

Social workers' perspectives on people parenting while patients in a secure hospital

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Abstract

Up to half of the approximately 10,000 people resident in a UK secure hospital are parents. There are well established child safeguarding policies, but no model for social work support of parenting. Our study aimed to investigate social workers' experience of secure hospital patients as parents and develop a testable model of good practice. Each social worker in one medium security hospital unit was invited to an individual semi-structured interview about his/her perspectives on patients parenting from the unit.

Six social workers participated; all had experience there of patients with and without children. A core concern of 'artificiality' best encompassed the emergent themes covering the nature of the setting, poor mental health with sometimes delusional family life, difficult family dynamics, weakened parenting skills and patient-parent wish for communication inhibited by sense of stigma. Resolution towards 'naturalness', with improved mental health, communication skills, family dynamics and reducing confinement was partially achieved during the inpatient stay, much of the change actively facilitated by clinical interventions.

While child safeguarding during a parent's secure hospital stay is vital, longer-term psychosocial repair of relationships seems feasible. An actively restorative model envisaged by these social workers offers a testable progression towards responsible parenting.

Keywords:

Child welfare; Parenting; Social work and health; Mental Health; Grounded theory; Child visiting

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Introduction

Both parents are important even if one is no longer in the family home. Any sense of continuity no matter how tenuous is to be nurtured (Department of Health, 1990).

Many countries now provide secure hospital services. Wherever this is so, a substantial minority of patients there are likely to have children. In England alone it is estimated that there are nearly 8,000 secure hospital beds, nearly half of them in medium security (NHS England, 2013). Scotland also has a full range of high, medium and low security beds and Wales and Northern Ireland have medium and low security hospital facilities. These are for people who are at a sustained high risk of harming others rather than being simply acutely unwell, and many have already been convicted of a serious criminal offence. Nearly half of patients there stay for more than five years (Rutherford & Duggan, 2008); very few stay less than two years. The average age of inpatients is between 20 and 40 years – peak years for child bearing and rearing. Between one third and one half of people in UK secure hospitals have children (Chao & Kuti, 2009; Gow et al, 2010; Parrott, MacInnes & Parrott, 2015; Argent et al., 2018). At a conservative estimate, therefore, at any one time there are over 1,300 patients in England and Wales who are parents but separated from their child(ren) because of living in a secure hospital. In addition, some patients may have married a partner who already has children who were living with them at least some of the time prior to admission and for whom they were expected to deliver care and some control; others may have taken on similar, effectively parenting, roles for younger siblings.

Healthcare professionals have been criticised for not considering sufficiently the parenting roles of patients with mental disorders (Howard, 2000). Montoliu Tamarit and Lau (1999), after reviewing clinical files of women in acute mental health inpatient units, found that childcare roles are generally overlooked; in over 70% of cases where children had been identified, there was no further mention of the child in the clinical record, so it was not clear even whether the hospitalised parent and child were seeing each other let alone whether this parent had any active role in the child's care or decisions about who should deliver that care in his or her absence. Such children have been described as an "invisible" population (Cowling, 1999), and hospitals have sometimes been criticised for focusing on the individual rather than the family (O'Brien et al.,

2011). Further, it seems that the patients themselves are likely to want help in this area. Chao and Kuti (2009), for example, reported that while most patients across two medium secure hospitals were not offered staff support with parenting or child visits, most of those who were offered support accepted it. Supporting a patient's role as a parent, where possible, is likely to provide that parent with a sense of agency, hope, self-determination, purpose and potentiality (Nicholson, 2010; Onken et al., 2007). It is likely also to help the children, but the child's voice in this matter is even more rarely documented. In a review of reviews of child outcomes when a parent has a similar range of disorders to those of parents in a secure hospital unit - major mental illness or personality disorder – we identified seven good quality reviews which between them included nearly 300 papers, but all focussed on adverse childhood outcomes; child wishes, positive child outcomes and contact arrangements or assessments for them did not feature (Argent et al, accepted for publication). In secure hospital units any parent carries the added burdens of having committed a very serious offence or offending act and being subject to indeterminate detention there.

