as editor-in-chief. Prof Lielz Koen (Stellenbosch University), Prof Soraya Seedat (Stellenbosch University) and Prof Bernard Janse van Rensburg (Wits) joined the editorial team as deputy editors in 2013. During the last 5 years or so, SAJP achieved several significant listings including the Web of Science (ISI) and SCiELO. Issues since 2002 are available open-access gratis under a Creative Commons (CC) license as well as in print version.

CEU certification

The journal is accredited by the Health Professions Council of South Africa (HPCSA). This accreditation enables AOSIS to offer Continuing Education Units (CEU) certification to authors, co-authors and reviewers of the journal.

Marketing

AOSIS has a number of ways in which we promote publications. **Learn more here**.

Types of Articles published

Original articles

An original article provides an overview of innovative research in a particular field within or related to the focus and scope of the journal, presented according to a clear and well-structured format (3000 words with a maximum of 15 references).

When presenting your article in English. Please use British English, that is,

according to the Oxford English Dictionary. Avoid Americanisms (e.g. use ‘s’ and not ‘z’ spellings). Consult the Oxford English Dictionary when in doubt and remember to set your version of Microsoft Word to UK English.

- Language: Manuscripts must be written in British English.
- Line numbers: Insert continuous line numbers.
- Font type: Palatino
- Symbols font type: Times New Roman
- General font size: 12pt
- Line spacing: 1.5
- Headings: Ensure that formatting for headings is consistent in the manuscript.
    - First headings: normal case, bold and 14pt
    - Second headings: normal case, underlined and 14pt
    - Third headings: normal case, bold and 12pt
    - Fourth headings: normal case, bold, running-in text and separated by a colon.

Our publication system supports a limited range of formats for text and graphics. Text files can be submitted in the following formats only:

- Microsoft Word (.doc): We cannot accept Word 2007 DOCX files. If you have created your manuscript using Word 2007, you must save the document as a Word 2003 file before submission.
- Rich Text Format (RTF) documents uploaded during Step 2 of the submission process. Users of other word processing packages should save or convert their files to RTF before uploading. Many free tools are available that will make this process easier.

Your manuscript must adhere to the AOSIS house style. Refer to the new.
Structure and style

Page 1

The format of the compulsory cover letter forms part of your submission and is on the first page of your manuscript and should always be in English. Refer to the **new submissions checklist**.

Page 2 and onwards

Title

The article’s full title should contain a maximum of 95 characters (including spaces).

Abstract

The abstract, written in English, should be no longer than 250 words and must be written in the past tense. The abstract should give a succinct account of the objectives, methods, results and significance of the matter. The structured abstract for an Original Research article should consist of six paragraphs labelled Background, Aim, Setting, Methods, Results and Conclusion.

- Background: Summarise the social value (importance, relevance) and scientific value (knowledge gap) that your study addresses.
- Aim: State the overall aim of the study.
- Setting: State the setting for the study.
- Methods: Clearly express the basic design of the study, and name or briefly describe the methods used without going into excessive detail.
- Results: State the main findings.
- Conclusion: State your conclusion and any key implications or recommendations.

Do not cite references and do not use abbreviations excessively in the abstract.

The following headings serve as a guide for presenting your research in a well-structured original article. As an author you should include all first-level headings, but subsequent headings (second- and third-level headings) can be changed.

<u>Introduction (first-level heading)</u>

The introduction must contain your argument for the social and scientific value of the study, as well as the aim and objectives:

- Social value: The first part of the introduction should make a clear and logical argument for the importance or relevance of the study. Your argument should be supported by use of evidence from the literature.
- Scientific value: The second part of the introduction should make a clear and logical argument for the originality of the study. This should include a summary of what is already known about the research question or specific topic, and should clarify the knowledge gap that this study will address. Your argument should be supported by use of evidence from the literature.
- Conceptual framework: In some research articles it will also be important to describe the underlying theoretical basis for the research and how these theories are linked together in a conceptual framework.

The theoretical evidence used to construct the conceptual framework should be referenced from the literature.

- Aim and objectives: The introduction should conclude with a clear summary of the aim and objectives of this study.

