GUIDE 1

Asking the question parents fear: talking about thoughts of harming a child

We now ask depressed people whether they have thought about suicide. We rarely ask parents whether they have thought about harming their children. This guide is for the professionals who could.

Dr Charlotte Ritchie October 2026

For GPs, midwives, health visitors, mental health and social care staff Reading time 10 minutes

Child Protection: A Public Health Approach · Guide 1 · October 2026
Based on chapters 2, 4 and 6 of *Child Protection – A Public Health Approach: Reducing the Numbers in Care* (2021), updated with current guidance and research.

This is not clinical guidance

This guide sets out an argument and a way of working. It does not replace NICE guidance, your professional standards or your local safeguarding procedures. If a child is at immediate risk of harm, act on it now under your local safeguarding procedures.

Key points

- Parents who kill their children are often depressed, psychotic or in despair, and some believe they are saving their children from something worse. These mental states are treatable, but only if they are first talked about.
- Just as we now ask about suicide, professionals working with parents in crisis should ask: “Have you had any thoughts about harming the children?”
- To get an honest answer, the parent must feel safe giving it. If the answer leads straight to the children being taken, parents will not answer honestly, and the risk stays hidden.
- The weeks after birth and the weeks after a parent leaves psychiatric hospital are critical. Fathers matter too: two thirds of parents who kill their children are fathers.
- The response should be support around the family, in the home where possible, with the parent and children kept together wherever it is safe.

1 Why ask

Many of those who have killed their children have done so for what they believed were loving reasons: believing their children would be better off in heaven than left behind, or for delusional reasons, such as a belief that the child is “evil”. A depressed parent may believe the family will be better together in death. A psychotic mother or father may believe they are saving their children from a terrible imagined event, or may hear voices that “command” them to act.

Psychiatrists Susan Hatters Friedman and Phillip Resnick describe the same motives in their review of mothers who kill: “in an altruistic filicide, a mother kills her child out of love; she believes death to be in the child’s best interest”. Their advice is direct: mothers contemplating suicide “should be asked directly about the fate of their children if they were to take their own life… Thoughts or fears of harming their children should be queried.”[1]

Such thoughts are not rare. In a study cited in the same review, 41% of depressed mothers of children under three had thoughts of harming a child, compared with 7% of mothers in a comparison group. Yet Friedman and Resnick found that many psychiatrists do not ask mothers specifically about thoughts of harming their children; they ask in general about thoughts of harming others.[1]

> These mental states are treatable, but only if they are first addressed.

Fathers too

Antenatal and postnatal services tend to see mothers, not fathers. But in a study of every filicide in England and Wales over ten years, 66% of the parents who killed their children were fathers, and in most cases mental illness was not a feature.[2] Asking only mothers, and only about diagnosed illness, misses most of the risk.

The risk of not asking

The national panel that reviews serious child safeguarding cases has found that parental mental health was "often overlooked as a potential risk factor when considering parents' capacity to care for their children", with professionals focusing on more visible things such as the state of the home.[3] That is a reason to ask more, and more openly, not a reason to remove more children. Asking is how professionals find out what is really happening.

---

2 When to ask

It is known from serious case reviews that a critical period, both for a mother harming herself and for infanticide, is the first few weeks after leaving hospital, when the parent is back home and facing the same pressures again. The same is true after a stay in psychiatric hospital.

For mothers, the year after birth is a time of real danger. Mental health-related causes accounted for 34% of maternal deaths between six weeks and a year after the end of pregnancy in the 2024 UK confidential enquiry, and in the 2025 enquiry maternal suicide was the leading cause of death in that period.[4]

Consider asking:

- [ ] whenever you ask a parent about suicidal thoughts
- [ ] during pregnancy and in the year after birth, especially where there is depression, anxiety, psychosis or a history of them
- [ ] in the days and weeks after a parent is discharged from psychiatric hospital or a crisis team
- [ ] when a parent is separating from a partner, particularly where there is domestic abuse or a dispute over the children
- [ ] when a parent seems overwhelmed, keeps checking on the children's safety, or talks about the children being "better off" without them
- [ ] with fathers and partners, not only mothers

NICE guidance already expects professionals assessing a woman with a mental health problem in pregnancy or after birth to consider "risks to others (including the baby)".[5] Asking directly is how that risk is discussed rather than guessed at.

3 How to ask

Asking the question, and expecting an honest answer, also requires the parent to feel safe giving it. They must not believe that their children will be taken from them for saying so.

NICE recognises the problem: women with mental health problems in pregnancy or after birth may be "unwilling to disclose or discuss their problem because of fear of stigma, negative perceptions of them as a mother or fear that their baby might be taken into care".[5]

Some ways of opening the conversation, offered as suggestions rather than a script:

SUGGESTED WORDING

- "Lots of parents who are as exhausted and low as you are have frightening thoughts about their children. Has anything like that happened to you?"
- "Have you had any thoughts about harming the children, or about what would happen to them if you weren't here?"
- "If you were to take your own life, what do you imagine would happen to the children?"
- "Do you ever hear or see things that tell you to do something to the children, or that something bad will happen to them?"

