Mental illness and parenthood: being a parent in secure psychiatric care

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ABSTRACT

Background *Research into parenting and mental illness seldom includes forensic mental health service users, despite its relevance to therapeutic, family work and risk management.*

Aims *This study aimed to understand the experiences of parents and the variety of parenting roles maintained during admission to a secure forensic hospital.*

Methods *Narrative interviews with 18 parents (eight mothers and 10 fathers) at an English medium security hospital were analysed thematically, using the framework approach. The proportion of patients who are parents and their contact patterns with their children were estimated from records.*

Results *About a quarter of men and 38% of women were parents. Parenthood was of central importance to their emotional life, spanning experiences of loss, shame and failed expectations, joy, responsibility and hope. Fewer fathers maintained contact with their children than mothers yet fatherhood remained a vital aspect of men's identities, with impact on their self-esteem. Parenting during lengthy admissions – while constrained and dependent on professional support and surveillance – ranged from sending gifts and money to visits and phone calls. Offending was seen as a particularly shameful aspect of admission, contributing to distancing from the children and difficulty explaining detention to them.*

Conclusions *Such complex experiences call for multidisciplinary knowledge and skills. Provision of focused therapy, as well as appropriate visiting spaces, creative approaches to contact time and support for patients in explaining their mental illness and detention to their children are recommended. © 2015 The Authors. Criminal Behaviour and Mental Health published by John Wiley & Sons Ltd.*

Introduction

Forensic mental health services provide assessment and treatment for people with mental disorder who are charged with or convicted of a criminal offence and/or pose a serious risk to other people. About a third of forensic in-patients are parents, some retaining contact and even a caregiving role with their child(ren), (Chao and Kuti, 2009; Gow et al., 2010; Robinson and Scott, 2007; Adams, 2012; Tobin and Taylor, 1999). Research from the perspective of mothers and fathers with severe mental illness alone highlights the rewards, anxieties and demands of parenting (Nicholson et al., 1998; Diaz-Caneja and Johnson, 2004; Evenson et al., 2008) and has a range of effects on the children (Hawes and Cottell, 1999; Howard et al., 2004; Smith, 2004) but has not been extended to parents in forensic health services. Here, violent or other serious antisocial behaviour, commonly involving family members (Chao and Kuti, 2009) and substance misuse (Mullen, 2000) further complicate parent–child relationships. For some, the index crime was killing his or her own child (Friedman et al., 2005; West et al., 2009). The views and experiences of such parents are important in managing and promoting the interests of the child(ren) (Royal College of Psychiatrists, 2002, 2011). Research with women hospitalised by severe mental illness suggests that recognising their parental roles and grief over lost relationships with children should be central to recovery-orientated care (Dipple et al., 2002; Benders-Hadi et al., 2013). Male psychiatric patients' experiences of fatherhood remain almost entirely unresearched (Evenson et al., 2008; Grube, 2011), perhaps partly because they are less likely to be in contact with their children (Chao and Kuti, 2009). Given the knowledge gap about forensic mental health service users, our aim was to examine in depth their experiences of parenting.

Method

Ethical approval

Ethical approval was received from the NHS National Research Ethics Service, Guy's Research Ethics Committee (REC ref 10/H0804/12) and The London School of Hygiene & Tropical Medicine Research Ethics Committee (REC ref 5660).

Study sample and recruitment

An independent review of clinical and social work records of all in-patients in the secure hospital unit on one day in 2010 was carried out to establish their demographics, the point prevalence of parenthood and extent of contact between those parents and their children.

One male and one female admission ward, the long-term male accommodation and male and female predischarge accommodation (totalling 46 male beds and 12 female beds) were theoretically sampled, as we envisaged that relationships with children might differ by gender, treatment or rehabilitative stage. Information about the study was presented at ward community meetings, with an invitation to participate. Participants gave written, informed consent to interview and for anonymous quotations to be used in publications. Because of the small number of women, three additional mothers were recruited from subsequent admissions in 2011 in order to achieve data saturation – the point at which no new data categories or themes are emerging.