Research methods and design (first-level heading)

The methods should include:

- Study design (second-level heading): An outline of the type of study design.
- Setting (second-level heading): A description of the setting for the study; for example, the type of community from which the participants came or the nature of the health system and services in which the study is conducted.
- Study population and sampling strategy (second-level heading): Describe the study population and any inclusion or exclusion criteria. Describe the intended sample size and your sample size calculation or justification. Describe the sampling strategy used. Describe in practical terms how this was implemented.
- Intervention (if appropriate) (second-level heading): If there were intervention and comparison groups, describe the intervention in detail and what happened to the comparison groups.
- Data collection (second-level heading): Define the data collection tools that were used and their validity. Describe in practical terms how data were collected and any key issues involved, e.g. language barriers.
- Data analysis (second-level heading): Describe how data were captured, checked and cleaned. Describe the analysis process, for example, the statistical tests used or steps followed in qualitative data analysis.
- Ethical considerations (second-level heading): Approval must have been obtained for all studies from the author's institution or other relevant ethics committee and the institution's name and permit numbers should be stated here.

Results (first-level heading)

Present the results of your study in a logical sequence that addresses the aim and objectives of your study. Use tables and figures as required to present your findings. Use quotations as required to establish your interpretation of qualitative data.

All units should conform to the SI convention and be abbreviated accordingly. Metric units and their international symbols are used throughout, as is the decimal point (not the decimal comma).

Discussion (first-level heading)

The discussion section should address the following four elements:

- Key findings: Summarise the key findings without reiterating details of the results.
- Discussion of key findings: Explain how the key findings relate to previous research or to existing knowledge, practice or policy.
- Strengths and limitations: Describe the strengths and limitations of your methods and what the reader should take into account when interpreting your results.
- Implications or recommendations: State the implications of your study or recommendations for future research (questions that remain unanswered), policy or practice. Make sure that the recommendations flow directly from your findings.

Conclusion (first-level heading)

Provide a brief conclusion that summarises the results and their meaning or significance in relation to each objective of the study.

Acknowledgements (first-level heading)

If, through your study, you received any significant help in conceiving, designing or carrying out the work, or received materials from someone who did you a favour by supplying them, you must acknowledge their assistance and the service or material provided. Authors should always acknowledge outside reviewers of their drafts and any sources of funding that supported the research.

Competing interests (second-level heading)

A competing interest exists when your interpretation of data or presentation of information may be influenced by your personal or financial relationship with other people or organisations that can potentially prevent you from executing and publishing unbiased research. Authors should disclose any financial competing interests but also any non-financial competing interests that may cause them embarrassment were they to become public after the publication of the manuscript.

Where an author has no such competing interests, the listing will read as follows: 'The authors declare that they have no financial or personal

relationship(s) that may have inappropriately influenced them in writing this article.'

Authors' contributions (second-level heading)

This section is necessary to give appropriate credit to each author, and to the authors' applicable institution. The individual contributions of authors should be specified with their affiliation at the time of the study and completion of the work. An 'author' is generally considered to be someone who has made substantive intellectual contributions to a published study. Contributions made by each of the authors listed can follow the example below (please note the use of authors' initials):

J.K. (University of Pretoria) was the project leader, L.M.N. (University of KwaZulu-Natal) and A.B. (Stellenbosch University) were responsible for experimental and project design. L.M.N. performed most of the experiments. P.R. (Cape Peninsula University of Technology) made conceptual contributions and S.T. (University of Cape Town), U.V. (University of Cape Town) and C.D. (University of Cape Town) performed some of the experiments. S.M. (Cape Peninsula University of Technology) and V.C. (Cape Peninsula University of Technology) prepared the samples and calculations were performed by C.S. (Cape Peninsula University of Technology).

References (first-level heading)

Begin the reference list on a separate page, and give no more than 15 references in all. The journal uses the Vancouver referencing style. Note: No other style will be permitted. Refer to the **new submissions checklist**.

Appendix 8: Editor's certificate

Megan Moll

Writing Development Coach
Editor

Website: www.meganmoll.com
Email: megan@meganmoll.com
Cell: 082 491 9090

30 January 2018

Declaration of professional edit

"Documenting of Care Arrangements for children of mothers admitted to a Psychiatric Hospital: A South African Case study"

by Dr Nisaar Ahmed Dawood

I declare that I have formatted this thesis and the referencing style according to the South African Journal of Psychiatry guidelines. My involvement was restricted to formatting and referencing style. I did no copy-editing, proofreading, or structural re-writing of the content.

As the copy editor, I am not responsible for detecting, or removing, passages in the document that closely resemble other texts and could thus be viewed as plagiarism.

I am not accountable for any changes made to this document by the author or any other party subsequent to my edit.

Sincerely,

Megan Moll

Professional EDITORS Guild

Megan Moll
Associate Member

Membership number: MOL007
Membership year: March 2017 to February 2018

082 491 9090
meganmoll@gmail.com
www.meganmoll.com/editing

www.editors.org.za