**Title:** A period prevalence study of being a parent in a secure psychiatric hospital and a description of the parents, the children and the impact of admission on parent-child contact.

**Running title:** Parenting from a secure psychiatric hospital

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**Abstract**

**Background** Most **s**ecure psychiatric hospital patients are of childbearing age, but their parental status is minimally researched.

**Aim** To describe the parent-patients in one regional secure hospital and explore post-admission child-parent contact.

**Methods** A 9-year records survey of a complete secure hospital admissions cohort.

**Results** Nearly half of the cohort of 165 patients (46%) were parents. Parent-patients were less likely than childless-patients to have diagnostic comorbidity or to have received childhood mental health care, but were more likely to have committed a homicide/life-threatening index offence with family or friend victims. Men, whether fathers or not, and childless women were unlikely ever to have harmed a child, but it was more likely than not that mother-patients had.

Records indicated minimal discussion about childlessness.

Ninety-four (60%) of the 157 children involved were under 18-years on parental admission. Adult children who had been living with the parent-patient before the parent's admission, invariably maintained contact with them afterwards, but nearly half (48%) of such under 18-year-olds lost *all* contact. The only characteristic related to such loss was the index offence victim having been a nuclear family member.

**Conclusions** As the discrepancy in whether or not parent-patients and their children continued contact with each other after the parent's admission seemed to depend mainly on the child's age and his/her resultant freedom to choose, acquisition of accurate data about affected children's perspective on visiting seems essential. Given that parent-patients had experienced relative stability in interpersonal relationships and had rarely had childhood disorders, parenting support in conjunction with treatment seems appropriate.

**A period prevalence study of being a parent in a secure psychiatric hospital and a description of the parents, the children and the impact of admission on parent-child contact.**

The United Nations Convention on the Rights of the Child (UN CRC) Article 18.1 states that parents or those with parental responsibility have the

*'primary responsibility for the upbringing and development of the child'.*

and, according to UN CRC Article 18.2, a nation's government also has a responsibility to

*'render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities'* (UNICEF, 1990).

People who are physically separated from their families by involuntarily detention in a secure psychiatric hospital pose a special problem in this respect. Such complexities are reflected in Parrott et al.'s (2015) qualitative study, which found that the combined stigma of mental illness and a criminal record rendered some parent-patients unwilling to contact their children, even though they regarded parenthood as central to their identity. Two London (England) studies (Chao and Kuti, 2009; Parrott et al., 2015) indicate that about a quarter of men and a third of women in secure hospitals are parents. A Scottish study of similar service users (Gow et al., 2010) similarly found a third of patients to be parents. These studies, however, relied on point or short-period prevalence.

Our aims were to find the prevalence of parenthood in a 9-year admissions cohort from one regional secure hospital unit, compare mental health characteristics and offending between parent-patients and childless patients and describe effects of the admission on parent-child contact.

## Methods

The study was undertaken as a service evaluation (NHS Health Research Authority, 2016) as confirmed with the local (Abertawe Bro Morgannwg University) Health Board's Research and Development Department.

### *Procedure*

We conducted a retrospective records survey of the complete cohort of admissions to the South Wales (UK) regional secure hospital unit from April 2004 until December 2012.

Information was extracted from the full multidisciplinary clinical records by medical and psychology undergraduates, who were trained to code items to over 90% agreement with each other and a senior clinician (PJT). Data, which were recorded on a checklist, anonymized and entered into an electronic database, included personal demographics, mental health and offending history, childhood trauma and parenting status. Clinical and criminological items were chosen to give some indication of duration and persistence of the problems (e.g. age of onset), of their complexity (e.g. multiple diagnoses, evidence of difficulties already apparent in childhood) and severity (e.g. suicide related behaviours, seriousness of violence). Details of index offences and offending histories varied considerably, so seriousness of violence was coded according to the Gunn and Robertson (1976) violence subscales; scores for each scale range from '0' (no violence) to '4' (danger to or loss of health or life). Childhood trauma was coded as yes/no for each of physical, sexual and/or emotional abuse.

Being a parent was defined as ever having had a biological child or stepchild. For each child, gender, age and any special needs were recorded, together with the nature, frequency and duration of parent-child contact in the year before and the year after the parent's admission. For children under 18 years (dependent children), we also collected data on legal parental responsibility over the same periods and on who was the child's primary carer.