Data collection and analysis

A topic guide for narrative interviews (Riessman, 2006) on parenthood and parenting was developed in collaboration with an expert reference group of a service user and clinicians. This focused on parenting practice, identity and aspirations, and the role of illness and impact of admission to a secure hospital, the latter covering views on facilities, procedures, constraints and supports relating to the current admission. Interviews of 30–70 minutes were conducted in private by the first author, a trained qualitative researcher, recorded and transcribed. Initial nondirective prompts, such as 'tell me a bit about yourself and your interest in this study' elicited accounts of children, feelings and relevant personal relationships. Open-ended questions were then posed until both guiding topics and any unforeseen issues had been discussed.

Transcripts were analysed using the framework approach (Ritchie and Spencer, 1994; Pope et al., 2000). A detailed index of the data was created from thorough reading of the transcripts and charts created for each topic, using condensed summaries and key quotations. The authors then discussed overarching associations, for example, gendering of themes and potential explanations for the findings. 'Silences' within the data as well as positive content were considered.

Results

Prevalence and patterns of parenting

Demographic data on the total secure hospital population of 91 men and 24 women are shown in Table 1. Their median age was 34 years. They were ethnically diverse. Almost all who had been married were divorced or separated, but most had never married (71% men and 65% women). Most people had schizophrenia; half had convictions for serious interpersonal violence. Around a third of offences involved family members, a minority involved children. The longest current admission was 51 months for women (median 16.5 months) and 122 months for men (median 24 months).

Table 1: Characteristics of forensic in-patients

	Men	Women
Total, N (%)	91 (79)	24 (21)
Age (years), median (range)	34 (18–79)	34 (19–57)
Ethnicity, n/N%		
White/White British	43/91 (47)	12/24 (50)
Black/Black British	40/91 (44)	10/24 (42)
Asian/British Asian	7/91 (8)	2/24 (8)
Mixed ethnicity	1/91 (1)	0/24 (0)
Marital status n/N (%)		
Single/never married	61/86 (71)	15/23 (65)
Divorced/separated	22/86 (26)	6/23 (26)
Married (current)	3/86 (3)	1/23 (4)
Widowed	–	1/23 (4)
Primary diagnosis[a], n/N (%)		
Schizophrenia	84/91 (92)	16/24 (67)
Personality disorder	3/91 (3)	4/24 (17)
Affective disorder	2/91 (2)	2/24 (8)
Unconfirmed	2/91 (2)	2/24 (8)
Length of admission (months), median (range)	24 (1–122)	16.5 (2–51)
First admission, n/N (%)	23/91 (25)	5/24 (21)
Conviction for interpersonal violence[b], n/N (%)	53/91 (58)	11/24 (46)

[a]Co-morbidity is relatively common.
[b]Defined as an index offence for severe violence (homicide, attempted homicide, grievous bodily harm or wounding) or other violence (common assault, robbery and threatening behaviour).

Twenty-four (27%) men and nine (38%) women were parents (Table 2). On average, the men had one child (maximum of five) and women two children (maximum of three). Most had at least one child under the age of

Table 2: Parenthood among forensic in-patients: family size and contact

	Men	Women
Parents in population		
Total number of parents n/N (%)[a]	24/90 (27)	9/24 (38)
Total children	41	20
Number of children per parent and contact		
Children per parent, median (range)	1 (1–5)	2 (1–3)
Parents in contact with at least one of their children, n/N (%)	6/24 (25)	6/9 (67)
Parents of children aged below 18 years		
Parents of at least one minor child, n/N (%)	22/90 (24)	9/24 (38)
Minor children per parent, median (range)	1 (1–5)	2 (1–3)
Parents in contact with at least one minor child, n/N (%)	5/22 (23)	6/9 (67)

[a]Ninety-one male patients were present in the population. Data on parental status were missing for one individual.

18 years. Eighteen parents (eight mothers and 10 fathers) completed in-depth interviews.

Contact

Two-thirds of mothers and a quarter of fathers were in contact with their children, meeting weekly to biannually (Table 3). Mothers tended to see their children more frequently than the fathers did. Most children with contact had visited their parent at the hospital. This made parenthood visible at defined times on-site and in records. In-depth interviews showed parents relied on a range of forms of communication, including news about their children. Figure 1 maps these informal and formal channels.