It may seem surprising, therefore, that there is no clarity on who is responsible for supporting the parent-child relationship while the parent is detained in a psychiatric hospital. A survey of community and non-secure but inpatient mental health professionals in one London borough found that most staff did not consider it to be their responsibility to support patients' children (Slack & Webber, 2008) and yet the *Protecting Vulnerable Children Inquiry* stressed the importance of adult services recognising and responding to children's needs (Cummins et al., 2011). Slack and Webber found that the social work team were the least likely to consider supporting the patients' children as 'not their role' compared to all other health professionals. In a UK secure forensic mental health unit, social workers were, indeed, the most likely staff to provide patients with support in relation to contact with or care for their children (Chao & Kuti, 2009).

Perhaps this is unsurprising, given a key aspect of the social worker role is to "promote social inclusion by helping people ... to maintain positive relationships and family contact" (Skills for Care, 2014). It is not clear, however, how social workers perceive their own roles in this area. Further, they hold a unique position in clinical teams in a secure hospital in England and Wales.

Although regarded from a team perspective as integral to it, social workers retain the independence of being employed by the local government authority rather than the health authority. Further, in respect of the legislation under which most patients are detained in England – the Mental Health Act 1983/2007, they are expressly charged with seeking less restrictive alternatives to hospital and, where there are none, evidencing why continuing detention in hospital is appropriate. Routinely for detained patients, thus, they take as wide a perspective as possible of family and other social arrangements, and supply such information for multidisciplinary reviews. We therefore considered that social worker perspectives on childcare by such patients would be crucial in developing testable models of service for such people and their children.

Our aims, therefore, were to investigate social work staff experiences of patients' parenting and parenting needs while detained in one medium secure unit and develop a testable model of parenting support for them during secure hospital residence.

Method

Ethics

Ethical approval was obtained from NISCHR Research Ethics Service, Dyfed Powys Research Ethics Committee (12/WA/0087).

Research design

We used a grounded theory approach (Glaser and Strauss, 1967). This was chosen because we wanted to make no *a priori* assumptions about how social workers think and act in relations to the possibility that patients detained in a medium secure hospital unit have children. This approach allows a substantive theory of behaviour to emerge from unforced narrative accounts.

Social worker recruitment

There was no pre-determination of sample size because in a grounded theory approach the sample size is determined by data saturation – the point at which no new categories of information are emerging from the narrative data.

The nature of the sample was defined by the requirement that participants should be social workers and have knowledge and practical experience of working with people resident in a secure hospital unit who had children. The unit provides all medium security hospital services for one region with a population of about 2 million and from a mix of urban and rural communities. Candidates for the sample were selected on the basis of their capacity for providing data on different aspects of the research question. Thus, as the task was to develop a substantive theory of the main concerns of social workers about parent-child interactions while the parent is resident in a secure hospital, there was a requirement that the candidates for the sample had knowledge of the hospitals, their residents, the full range of other relevant services and child protection and welfare issues. All social workers at the specialist medium secure forensic unit were invited to take part in the study. Consideration was given to extending the study to other units in the event that new data categories were still emerging after interviewing this group

Details of a cohort of patients resident in the unit at any time during a nine year period, and thus indicative of the clinical experience of the social workers, are given elsewhere (Argent et al., 2018), but, in brief, were typical of secure hospital patients in the UK, with a ratio of about 4 men to five women, approaching 90% of them having had previous psychiatric treatment, about two-thirds a psychotic illness, few with personality disorder and about half having comorbid substance misuse disorders. The age range was also broadly similar to that in other units, but it was noted that parent-patients as a group were significantly older (mean 40, standard deviation [SD] 11.9 years) than the childless parents (mean 33, SD 9.6 years). The patients had often been struggling socially. Although most had been in the community prior to admission, few had been in paid employment and about half of those in the community were the only adult in the household, whether or not there was also a child.

The interviews

The interviews were all conducted by a medical undergraduate (AA), trained in the open interviewing technique, who did not know any of the social workers personally and had never been in a clinical relationship with them. Each interview was recorded in contemporaneous notes and then written up in full immediately afterwards. There was no audio-recording of the interviews, often regarded by interviewees as intrusive.

The semi-structured interview had the following open questions: do you have any general concerns about patients as parents on the unit? Please can you tell me a bit about how you think parenting needs are currently met on the unit? Only very general prompts were allowed during this stage of the interview, such as 'tell me a bit more about that', or 'I am sorry, I didn't quite understand that, could you try and put it in a different way', as appropriate. These very broad questions were chosen as unlikely to introduce any interviewer bias into the responses. Once it was clear that a participant had said all s/he wanted to say, if disadvantages and benefits of the setting had not already been described, then the participant was asked: Please can you describe up to three things which you think are currently good about the arrangements at the clinic? Please can you describe up to three things which you think are not so good about the arrangements at the clinic? Do you have ideas about how things could be improved in this respect?