*Planned analyses*

Categorical variables were compared between any two patient groups – for example, parent-patients and childless patients - using chi-squared ($X^2$) statistics or, if the cell size fell below 5, Fisher's exact test (FET). Where data were missing for an analysis, the sample size for that analysis is specified. For continuous variables, means were calculated for each group and compared by either an ANOVA, if the data met parametric requirements, or with a Mann-Whitney test if non parametric analysis was required. Significance was set at $p<0.05$. We used SPSS version 20 for analyses.

We explored observed differences in trajectories of parental responsibility or contact for different dependent child/parent-patient pairs, by examining the frequencies of possible contributory variables present in each pair, for example child age or gender, and parental psychiatric or violence histories. If parent-patients had more than one dependent child, and the parent appeared more than once, we allowed this, as we were interested in the possible effects of mental disorder or offending on the dyad.

**Results**

*Prevalence of parenthood*

One hundred and sixty-nine people were admitted during the 9-year period. Four patients' characteristics rendered them potentially identifiable and they were thus excluded, leaving a sample of 165 (27 women; 138 men). Nearly half (76, 46%) of the patients were parents; 17 (63%) women and 59 (43%) men. About two-thirds of the mothers (11, 65%) and fathers (41, 69%) had at least one dependent child.

*Comparison of the characteristics of the parent-patients and childless parents*

Almost all patients were White (144, 87%) and UK born (155, 94%). At the time of admission, parent-patients were older (mean 40, standard deviation [SD] 11.9; median 35, range 18-77) than childless patients (mean 33, SD 9.6; median 33, range 18-65, Mann-Whitney U = 2067, Z = -3.94, p = <0.001). Employment at the time of admission was uncommon with only 18 (11%) of 161 patients employed (11, 15% parent-patients, and 7, 8% childless-patients); one patient was a student and two were retired.

At the time of admission, 11(15%) parent-patients but no childless-patients were married. A lifetime history of marriage was more likely among parents (35, 47%) than childless-patients (3, 3% n=162, FET, p<0.001).

Table 1 about here

Table 1 shows the patients' pre-admission living arrangements. Most had been in the community, whether parents (57, 74%) or not (54, 68%). Nearly half of those in the community were the only adult in the household (52, 47%). Despite the absence of support

from another adult at home, two fathers and three mothers had one or more dependent children residing with them. Parent-patients were more likely (20, 27%) than childless patients (1, 1%) to have been living with a partner up to admission (n=156, FET, p<0.001).

Table 2 shows differences in psychiatric history between fathers and childless men and between mothers and childless women. Where sex differences were apparent, we report this in the text, otherwise comparisons in the text are simply for parent-patients and childless-patients. Most patients, regardless of parent status, had previously received psychiatric care (parents: 60, 82%; childless 80, 92%); about half of each group had had a prior secure hospital admission. Parent-patients (15, 21%) were, however, less likely than childless-patients (34, 42%) to have used psychiatric or psychological services as children ($X^2$ = 8.13, n=154, p=0.004). When fathers and mothers were analysed separately (Table 2), this difference held only for fathers ($X^2$ = 12.32, n=130, p<0.001; mothers, n=24, FET=1).

Table 2 about here

Parent-patients (49, 64%) were less likely than childless-patients (71, 80%) to have psychosis (n=165, $X^2$ = 4.84, p=0.028) or diagnostic comorbidity other than substance misuse disorders (parent-patients 19, 25%; childless-patients 37, 42%; n= 165, $X^2$ = 5.02, p=0.025). The groups were similar in their substance misuse histories (parent-patient users 39, 51%; childless patient users 55, 63%; n=164; $X^2$ =2.09, p=0.15). Again, however, there was a gender effect. Mothers were less likely to have misused substances than the childless women (n=26, FET p=0.01) or fathers (n=76, $X^2$ =4.21, p=0.04).

Over half of the patients (96, 60%, n=160) had suffered childhood abuse, irrespective of parental status. Among patients abused in childhood, however, fewer parent-patients had experienced emotional abuse (n=96, $X^2$= 4.06, p=0.04).