Care arrangements

Children lived with their other parent, extended family members, adoptive or foster parents, with different arrangements pertaining to each sibling in some cases. Care arrangements varied by gender and influenced contact. Closed adoptions accounted for the loss of direct contact between mothers and

Table 3: Children (aged under 18 years) of forensic in-patients with contact: care arrangement, type and frequency of contact

	Fathers ($n = 5$)	Mothers ($n = 6$)
Number of children	5	8
Age of children median (range)	6 (1–9)	8 (4–12)
Type of contact		
Face-to-face contact	5/5 (100)	6/8 (75)
Other direct communication	–	2/8 (25)
Care arrangement n/N (%)		
Other parent	5/5 (100)	4/8 (50)
Family care/family adoption	–	3/8 (38)
Foster care	–	1/8 (12)
Frequency of contact n/N (%)[a]		
Weekly	–	2/7 (29)
Monthly	2/5 (40)	4/7 (57)
Intermittent	3/5 (60)	1/7 (14)
Ever visited the unit n/N (%)	5/5 (100)	5/8 (53)
Facilitator of visit ($n = 7$) n/N (%)[b]		
Other parent	2/2 (100)	4/5 (80)
Family member	–	1/5 (20)

'–' not present in this category.
[a]Excludes children without direct contact with their parents (e.g. face to face, phone and email).
[b]Frequency of contact was missing for one child, facilitator of visit was missing for six children.
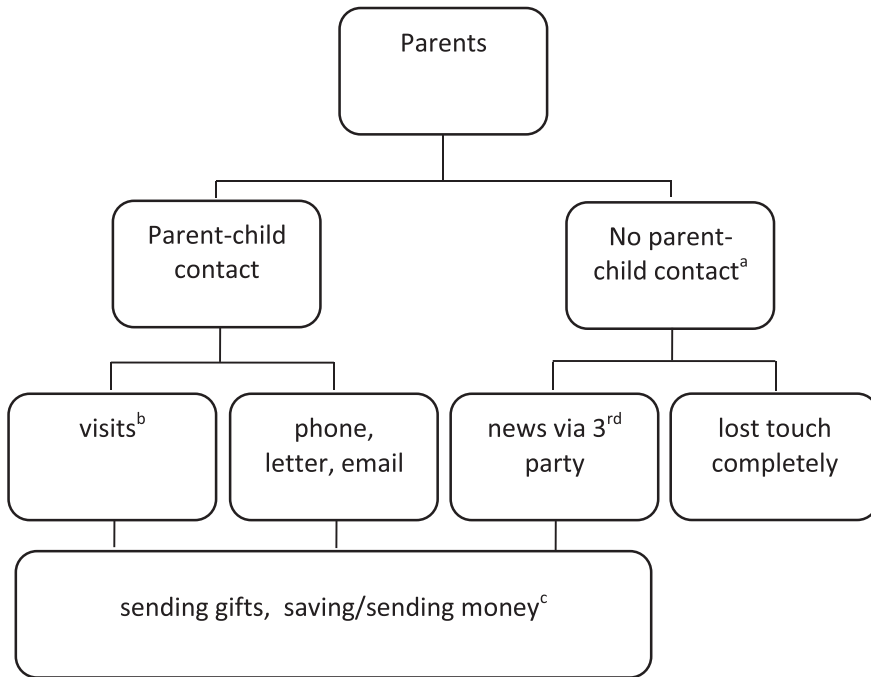
Figure 1: Parenthood and range of parent–child contact among forensic in-patients. [a] No direct contact between parent and their child. [b] Hierarchical representation: face-to-face visits take place in addition to other communication. [c] Depositing money for a child could occur in the absence of contemporary, direct parent–child contact.

children under 18 years old. Men's partners usually remained the primary carer. Interviews suggested that fewer fathers had lived with their children prior to admission, and some fathers had lost touch. Place of residence further complicated contact, for instance, the children of interviewed parents lived elsewhere in the UK, and some further afield in Europe, Africa, the Caribbean and North America.

Themes of parenthood

Parenthood and self-identity
Participants described being a parent as a continuous aspect of their identity:

  It never stops; it's something you just are (SU17 – mother).

An identity they wanted remembered by staff:

  They should recognise first and foremost that we are parents (Service User – 11).

Being out of contact did not stop parents from thinking of their children:

Wondering how they are, what they look like now (SU7 – father).