Data analysis

The transcripts were then analysed by three of us (AA, ZB and PJT), each blind to the ratings of the others during extraction of first level categories. Each transcript was analysed line-by-line, using a process called open coding, as required by grounded theory method. Key words and/or phrases were used to name categories, each referring to a different idea emerging from the narratives. Notes were kept about each category and any changes in each coding session. Categories were discussed only after we had completed the independent analyses. We agreed on 32 of these 35 first level categories, to the extent of having independently chosen almost identical descriptor words for these; titles for the remaining categories were resolved between us during discussion, for example one of us had titled a category 'poor family dynamics' and the others had named it 'bad relationships problems', and it was agreed to retain only the former

nomenclature. Categories were not mutually exclusive, so one category could be illustrated by many indicators or incidents in the data. Each indicator was compared to others, and to new ones as they emerged, using the process of constant comparative analysis. During this process, important categories were collapsed into more general categories, and subsequent texts coded using these. Text excerpts were gathered under each category to show the range of variation within each and where any new category not previously accounted for emerged. All categories came directly from the data. The decisive criterion for the core category was that it best encompassed and explained the area of interest.

Results

Characteristics of the sample

Three male and three female social workers were interviewed; it proved impossible to agree a scheduled time during the study period with two additional social workers. The participant social workers were aged from about 25 to just over 60 years and all white, UK born. In this South Wales unit, there is little ethnic diversity among the patients; well over 90% of patients are British and nearly 90% white (Argent et al., 2018). The social workers' experience ranged from being newly qualified to having nearly 40 years' experience in social work. The average length of service on this unit was 4.32 years (standard deviation [SD] 4.38). In narrative extracts below, we refer to the three men variously as David, Simon and Stephen and the women as Emma, Gemma and Anna so that transcripts may be distinguished. These are not, however, their real names in order to protect identities. As described above, there were many more male than female patients, so the most common experience was of working with men, but each social worker had had responsibility for female patients at some time in their period of service.

No new categories of data emerged in the fifth or sixth interviews, so the data could be regarded as saturated and the sample complete after five interviews, although all interviews were, in fact, used in the analysis.

Table 1 shows the first level categories of concern which were identified in the narratives, with the supporting data, that is quotations from the narratives. The quotations presented are also representative of the data in that, although the social workers occasionally referred to a specific case as illustrative of a particular issue, they were more likely to talk in general terms.

(Table 1 about here)

Social worker perspectives on parenting in a secure hospital

The core concern

The core category, or concern, was of 'artificiality', recurring and resonating in the circumstances of living or working in a secure unit. This most straightforwardly referred to the nature of the unit as a place securing the patients away from the wider community – and sometimes each other if interpersonal tensions ran high. It also encapsulated how staff themselves sometimes found their relationships with other professionals in the community. Patients' legal, mental health and social characteristics were seen as having rendered their outside life as artificial in its distance from the ordinary.

The secure unit was described as:

Not the best place for children to come to – Stephen.

It was observed that a requirement for trained staff to sit in on any child visits, as a safeguarding measure, could be distracting and seem 'unnatural' to parents and/or children so that:

Often contact can be stunted, stilted and not normal - Anna.

Even the artificial circumstances of such visits, however, were acknowledged as hinting at the prospect of a new normality, perhaps allowing all parties to feel safe again and/or to understand what is happening to them:

It encourages safety - Anna.

It has a clear paper trail as evidence of what has been done and why – Anna.

Social workers also saw themselves as being in a service structure which was not invariably logical, and thus, to an extent, also artificial. The bureaucracy, while perhaps safeguarding the staff, was, for example abnormally time consuming:

Some processes can be cumbersome and unwieldy – as there are 9 forms which needed to be completed in order to grant visits - David.

Their regional role as affiliates of the secure forensic mental health service left them feeling cut off from the kind of easy knowledge and relationships with local social services that generally facilitate service delivery in complex cases in more ordinary circumstances. There was even a sense that these put them in the strange situation of being professionally mistrusted:

A lot of services don't know how to react to these types of patients and don't look to us to guide that. Often they are dubious about our assessment of risk - Emma.