Parent-patients (31, 41%) were less likely than the childless-patients 63%) to have self-harmed (n=164, $X^2$ = 7.71, p=0.006) (Table 3). When men and women were examined separately, this was true only of the men (n=137, $X^2$ = 8.17, p<0.001). Acts regarded as suicidal did not significantly differ between parent-patients (45, 60%) and childless patients (43, 49%).

Parent-patients and childless-patients had similar violence histories before the index offence (Table 3), but parent-patients' index offences were more likely to have been seriously violent (n=158, $X^2$ = 5.42, p =0.012) and index victims more likely to have been related/known to them (n=131, $X^2$=5.91, p=0.015). Most patients (125, 76%) had never hurt a child but, while this was consistently unusual among men (fathers 13, 22%: childless men 15, 19%), mothers (10, 59%) were more likely to have done so than childless women (1, 10%; FET, p=0.018).

Table 3 about here

*Childless patients*

We were able to find only eight records indicating that a patient's childless status had ever been discussed with them.

*The children*

The 76 parent-patients had 157 live children between them (83 sons, 67 daughters; 7 gender data missing). Ninety-four (60%) children were under 18 years (dependent) at the time of the parental admission; 56 (36%) were adults (missing data: 7). Data were available on the health of 130 of the children. Twelve (9%) had special needs (4 with autistic spectrum disorders, 2 epilepsy, 2 born dependent on substances, 1 ADHD and Tourette's syndrome, 1 serious mental illness, 1 learning disability, and 1 was registered blind).

*Parental responsibility and primary caregivers*

In the year before admission, 11 mothers had 25 dependent children between them; eight of these mothers had had parental responsibility (four for one child each, two for two children each, two for three children each). Eight of these 14 children had had no other legal guardian, although two of the eight had already been with another relative and remained so. Of the 6 children whose mother's admission meant a change of household, two subsequently lived with their father, three with another relative and one was placed outside the family. Only one mother retained parental responsibility in the post-admission year. The 11 children of the other three mothers had already been placed elsewhere.

Four of the 6 children for whom the mother-patient had shared parental responsibility had been with both parents and were parented by father after the mother's admission; one child parented only by the mother before her admission was also subsequently cared for by the father. The sixth child had been separated from both parents before the mother's admission.

Among the 11 children for whom the mother had no parental responsibility in the pre-admission year, nine had been in their mother's primary care earlier in their lives; eight of

these nine children were adopted, being adopted or in foster care during the pre-admission year and one was with another relative. The two children who had never had their mother as a primary carer were also in the process of being adopted.

Forty-one fathers had 69 dependent children between them. A minority of fathers had had parental responsibility (11, 27%; missing data 8) for 18 children between them, in the pre-admission year, a rate significantly lower than for the mothers (8, 79%; n=52, FET p=0.011). Further, the fathers had always shared parental responsibility and none retained it after admission. For 11 of these 18 children the mother maintained responsibility after the father's admission, one child became of adult age and one had been accommodated away from both parents before and after the father's admission (5 cases unknown).

Thirty-one (72%) of the 43 dependent children not under paternal responsibility in the year before their father's admission had never had him as a primary caregiver. In the year before father's admission, mother had been the primary caregiver for most of these children (30, 70%); four (9%) had been adopted, three (7%) were with other relatives and 6 unknown.

*Parent-child contact*

Table 4 shows stability and change in parent-child contact for the 123 child-parent pairs for whom we had adequate contact information. It is perhaps unsurprising that there were missing data for only 11 (12%) of the dependent children but records were less complete for the adult children (16, 29% missing data). In most pairs (102, 83%) contact status was unchanged, but this reflected persisting separation for nearly a third of this group (37, 30%).

Nearly half (14, 48%) of the dependent children who had been living with the parent-patient prior to his or her admission lost *all* contact with the parent after his/her admission for at least a year, but no adult children who had been living with a parent did so. Considering only the 41 parent-child pairs living together in the year prior to admission, this was a very significant difference (FET = 0.003). When dependent child-parent pairs were compared with adult child-parent pairs on having had any contact in the year prior to admission but none in the year after, the difference was also significant (FET = 0.032).