Say before you ask, and mean it, that the reason for asking is to get the right help to the whole family. Be honest that if there is an immediate danger you will have to act to keep the child safe, but that the aim is to keep the family together wherever it is safe to do so. Many parents feel inadequate, angry, exhausted or irritated by a newborn. All of that is within the range of ordinary parenting, and parents need to be able to talk about their feelings without fear of judgement.

4 What to do with the answer

The way a service responds to an honest answer decides whether the next parent will give one.

1

If a child is in immediate danger, act now

Follow your local safeguarding procedures straight away. NICE guidance is clear that where there is a risk of, or concerns about, suspected child maltreatment, local safeguarding protocols must be followed.[5]

2

Thank the parent and stay with them

Telling you was hard. A calm, non-judgemental response keeps the door open for the conversations that follow.

3 **Get specialist mental health help quickly**

Refer to a perinatal mental health team, crisis team or community mental health team, as appropriate. These states are treatable.

4 **Put support into the home**

If the parent needs time out, or a hospital stay, put support into the home so the children can stay there, among their familiar things, attending their usual school. Where it is safe, a mother and baby unit keeps mother and baby together during treatment.

5 **Plan for the critical weeks**

Agree daily contact with someone the parent trusts in the weeks after discharge or birth, not occasional appointments.

6 **Involve the wider family, with consent**

A partner, grandparent or friend can be part of the plan, as they would be in a better-off family.

7 **Record and share proportionately**

Share what is necessary to keep the child safe, and tell the parent what you are sharing and why.

Living in fear that your children may be taken from you if the powers that be know how you think is unhelpful and dangerous. Living in the knowledge that you will be supported and treated, and that your children will not have to leave either you or your home, offers hope, safety and a familiar context for both parent and child.

5 What services should change

A professional can only ask the question safely if the services behind them can respond. At present, for a lone parent with severe mental illness, there is often no one waiting to step into the breach: only medication, a long wait for admission, and the knowledge that the children are unlikely to be supported at home. Better-off parents can pay for childcare, a nanny or private counselling. They are not forced to go cap in hand to the state, so the state does not intervene.

Getting perinatal mental health care right also saves money. Perinatal depression, anxiety and psychosis together carry a long-term cost of about £8.1 billion for each year's births in the UK, and nearly three quarters of that falls on the child.[6]

1 **Make the question routine**

Train GPs, midwives, health visitors and mental health staff to ask about thoughts of harming children whenever they ask about suicide, and with fathers as well as mothers.

2 **Support in the home during a crisis**

Councils should commission a home support service for parents on low incomes during a mental health crisis and after hospital discharge, so children can stay at home. We already have an army of carers serving older people; this is the same idea for families.

3 **A right to be admitted, and to a mother and baby unit**

Parents should be able to ask to be admitted when they are unwell, with support at home for the other children, and a mother and baby unit should be within reach of every family.

4 **Daily support after discharge**

Contact from someone the parent trusts every day in the weeks after leaving hospital, when the risk is highest.

5 **Home visiting for every new parent who wants it**

Not only young first-time mothers. The Family Nurse Partnership currently recruits first-time mothers aged up to 24 under local criteria.[7]

Questions for discussion

Q1 Why do professionals find it easier to ask about suicide than about thoughts of harming a child?

Q2 What would a parent need to know about what happens next, before they could answer honestly?

Q3 How could your service reach fathers as well as mothers?

Q4 What support would need to exist locally for a professional to feel able to keep a family together after an honest answer?

Sources

1. Friedman, S.H. and Resnick, P.J. (2007) Child murder by mothers: patterns and prevention. *World Psychiatry* 6(3): 137–141.
2. Flynn, S.M., Shaw, J.J. and Abel, K.M. (2013) Filicide: mental illness in those who kill their children. *PLOS ONE* 8(4): e58981. England and Wales.
3. Child Safeguarding Practice Review Panel (2024) *Annual report 2023 to 2024*.

4. MBRRACE-UK (2024 and 2025) *Saving Lives, Improving Mothers' Care*. UK data.
5. NICE (2014, updated 2020) *Antenatal and postnatal mental health: clinical management and service guidance* (CG192), recommendations 1.5.1, 1.6.3 and 1.6.4.
6. Bauer, A. et al. (2014) *The costs of perinatal mental health problems*. Centre for Mental Health and LSE. UK.
7. Office for Health Improvement and Disparities (2026) *Family Nurse Partnership programme* guidance.



Dr Charlotte Ritchie is a former researcher at the University of Oxford and Deputy Director of its Centre for Research into Parenting and Children. She qualified as a social worker in 1997 and was a Senior Lecturer in Social Work at Oxford Brookes University. She is the author of *Child Protection – A Public Health Approach: Reducing the Numbers in Care*.

Child Protection: A Public Health Approach · Guide 1 · October 2026 · Not clinical guidance.