The patient centred categories fitted with the concept, although always with the inherent tension that what could seem artificial to the social workers and in the context of parenting had become a kind of perverse normality for the patients, and their children. It seems 'artificial' for children to grow up with a parent who has committed a serious offence, often within the family, and who has a serious, often treatment resistant mental illness which may even create delusional relationships. Of one man, for example:

The team can't find any evidence of a daughter or a mother and so think this may be part of his delusions – Emma.

Another aspect was an almost constant state of conflict or competition between the rights, needs and wishes of the patients and their families, and sometimes more specifically the children.

There is a conflict Especially if the children don't wish to have contact with their parents – Gemma.

Determining rights and wishes of the patient without letting visits or the family have negative impact is hard – Simon.

Social workers felt this directly when they found themselves caught between distinctly demarcated services – one set explicitly for the children and one set (theirs) they thought seen by the others as being for the patient-parent. At the same time, this had generally gone on for so long that the parent child relationship has become both artificial and 'perversely normal'.

A model of resolution

Resolution of the artificiality-perverse normality concern was envisaged as moving towards true, healthy normality. True normality as a concept here is more weakly defined from the data than the core category, because this group of social workers was working with patients who were still hospitalised, albeit many of them making good progress, and so moving towards a more ordinary existence rather than having attained it. Thus, aspects of normality attainable while parenting as an inpatient included improvements in or stability of mental health, ability to recognise that in certain circumstances they could pose risk to others, to want to manage this risk and to be able to do so, sufficient stability in these conditions to be trusted with leave outside the hospital and being well enough for individualised focus on parenting to be feasible as a clinically significant part of the treatment plan. Although there was approval of the family room, a space within the secure unit but away from the main patient area and provided with easy chairs, toys and a television:

The family-visiting suite is a nice environment – Gemma.

child visits there had to be observed, and only being outside the unit with the children was regarded as truly 'natural'. A continuum was envisaged between the core concern of artificiality/perverse normality and true normality. As shown in figure 1, movement could happen in either direction, but generally towards true normality by an active process of interventions. Initially, the social workers saw themselves as 'paving the

way', with their own honesty and openness with patients and others, first beginning to engage the patients, then getting themselves in a position to manage both the general mistrust of services and person specific mistrust of the patients in patients' families. They would have a task too to explain and promote the unit's policies and procedures for safeguarding and establish credibility among other professionals essential to any re-establishment of active parenting. Others in the clinical team would focus in symptom reduction, and, with some evidence of primary mental disorder treatment responsiveness, practical discussions with patients about their wishes in respect of their child(ren) could start seriously. Once symptoms had resolved, or at least become substantially less intrusive, psychosocial interventions specific to parenting could be considered, including family therapy – and so paving the way would merge into treatment and rehabilitation. While clinical team activities generally and social worker activities specifically fostered movement in this positive direction, these social workers observed that their activities could leave the patients stuck in artificial relationships with their children or push them back in this direction even though the fact that a patient wanted to explore contact had seemed positive and normalising. In the process of that exploration, reasons for not progressing, at least at that stage, might be uncovered and/or dynamics between the patient and others found to be too toxic or risky to continue at that time. An example was given of one patient's partner:

[the mother] has come round to his having mental health problems, she is almost in danger of minimising it too much – Anna.

And of another:

He's basically a mirror image of his Dad who was sexually and physically abused and out into care and then had drug and alcohol problems - Anna.

Nevertheless, the sense still that movement along the continuum could be truly bidirectional was often retained:

Not to say that it wouldn't happen in the future, but at present we would have grave concerns - David.

(Figure 1 about here)

Although much of this process and movement could be managed, figure 1 also shows that the social workers were aware of the power of factors external to their work and to the patient in influencing the direction of movement. Most immediately, the attitude of the co-parent or guardian was critical, positive co-parenting ensuring more rapid progress towards normality, but figures hostile to the idea of contact or ambivalent about it influencing movement along the continuum towards true normality and artificiality respectively.

*She didn't understand about his mental health and, in a way, ostracised his children from him
– Anna.*

Dysfunctional extended families were not uncommon for these patients, and maintenance of 'artificiality' as much about protecting the child (as well as the patient) from the patient's relatives as from the patient him- or her-self. Sometimes, simpler, practical issues proved to be the limiting steps, for example the distance between the child's current home and the unit; sometimes the parent had to be helped to adjust to the reality of a child having already been adopted away, and contact impossible at least until the child's 18th birthday.