Some parents had photographs from when they had lived with their children. This also raised awareness of parental status among nursing staff. Others found pictures too painful. While different institutional and contact histories were important in shaping experience, they bore little relationship to strength of parental feeling, although being a parent in their children's eyes depended on making and sustaining the relationship:

Luckily my children see me as a mum, rather than someone in hospital (SU16 – mother).
Parenthood was a source of joy:

Having someone to love, totally and unconditionally (SU14 – mother).

Seeing them smile (SU11 – mother).

Pleasure at having built a relationship with a child was, however, coupled with the pain of being unable to maintain it, at least as wished.

Mothers were more likely to talk with their psychologist about these issues than fathers and had found this helpful.

Impact of mental illness on parenting

Mothers' narratives focused on the multiple impacts of mental illness on their parenting. 'Being unwell' included periods of being unable to take care of oneself, fears about psychotic symptoms, difficulties in communicating and in coping with the children's needs:

If you can't look after yourself, you can't look after them (SU13 – mother).

If I sit there and want to write a letter [to my children] the noise that comes into my head, I can't even make sentences... (SU12 – mother).
'Drug issues' were perceived as a major contributor to custody-loss and an even greater complication to parenting with mental illness:

I used a lot of cannabis and didn't look after my kids (SU5 – father).
Parents rarely saw themselves escaping the burden of living with severe mental illness:

I wish I could have been a normal parent without any mental health problems (SU16 – mother).
Admission brought mixed feelings. Three women found comfort from knowing their children had not been with them at their most unwell. Equally, dealing with distress associated with separation from children could be overwhelming. One father described how losing and regaining contact with his child affected his well-being:

I attempted suicide I was so depressed… [now] just knowing what they are up to lifts your mood (SU3 – father).

For those with some contact, the desire to be a good parent was a strong motivator to 'get better', 'stay well' and 'not mess up'. One mother summarised

… to get out and be there, to have as much contact as possible and do normal mother-daughter things (SU16 – mother).

A father with chronic illness in long-stay accommodation considered that becoming 'more insightful' about his illness was key to developing a good relationship with his daughter. Medication was generally favoured but sometimes seen as complicating parenting, for example by drowsiness:

It was nice for them to see 'yes Mummy does take medication now, but Mummy's quite normal. She's not strange, she's the same Mummy really' so they were really happy (SU18 – mother).

Parental concepts of offending and risk

Offending behaviour was seen as a particularly shameful aspect of admission by almost all participants. Several fathers gave this as a reason for not contacting their children:

They wouldn't understand....I can't tell them why I'm in hospital. I committed a crime (SU10 – father).

Mothers described the secure architecture as daunting:

It looks like a jail with the locks and doors (SU12 – mother).

They hoped visiting children understood that the unit was a hospital 'not a prison'. Men without contact were more likely to justify the unit as 'no place for children' saying

… people [here] have got offences (SU1 – father).

Participants usually referred to their offence in generic terms – 'what happened'. An exception was the one participant whose offending directly involved her children. Women tended to focus on the impact of their mental state on their parenting capacity and risk rather than on risk as a separate concept:

It is hard if you're mentally ill and have children. I'll never hurt my children…but you never know what you are going to hear (SU12 – mother).

Some participants explicitly distanced themselves from their own risk:

I mean obviously people that have tried to hurt their children, I mean I can't understand that at all, someone wanting to hurt their own child. 'Cos ill as I was, I was so paranoid I would sleep next to my son's bed with a hammer just in case someone

was going to hurt him, like my main thing was making sure he was okay (SU18 – mother).

Occasionally, fathers mentioned the direct impact of offence behaviour on contact with their child, in terms of needing to convey to the child's mother or external agencies, such as Social Services, that they were 'not threatening':

A person who doesn't know me thinks I'm dangerous (SU3 – father);

I've never been allowed out legally with my son – spent all my time in here (SU6 – father).

Parenting from within the unit – maintaining relationships

Child visits

Contact with children during admission was primarily arranged by forensic social workers at the unit, once risk assessment by the multidisciplinary team had determined that visits would be safe. Children under 18 years old are subject to local child protection procedures, under which the child's interests are paramount. Parents acknowledged this necessity but found it frustrating to wait for agreement to see their own children. One mother felt it was unfair that she had seen her children immediately in prison but had to wait weeks for permission after transfer to the unit. Trust could, however, be established in the process of seeking contact, especially if it involved liaison with the family court:

My team…have worked really hard (SU3 – mother).