Table 4 about here

We examined the 29 dependent-child/parent-patient pairs who had been living together before the parent's admission more closely to seek possible explanations for the changes. Neither dependent-child age nor gender distinguished the group in which contact was lost versus that in which it was maintained. No measured aspect of parental psychiatric history (previous hospitalization, primary diagnosis of psychosis, admission diagnosis or presence of comorbidities) differed significantly between groups, nor did seriousness of the index offence, parental lifetime violence or the parent ever having been convicted of an offence against a child. Those patients whose victim was a nuclear family member were significantly more likely to have lost contact with their child (FET=0.01).

**Discussion**

We found a higher prevalence of parenthood among secure hospital patients than previous surveys. Allowing for the number of secure forensic hospital beds in England and Wales - probably about 6,000 – these various estimates suggest that 5,000-7,000 children could be

affected at any one time by a parent's admission. We also found that parent-patients had had less troubled backgrounds or diagnostic comorbidity on admission than childless-patients, but that their index offence was more likely to have involved serious violence within their social circle. All but one parent-patient who had had parental responsibility up to admission lost this afterwards. Nearly half of the under-18-year-old children who had been living with their parent experienced complete loss of contact with him/her after admission, but all the adult children living with the parent maintained contact after the parent's admission.

*Prevalence of parent-patients*

Our finding that over 40% of male and two-thirds of female secure hospital inpatients were parents, places the prevalence of parenthood at nearly twice the rates previously reported in the UK (Chao and Kuti, 2009; Parrott et al., 2015). These studies were point prevalence surveys and, as small populations often fluctuate, documentation over the longer period of nine years probably provides a better indication of true prevalence. Regional differences are also possible. Both London studies reported more ethnic diversity than our sample. The 5-year Scottish secure psychiatric hospital study (Gow et al., 2010) might provide a closer reference sample for Wales, but parenting was not the primary focus of that investigation and may thus have been underestimated. We found no evidence of parent-patients concealing children, although this may happen among prisoners, largely because of fears that their children may be taken away (Mulready-Jones, 2011). Our finding that proportionately more women than men were parents replicates previous findings. As we had full access to the patients' social work data as well as information from all other clinical disciplines, material about family relationships was particularly rich and we found that some patients also had important and often responsible relationships with other children, such as nieces and nephews, stepsiblings and grandchildren. We had not expected the patients to have such an

extensive network of child-support roles, so had not set out to record these data systematically. Future studies should do so.

*Parental characteristics*

Our finding that parent-patients had less psychiatrically and socially disordered pre-admission histories than childless-patients suggests grounds for optimism that family interventions could improve circumstances for the children affected by their parent's admission as well as the parent themselves. There is a substantial literature on the impact of mental disorder *per se* on the likelihood and stability of marriage (Breslau et al. 2011), but it may be that patients involved with mental health services from childhood, with changing diagnoses and often several concurrent ones, particularly struggle to establish lasting intimate adult relationships. The possibly greater potential of parent-patients than childless-patients to have stable relationships has, however, to be balanced with the finding that their index offences tended to be more violent than those of the childless-patients and more likely to be directed within the family. While the latter may bring parent-patients within the scope of Andrews et al.'s (2011) risk/need/responsivity principles, which suggest that interventions are most effective with the riskiest and most engaged offenders, caution is understandable. Nevertheless, the parent's placement' in a secure hospital, with health care professionals available, is a key opportunity to work with those parents who have been recently involved in their child's care, to help the child adjust to his or her new circumstances, while maintaining immediate physical safety. It may be particularly important for a trained therapist to be available, specifically for the child, in order to develop such work, but, to date, there is little more than anecdote to guide practitioners.

