Parents in Hospital: How can mental health services best promote family contact when a parent is in hospital?

Preliminary findings from a review of hospital contact arrangements to support parents, carers and children.

KEY FINDINGS

- Family-friendly facilities are necessary, but not sufficient, to enable parents, carers and children to spend time together in hospital. The needs of the whole family, as well as the stigma attaching to parental mental illness and to mental health services, need to be addressed directly by staff as part of holistic care.

- Although many Trusts have good policies on family visiting, this review found no correlation between good policies and good practice. Indeed, three of the poorest family visiting facilities were identified in three of the four Trusts with the most comprehensive policies.

- In nearly half of the facilities inspected there were no toys or activities provided for visiting children. Despite this staff in almost all units thought the facilities provided were satisfactory.

- Patients were considerably less positive than staff about the support for family contact available to them while in hospital.

- Small, practical improvements could go a long way to making visiting facilities family-friendly.

INTRODUCTION

A stay in hospital can represent a significant crisis, not just in terms of a parent’s individual mental health but in family life overall, and may have long term repercussions beyond the period of hospitalisation itself. At the time everyday routines are disrupted, other adults are overstretched, and both parents and children often feel worried and powerless. An intervention intended to provide safety and support during a time of acute distress, can fail to promote recovery if the specific effects of hospitalisation on the whole family are not taken into account. The findings of this review suggest that this ‘problem’ can be re-framed as an opportunity for services to provide more holistic care. Promoting contact between parents and children can be part of positive therapeutic provision rather than a difficulty to be managed or an issue to be ignored.

The last decade has seen a gradual recognition that many adult mental health service users are also parents, and a steady growth in concern over the implications of this for their children. The possible effects of parental mental ill health on children are well documented. Children often take considerable practical and emotional responsibility for their parent and for other family members. For parents the potential ‘over-burdening’ of their children, along with concern about the adequacy of their parenting, and the anxiety that their children could be taken into care, is a source of great stress. (See for example: Hugman and Phillips, 1992; Shah and Hatton, 1999; Jones, Jeyasingham and Rajasooriya, 2002; Cogan, Riddell and Mayes, 2003; Aldridge and Becker, 2003).
The interests of children are supposed to be taken into account in the formulation of care plans, and inpatient services are all required to have policies on family visiting. (HSC 1999/222:LAC(99)32). Since the Laming report of the inquiry into Victoria Climbie’s death in 2003 adult mental health services have been required to know whether patients are parents, and whether they are in contact with children. These are recent changes - five years ago there were no family visiting rooms. The findings of this review should be understood within this context, but it is clear that there remains considerably more that can be done.

THE REVIEW

This review was commissioned and project managed by the Care Service Improvement Partnership (CSIP) as part of the implementation of the Mental Health and Social Exclusion Action Plan (Action 16, ODPM 2004). The project had a steering group composed of partners from CSIP, Barnardo’s, the Mental Health Act Commission and the Family Welfare Association. Barnardo’s research staff lead on the design and conduct of the review.

The key questions the review sought to address were as follows:

- How are parents identified and supported to maintain relationships with their children while in hospital?
- How are children supported to maintain relationships with their parents?
- What protocols are in place in relation to children and young people’s contact with parents in hospital?
- What facilities are available for family visiting?
- Is provision and support for children age appropriate?
- How effective is inter-agency communication between adult and children’s services (across health, social services and education) – particularly around admission and discharge?
- What are the barriers/facilitators to services responding effectively to the needs of parents and children?
- What is good practice? What makes it effective?

The review was intended to investigate the policies, systems and arrangements to facilitate parent-child contact when a parent is in hospital. It also intended to gather information on the views and experiences of a range of informants: current and previous patients who are parents; children of parents who have been hospitalized with mental health problems (primarily young carers); commissioners and managers of in-patient services; social work and nursing staff working with children and parents.
Data were gathered by Mental Health Act Commissioners\(^1\) undertaking 60 announced visits to a sample of adult residential mental health services in England (representing medium/low security and acute services across private, voluntary and public sector providers)\(^2\). Commissioners undertook short semi-structured interviews with 56 patients who were parents, and who at the time of the visit were willing and well enough to participate. During their visits Commissioners also undertook short semi-structured interviews with 56 members of staff (usually the charge nurse on duty). A copy of the unit/hospital Family Visiting Policy was requested and facilities for family visiting inspected.