Wider community issues could also intrude, whether because, in general stigma, attaches to mental illness and offending or because a particular offence had created widespread publicity for a particular individual.

Discussion

This model for understanding work with secure hospital patients offers a framework for meeting the needs of parents and their children in safety even when the patient has been removed from home by a combination of mental disorder and offending behaviour which, on admission, is thought to put others at

risk of serious harm. It accepts that both the circumstances and the nature of the environment are artificial in all sorts of ways, but that active processes can be set in train to resolve this towards a more conventional normality in many cases, or acceptance of a child's absence in a few. The model is important because parent-child relationships when the parent is in a secure hospital have received very little research attention. It emerges from open reflections of social workers with as much experience as it is possible to have in this field, and fulfils the requirements set out by Glaser and Strauss (1967) – it explains that experience, is easily understandable and while being general enough to be applicable to a variety of specific patient-parent and child situations indicates where staff and patients together may begin to exert some control for the better over their situations. Further, the model provides a framework for evaluation of the complex interventions necessary.

By definition, some separation is inevitable, as the child(ren) continue to live in the wider community but the parent is confined to a secure building without the possibility of egress for social purposes for a period which is determined by pace of improvement in health and reduction in risks. It is thus initially difficult to estimate. Among those with real power in the matter – either those who have legal care and control of under 18-year-olds or any adult children or clinical staff responsible for the patient – it seems that opinion about any contact may be divided. Further, earlier qualitative work with patients showed that the patients themselves feel distanced from their children by a sense of shame in their circumstances, and how reliant they are on professional staff to manage this complicated situation (Parrott et al., 2015). This latter work, however, also noted that lack of contact is more sustained during a stay at a secure hospital compared to prison. In secure hospitals, in relation to children under 18 years-old, this may not happen at all in the first year of admission (Argent et al., 2018). Our research with these social workers, routinely inquiring about existence of children and generally positive about making links for the parent, offers some explanation for the length of time which may elapse between admission and contact, although at no point were the social workers asked to explain or to justify their actions. Their perception is that the artificiality of the parent's personal situation may have to be reduced before working towards restoration of a natural relationship at least with a child of 17 or under. Even older family members are, though, subject to some limited inquiry before being allowed

to visit. Prisoners may also be unwell and/or at risk of being violent too, and prisons may hardly be described as 'normal' environments either, and yet in prisons, families are advised that there may be a one or two day delay before they can visit a prisoner (Action for Prisoners' Families, 2013). The model provides for conceptualising the kind of artificiality construed as interfering with contact and, in turn, perhaps for breaking down that barrier more quickly and effectively while safeguarding the children.

The extent and complexity of the artificiality of the circumstances

It is acknowledged that, whatever a parent's wishes, the child's genuine best interests are paramount. It is apparent from this model, however, that the extreme and complex nature of the 'artificiality' of the child-parent circumstances may not be fully appreciated. The parent role is 'artificial' as the parent is ill and has acted dangerously, but so also is a secure hospital environment but, perhaps most pertinently, the service structures. Partly to ensure that the child's best interests are truly considered, the parent-patient's social worker does not relate directly to the child, unless perhaps the child is already adult. Often but not invariably the child has his or her own social worker. These work in hard pressed teams, generally with little experience of secure unit patients, and so a system of good intent often creates barriers to open exploration of all needs and effective communication about them. This model should encourage all social workers involved in such situations to look at the full range of needs across service boundaries. Recognition in the model that children's social services may be 'quite prescriptive' raises questions about joint training or perhaps simply the 'prescription' including required liaison between the services over such patients and their children.

First, of course, the child's physical safety must be secured. This will be happening away from the secure services initially, but then the unit, with its special visiting facility and visiting policies offer some basic structure is ready to offer safe space for renewed contact. Although well away from other patients, the parent-patient and child/children would be observed by staff and these social workers were concerned that the artificiality of this arrangement compared with, say, going out to meet the children in a café away from the unit might outweigh any benefits. Very little is known about any kind of psychiatric hospital visiting by children. Foster et al. (2018) and O'Brien et al. (2011) focussed on short-term admissions. Only Sivec et al.