*Relationship change: the relevance of child age and choice*

That older cohabiting children invariably continued contact with their parent but nearly half the dependent children did not, raises uncomfortable questions about freedom of choice among the younger children. How are the best interests of dependent children evaluated? To what extent is the view of younger children sought and taken into account? Post-admission assessment of the risks of the parent-patient to under-18 year-old children is required before contact can be responsibly authorised. The immediate post-admission phase for a person with complex problems is a time of great turmoil and it is assumed that some improvement in parental symptoms and behaviour should be achieved prior to contact, to reduce distress for the child (Adams, 2012). The child is, however, unlikely to be consulted about this. A child's distress alone has long since ceased to be an acceptable reason for barring the opposite – parents' visits to sick children (Ministry of Health, 1959). Distress is probably inevitable and questions should rather be about the least distressing alternative. Chao and Kuti (2009) reflected that when such children are denied contact with a parent, they may construct potentially frightening and fantastical impressions of that parent, but most previous research has been with children of prisoners (e.g. West-Smith, 2007). Again, it will be important to explore the views of children of secure hospital patients in a systematic way. In addition, it must be acknowledged that concerned family members may play a substantial role in keeping the child(ren) away from the patient, particularly where the family dynamic had become toxic during the period before admission, or especially if the index offence was against them. This too needs further exploration and understanding.

*Parents' childhood abusive experiences*

There is extensive evidence that childhood abuse is associated with later mental illness and/or behavioural disorders (for overviews, see chapters 7, 14, 15, 20 in Gunn and Taylor (eds.) 2014). In our secure hospital cohort, among patients who had suffered childhood abuse,

those who had experienced emotional abuse were less likely to be parents. This may indicate a particularly toxic effect of this type of abuse on future inclination or ability to have children. Qualitative analyses of in depth interviews would help to delineate this. We were concerned to find so little documented discussion with childless-patients about their childlessness and their feelings around this. Their childlessness may be relevant to how they would respond to children visiting the unit, or even for risk assessments for community visits, but it may also be an area of grief and concern to those patients, which they cannot articulate unless asked.

*Strengths and limitations*

Our survey includes the complete cohort of admissions to one regional secure unit over nine years, rather than point prevalence, and benefitted from social workers' extensive knowledge of patients' families and their detailed recording of this.

Our study was, however, confined to clinical and social work records. In particular, we lacked narrative from the children. Although a regional centre, the sample was confined to the population of South Wales and therefore may not be generalisable to dense urban areas with more ethnic diversity. Parent-patients were, on average, older than the childless patients, which may have been a confounding factor for some analyses. The small number of women in the survey may have precluded detection of features unique to mothers or childless women.

We only examined post-admission parent-child contact for 12 months. Although this is a long time for a child, contact may have been subsequently reinstated. There were gaps in the data, particularly in relation to the adult children and to the frequency and duration of contact, which may have biased the findings. We also lacked data on the *quality* of parent-child contact when it occurred.

## Conclusions

An issue which affects half the patients in a service – and their children – is worthy of more research attention than it currently attracts. Although many of the parent-child relationships among the patients we studied had already been disrupted, many were broken by events leading to the index offence coupled with the admission itself. Children who had previously been living with the parent-patient and who were able to choose whether to maintain contact with that parent on grounds of being over age 18 years invariably did so. Children in the same position but under 18 years did not have that free choice and half of them lost all contact. Indicators are that the parent-patients tended to have more stable lives prior to admission, which may provide grounds for optimism with family therapy. The index offence of parents, however, tended to be more violent and more often directed within the family, so a period of detailed evaluation of needs, taking the views of all parties involved, is essential.

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Table 1: Patients' living arrangements immediately prior to their admission

| Patient living arrangements at onset of current detention or index offence | Fathers | | Childless men | | Total (men) | | Mothers | | Childless women | | Total (women) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Living alone | 14 | 25 | 29 | 40 | 43 | 33 | 2 | 12 | 2 | 25 | 4 | 16 |
| Living with one or more dependent aged child only | 2 | 4 | 0 | 0 | 2 | 2 | 3 | 18 | 0 | 0 | 3 | 12 |
| Living with one or more adult aged child only | 1 | 2 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Living with children of adult age and of dependent age | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 12 | 0 | 0 | 2 | 8 |
| Living with a partner | 17 | 30 | 1 | 1 | 18 | 14 | 3 | 18 | 0 | 0 | 3 | 12 |
| Living with other(s) in domestic accommodation | 10 | 18 | 19 | 26 | 29 | 22 | 3 | 18 | 3 | 38 | 6 | 24 |
| Living with others in institutional accommodation[b] | 13 | 23 | 23 | 32 | 36 | 28 | 4 | 24 | 3 | 38 | 7 | 28 |
| Total with/without children (%) | 57 | 102[a] | 72 | 100 | 129 | 100 | 17 | 102[a] | 8 | 101[a] | 25 | 100 |