Forensic social workers sometimes mediated with the children's primary carers. The nature of relationships with, for instance, ex-partners, played a pivotal role in maintenance of regular visits:

He was a shitty partner, but I don't know what I would have done without their Dad (SU17 – mother).

All visits are supervised. Parents found this intrusive if they felt this made their child nervous or unable to focus

… trying to entertain everyone in the room (SU17 – mother).

Note taking when it occurred was experienced as distracting (parents suggested notes be written afterwards), yet being observed was also a chance to show one's capacity as a parent:

… shows how I am with my kid (SU3 – father).

It's when they actually remember I'm a mother (SU11 – mother).

Parents enjoyed preparing for a visit, buying games and toys; help from staff was appreciated. Parents encouraged children in school:

They showed me all their report cards and projects they've been doing and I saw loads of their schoolwork. I was really proud of them (SU11 – mother).

On-site visits were the only option for parents without escorted leave but meeting at a child contact centre or park, with space and a family atmosphere, was preferred. Visiting the unit could involve a long journey for the child, so some parents were escorted to a venue nearer the child's home, in one instance outside the UK. While one mother saw her children weekly and another had transferred to this unit to be nearer her children, some did not receive the external support required:

Although I can see them 4 days each month, I've only seen them twice in one year (SU16 – mother).

Keeping in touch, sending money and receiving news
Other forms of keeping in touch were viewed as vital. Several mothers called young children every day after school, including children who lived abroad. Mothers also called their children's father, advising him

.. what to cook them, what lotion to use on their skin (SU12 – mother).

One father (SU4) phoned to remind his daughter to visit or to 'ring her Nan', while other parents exchanged emails and received photographs from older children. Mothers were reassured if they knew their letters were being read to young children:

… then I'd feel a bit better 'cos it was all down on paper and he was going to get it. I'd address it to his social worker and then he reads it with him (SU18 – mother).

Sending birthday and Christmas presents, often with staff help, was highly valued. Receiving news, photos or a child's drawings from relatives was sometimes the only way parents heard about them. For mothers of children in closed adoptions, receiving an annual report and photographs was a precious right. Sending money, saved from benefits or unit jobs, carried particular emotional weight for men:

You've got to provide, that's the way I was brought up; the men provide (SU9 – father).

You might not believe this – it's the responsibility [I feel] – even though I haven't got much, no contact. I save and send £100 each birthday and £40 a month (SU6 – father).

Not being able to do so impacted negatively:

I felt totally inadequate because I couldn't help him financially…through university. It wasn't enough (SU2 – father).

Some parents tried to earn money in occupational therapy to increase their contributions.

Explaining mental illness and detention to children

Parents experienced great difficulty explaining admission to a forensic unit. A child's age played a decisive role in selecting what to tell them. Parents told children they were unwell and in hospital but said that young children had trouble understanding why their parent could not leave and why there was nothing visibly wrong. Parents used explanations such as:

> Sometimes the mind doesn't work properly and needs to be fixed with tablets – I say tablets even though I'm on depot (SU13 – mother).

One mother found it helpful that the child's guardian spoke to the child about what to expect. Illness explanations became easier as children reached young adulthood, but disclosing offence details remained hard. It took 6 months and staff support for one mother to tell her young adult children what had happened:

> I was so ashamed – they asked, 'how could this happen Mum, you're a good person' (SU15 – mother).

Parents who were able to explain their mental illness and detention, however, found it important:

> If you're not part of their life they need to know why…you reassure them it's going to be ok and tell them you are always in my thoughts (SU16 – mother).

Discussion

Being a parent has an enormous impact on a patient's quality of life. For many, parenthood is what defines them and their lives, despite differences in their parent–child relationships and contact patterns from those conventionally recognised. Mignon and Ransford (2012) noted that child contact is associated with more responsible parenting and that a parent can lose their parental drive and skills if contact cannot be maintained. Schen's (2005) work examining women in secure hospitals and prisons concluded that, without an ongoing relationship with their child, their identity as a parent is easily forgotten by others. Research has also shown that parent–child separation is associated with increased levels of stress, depression and feelings of loss (Houck and Loper, 2002; Poehlmann, 2005; Schen, 2005; Mignon and Ransford, 2012; Dolan et al., 2013). Conversely, frequent and flexible communication with children is correlated with reduced sense of stress (Houck and Loper, 2002). We highlighted the importance of activities such as phoning, emailing, sending birthday presents and money. These helped maintain a place for the parent in kinship networks, even when not the principal carer of their child (Parrott, 2010).