(2008) appear to have gone directly to the children for information about the experience. The secure unit-based social workers do not generally have the advantage at this stage of having spoken to the children and knowing the children's wishes. This should be known and could be researched.

With understandable emphasis on physical safety, the longer-term emotional needs of the children arising from the artificial distancing from the parent may be under-explored. It has been suggested that parent-child separation due to detention or incarceration affects the security of attachment in the relationship (Murray & Murray, 2010). An insecure attachment may develop as it is a stressful time for the child and their parent is less available. This not only affects the parent-child relationship but may also impact on the child's ability to form future positive relationships (Nolte, 2013). Shlafer and Poehlmann (2010) found that children were less likely to feel alienated and angry towards their incarcerated parent if they had had contact with their parent compared to those children who had not. Furthermore, contact between incarcerated fathers and their child while in prison has been found to be a predictor of prisoners' attachment and contact with their child after release (La Vigne, Naser, Brooks & Castro, 2005). All this work, however, is with prisoners and their children. There is almost nothing similar about children when parents are separated by compulsory hospitalisation, whether or not they are also offenders.

Individualised planning and relevant therapies

The experienced social workers in this study acknowledged the importance of initial, basic safeguarding of any under 18-year-old children generally meaning separation, but also beginning an open and honest conversation with patients who have children about the form their future relationships may take. The model incorporates this as an important step in 'paving the way' towards normality which social workers are likely to have to initiate. We have already noted some evidence that many patients feel too much shame to initiate the process of reducing the artificiality in their relationship with their child imposed by their circumstances (Parrott et al., 2015). These social workers also, however, expressed concerns about patients

lacking life and parenting skills. This fits with previous research which has found that people with severe mental illness are in need of support with their parenting skills over and above what they receive for their own needs (Oyserman et al., 2000). The social work team in this study felt that some of their patients – and the patients’ children – could, at the right time, benefit from parenting classes and/or family therapy at the hospital. While there is evidence of availability of family therapy within medium secure hospital units, it is provided in less than half units surveyed (Davies et al, 2014). Specific parenting work might also be useful, but there is nothing in the current literature in respect of parenting training for hospitalised patients. Loper and Tuerl (2006) reviewed parenting classes in prisons and found that some were able to improve the parents’ self-esteem and attitudes towards parenting. Mentally ill parents and their child who attended family and individual sessions with an adult *community* mental health service reported that they appreciated the sessions and the opportunity to express how they were feeling (Cowling & Garrett, 2012).

Family therapy with improvement of parenting skills as at least one aim, may allow the parent-child relationship to become less artificial, not least by embedding it in better relationships with the wider family. Goodyear et al. (2015), however, found that, despite supportive policies, family interventions are not common in practice, instead mental health teams persist only in focus on the individual and their mental health. Nurses working in secure hospitals and outpatient settings have reported that the lack of resources and resistance to family work in multi-disciplinary team act as barriers to a family centred care approach in psychiatric practice (Korhonen, Vehvilainen-Julkunen & Pietila, 2007).

Poor education was also recognised as a barrier to maintaining contact for some patients, for example when trying to write letters to their child. Education classes may support the parent to contact their child while they are living apart. Letter writing has been acknowledged as an important and flexible way of maintain parent-child contact. Loper et al. (2009) found that writing letters to children was associated with less parental stress in incarcerated parents. Psychiatric inpatients have reported to value keeping in touch with their children through letters, birthday cards, emails and phone calls (Parrott et al., 2015).

Limitations

This study was limited to a small group of social workers from one regional secure hospital, with a mixed urban-rural catchment area. Although some parts of this are regarded as being very economically deprived, the population is rather stable, and so there is perhaps a better chance of staff from various services knowing each other than in dense urban areas. In addition, there was little ethnic diversity in this sample. A qualitative study in an under-researched area is necessarily just the first step in developing appropriate knowledge and skills. Similar research in a unit with a very different patient group and perhaps social worker profile would begin to indicate the extent to which the model may need to be varied.

Future directions

The model of work which emerged from these interviews with experienced social workers could be evaluated in a new study to specify stages along the continuum and explore likely time scales for attaining each, with a view to more explicit guidance for clinical teams working in this difficult area.

Qualitative and quantitative evaluation of outcomes at each step through paving the way and more active treatments should follow.

Then too, as Mayberry and Reupert (2009) emphasised, it will be important to explore the views of the children involved.

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