[a] total is not 100 due to rounding
[b] includes hostel accommodation

Table 2: Patients' psychiatric history

| Characteristic | Fathers | | Childless men | | Total | | Mothers | | Childless women | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | (%) | N | % | N | % |
| Previous psychiatric treatment in adulthood | | | | | | | | | | | | |
| None | 9 | 16 | 7 | 9 | 16 | 12 | 4 | 27 | 0 | 0 | 4 | 16 |
| Outpatient only | 4 | 7 | 6 | 8 | 10 | 7 | 0 | 0 | 1 | 10 | 1 | 4 |
| General inpatient | 17 | 29 | 23 | 30 | 40 | 30 | 5 | 33 | 2 | 20 | 7 | 28 |
| Medium or high security admission | 28 | 48 | 41 | 53 | 69 | 51 | 6 | 40 | 7 | 70 | 13 | 52 |
| Totals | 58 | 100 | 77 | 100 | 135 | 100 | 15 | 100 | 10 | 100 | 25 | 100 |
| Child psychiatrist/ psychologist input | 8 | 14 | 31 | 42 | 39 | 30 | 7 | 44 | 3 | 38 | 10 | 42 |
| No child psychiatrist/psychologist input | 49 | 86 | 42 | 58 | 91 | 70 | 9 | 56 | 5 | 63 | 14 | 58 |
| Totals | 57 | 100 | 73 | 100 | 130 | 100 | 16 | 100 | 8 | 101[d] | 24 | 100 |

| Psychiatric diagnoses | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Psychosis only | 28 | 47 | 37 | 47 | 65 | 47 | 6 | 35 | 4 | 40 | 10 | 37 |
| Personality disorder only | 3 | 5 | 5 | 6 | 8 | 6 | 1 | 6 | 1 | 10 | 2 | 7 |
| Mood disorder only | 11 | 19 | 3 | 4 | 14 | 10 | 3 | 18 | 0 | 0 | 3 | 11 |
| Psychotic illness and personality disorder | 9 | 15 | 18 | 23 | 27 | 20 | 4 | 24 | 2 | 20 | 6 | 22 |
| Psychotic illness and mood disorder | 1 | 2 | 4 | 5 | 5 | 4 | 0 | 0 | 0 | 0 | 0 | 0 |
| Personality and mood disorders | 1 | 2 | 5 | 6 | 6 | 4 | 3 | 18 | 2 | 20 | 5 | 19 |
| Psychotic illness, personality and mood disorders | 1 | 2 | 5 | 6 | 6 | 4 | 0 | 0 | 1 | 10 | 1 | 4 |
| Totals | 54 | 92[a] | 77 | 97 [b] | 131 | 95 [c] | 17 | 100 | 10 | 100 | 27 | 100 |
| Co-morbid substance misuse | 34 | 58 | 47 | 59 | 81 | 59 | 5 | 29 | 8 | 89 | 13 | 50 |
| No co-morbid substance misuse | 25 | 42 | 32 | 41 | 57 | 41 | 12 | 71 | 1 | 11 | 13 | 50 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Totals | 59 | 100 | 79 | 100 | 138 | 100 | 17 | 100 | 9 | 100 | 26 | 100 |

[a] Does not equal 100 as 4 (7%) had still under assessment and 1 (1%) had only substance use disorder; percentage 101% due to rounding.

[b] Does not equal 100 as 1 (1%) still under assessment and 1 (1%) only substance use disorder; percentage 99% due to rounding.

[c] Does not equal 100 as 5 (4%) still under assessment and 2 (1%) only substance use disorder.