Overall, fewer men than women were in touch with their children, yet interviews showed that fatherhood and their ability or failure to provide for their

children was important to them, impacting on their self-esteem. Robinson and Scott (2007) reported that detained male patients were less likely to live with their children when not in hospital, and the few relevant studies examining parenting from a male perspective note that men in prison rarely have ongoing relationships with the mothers of their children, making it difficult to locate their children or maintain contact with them (Magaletta and Herbst, 2001). Visits allow the father to maintain a relationship, which may continue after release and may be lifelong. The greatest fear experienced by imprisoned fathers is that they are powerless and thus cannot be involved in the upbringing of their child, who will forget them. This is perhaps most clearly illustrated by Hairston (1995) who found that 50% of fathers in her study were unable to state one area of parenting they did from prison.

Parents in forensic health care, like most other parents, described their feelings of love and responsibility towards their children yet feelings of loss, shame, guilt or inadequacy about parenthood that fell short of their own aspirations were prominent. Negative feelings were strongest among parents of either sex who had lost touch with their children, although the reasons for this tended to differ. Dipple et al. (2002) emphasise that recovery-orientated care should include acknowledging lost parental roles. Robinson and Scott (2007) found the vast majority of children of detained patients did not live with them but typically with their partners' parents, their ex-partner or immediate family. Mignon and Ransford (2012) found that grandparents were the most likely people to become caregivers for the children (nearly 50% of their cohort). Both men and women navigated fraught relationships with former partners; Poehlmann (2005) reported that conflict between mothers and caregivers resulted in less contact between the mother and child. A study of male prisoners noted that the relationship with the mother can mean that the child is used as a tactical weapon in the battle between the two, making contact difficult (Hairston, 1991).

Participants described their mental state as dynamic and related parenting capacity or the quality of the relationship to their well-being. This conceptualisation aligns closely with that of mental health professionals, although there is disagreement in the literature, with Schen (2005) proposing that there is evidence that a diagnosis of mental illness, including schizophrenia, does not bring about damaged parenting, while Dolan et al. (2013) suggest that parents with schizophrenia or other psychotic disorders show a range of parenting disturbances. The Mental Health Foundation (2007) acknowledged that parents with mental health problems may struggle to manage their parenting roles. Putting their children's needs first can mean parents avoid hospital admissions or stop taking medication if it makes them tired or unable to think clearly. Exploring parental concepts of offending and risk suggested it was extremely difficult for parents to consider the possibility that they could harm their child, which did not stop them from holding negative views of other patients as parents.

Supervision of parental interactions could be experienced as surveillance or support, depending on circumstances. Inevitably, phase of admission was relevant and whether leave outside the unit was possible. Robinson and Scott (2007) highlight staff roles in helping to support parents to maintain contact with their children while noting that most secure hospitals in the UK do not provide child-friendly spaces for family visits, and amenities for older children are extremely limited. The greatest barrier to parents receiving visits, however, was the perceived sense of stigma associated with mental illness, not addressed by staff. While recognising staff as a major source of support for these patients and their families, the authors suggest that they could be more proactive. In our study, parents reflected on the difficulty, even impossibility, of explaining relationships between mental illness, offending and detention to their children. Robinson and Scott (2007) noted that parents rarely discuss the reasons for their stay in a secure hospital as they fear overburdening their children and that they will also be stigmatised. When supported, we found parents valued the opportunity to explain why they were away, unable to parent or provide financially.

Limitations

Our results may not be generalisable to other forensic settings, despite inclusion of a diverse range of people, as unit-wide priorities, resources and policies may moderate individual experiences. Service users who participated in interviews may have been more receptive to the topic than nonparticipants, and we studied only parental perceptions. Appropriate exploration of children's experiences would be valuable (Gladstone et al., 2006).

Implications for mental health practice

These complex experiences call for multidisciplinary knowledge, skills and commitment. Provision of focused therapy, creative approaches to contact time and support for patients in explaining their mental illness and detention to their children are recommended. Access to appropriate visiting facilities, communication technologies and finance is essential.

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