[d] percentage does not equal 100 due to rounding

Table 3 offending and risk of harm histories

| Characteristic | Fathers | | Childless men | | Total | | Mothers | | Childless women | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Risk to Self | | | | | | | | | | | | |
| Previous/current self-harm | 21 | 36 | 47 | 60 | 68 | 50 | 10 | 59 | 8 | 80 | 18 | 67 |
| No previous/current self-harm | 38 | 64 | 31 | 40 | 69 | 50 | 7 | 41 | 2 | 20 | 9 | 33 |
| Totals | 59 | 100 | 78 | 100 | 137 | 100 | 17 | 100 | 10 | 100 | 27 | 100 |
| Past suicidal acts | 34 | 59 | 36 | 47 | 70 | 52 | 11 | 65 | 7 | 70 | 18 | 67 |
| No past suicidal acts | 24 | 41 | 41 | 53 | 65 | 48 | 6 | 35 | 3 | 30 | 9 | 33 |
| Totals | 58 | 100 | 77 | 100 | 135 | 100 | 17 | 100 | 10 | 100 | 27 | 100 |
| Risk to others | | | | | | | | | | | | |
| Aged =/- 17 at 1st conviction | 24 | 44 | 39 | 53 | 63 | 50 | 4 | 27 | 3 | 33 | 7 | 29 |
| Aged 18+ at 1st conviction | 28 | 52 | 32 | 44 | 60 | 47 | 9 | 60 | 2 | 22 | 11 | 46 |
| No convictions | 2 | 4 | 2 | 3 | 4 | 3 | 2 | 13 | 4 | 44 | 6 | 25 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Totals | 54 | 100 | 73 | 100 | 127 | 100 | 15 | 100 | 9 | 99[a] | 24 | 100 |
| No prior incidents or offences against children | 46 | 78 | 63 | 81 | 109 | 80 | 7 | 41 | 9 | 90 | 16 | 59 |
| 1+ prior offence against children | 9 | 15 | 9 | 12 | 18 | 13 | 5 | 29 | 0 | 0 | 5 | 19 |
| Incident against children but no conviction/charge | 4 | 7 | 6 | 8 | 10 | 7 | 5 | 29 | 1 | 10 | 6 | 22 |
| Totals | 59 | 100 | 78 | 101[a] | 137 | 100 | 17 | 99[a] | 10 | 100 | 27 | 100 |
| Life critical index offence violence[b] | 33 | 57 | 31 | 40 | 64 | 47 | 09 | 60 | 2 | 25 | 11 | 48 |
| Low to moderate index offence violence[c] | 25 | 43 | 46 | 60 | 71 | 53 | 6 | 40 | 6 | 75 | 12 | 52 |
| Totals | 58 | 100 | 77 | 100 | 135 | 100 | 15 | 100 | 8 | 100 | 23 | 100 |
| Highest rest of lifetime violence – life critical[b] | 40 | 68 | 19 | 24 | 59 | 47 | 4 | 25 | 2 | 20 | 6 | 23 |
| Low to moderate rest of lifetime violence[c] | 19 | 32 | 59 | 76 | 68 | 54 | 12 | 75 | 8 | 80 | 20 | 77 |
| Totals | 59 | 100 | 78 | 100 | 127 | 101[a] | 16 | 100 | 10 | 100 | 26 | 100 |

[a] Total does not equal 100 due to rounding

[b] GR Gunn Robertson Score of 4

[c] GR Gunn Robertson Score of 0-3

Table 4: Parent and child contact before and after admission to one secure forensic psychiatric hospital

| Contact status | | | Parent-child pairs involving a child aged 17 years or under N=83 | | Parent-child pairs involving a child of 18 years or over N=40 | | Line totals | | Overall figures for contact status (gained/unchanged/ lost) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | N | % | N | % | N | % | N | % |
| Contact gained/reinstated | | | 1 | 1 | 1 | 3 | 2 | 2 | 2 | 2 |
| Contact status unchanged | No contact before or after admission | | 26 | 31 | 11 | 28 | 37 | 30 | 102 | 83 |
| | Maintained contact | Some contact before and after admission | 24 | 29 | 14 | 35 | 38 | 31 | | |
| | | Living together to some contact | 15 | 18 | 12 | 30 | 27 | 22 | | |
| Contact lost | Living together to no contact at all | | 14 | 17 | 0 | 0 | 14 | 11 | 19 | 15 |
| | Some contact to no contact at all | | 3 | 4 | 2 | 5 | 5 | 4 | | |
| Column totals | | | 83 | 100 | 40 | 101[a] | 123 | 100 | 123 | 100 |

[a] Does not equal 100 due to rounding