The views of mental health service users who had previously spent time in in-patient services were sought through contact with around 35 voluntary organizations and user networks. Questionnaires for both parents and children were available by post and e-mail. 32 questionnaires were returned from parents and 17 from children and young people. All of the parents had experienced a period of hospitalisation since 2000 – most had done so during the last three years.

**FINDINGS**

**Policies and practicalities**

All the staff interviewed by Commissioners knew about the Family Visiting Policy relevant to their ward and were easily able to access a copy of this. In NHS services these were generally Trust wide policies. In independent services the policies were specific to the ward or unit. In total we examined 21 policies: 10 from different MH Trusts across England plus 11 hospital/unit specific policies.

All policies were similar in terms of their expression of overarching principles; their references to national legislation, child protection and risk assessment, and all included some guidelines for decision-making. Differences were apparent in the level of detail provided on how to implement policies or whether this was left to the discretion of services. Four policies stood out as being concise, comprehensive and user-friendly.

However, there was no correlation between good policies and good practice. Indeed, three of the poorest family visiting facilities were identified in three of the four Trusts with the best policies.

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\(^1\) The Mental Health Act Commission: MHAC has a statutory remit to monitor the implementation of the 1983 Mental Health act. This is largely executed through a programme of visits to all wards and units on which detained patients are cared for.

\(^2\) There are approximately 270 institutions which provide inpatient mental health services, including private and statutory hospitals, in England & Wales. These provide for more than 33,000 patients. The majority of Black & Minority Ethnic patients are in a very few institutions. The sample of sites was therefore weighted to include a larger number of in-patient services in London which have relatively higher BME admissions.
Commissioners inspected a total of 39 visiting facilities (some facilities were shared by different wards visited). In 17 facilities there were no toys or activities provided for children and young people. Overall, spaces designated for family visiting were appropriately located and accessible, and booking arrangements were flexible. Seventeen were dedicated family visiting rooms; in 6 cases the designated space served a number of functions (e.g. doubling as a meeting or dining room) and was not considered by the Commissioner as a ‘family-friendly’ space; 16 had no designated space for family visiting. The facilities in five units were identified as ‘good’, in 21 as ‘adequate’, and in 13 as ‘poor’. The best provision took the form of a dedicated family visiting room which was:

- Clean, warm and light
- A reasonable size
- Had comfortable furniture
- Provided privacy
- Had a range of toys and activities
- Enabled families to share drinks and snacks

The poorest facilities were described as ‘cold’, ‘cramped’, ‘grubby’ and ‘clinical’.

Staff perspectives

All staff interviewed expressed their willingness to support and accommodate family visiting. The majority of staff believed that the help they provided for patients in preparing for visits, and the support they provided afterwards was good, and their comments regarding family visiting facilities were mostly positive.

All staff believed that a patient in their care would be identified as a parent either on admission or early in the assessment process. However, it was clear that rather different approaches were taken in different settings once a patient was identified as a parent. While many staff stated that they would routinely enquire about the living arrangements and well-being of a patient’s children, provide information on visiting arrangements, and offer support or referrals to other services, a significant number said that they would leave any contact with patients’ families to social services, or expressed wariness about getting involved with family issues. A small number of staff said that they would like to be more pro-active in engaging with patients’ families, but felt they lacked training and support to do so. Although they considered that their knowledge of, and co-operation with other services was generally good, many felt that inter-agency collaboration could be improved.

Patient concerns

The patients interviewed by Commissioners were less positive than staff about the support for family contact available to them while in hospital. The welfare of their children was a source of anxiety for nearly a third of parents. 21 out of 57 had current concerns about their children. 44 of the patients interviewed had regular contact with their children – via telephone calls, visits, leave and letters. 26 had been visited by their
children during their current admission and of these 15 gave negative feedback about the facilities for family visiting, with only two making positive comments about the provision. Rooms were reported as being too small and unwelcoming and lacking in toys: “More like a dentist’s waiting room than somewhere you could have a cuddle”.

Parents and children of all ages described the purpose of visiting as spending time together, and the primary activity as ‘talking’. They needed to be somewhere that felt comfortable, somewhere that gave children the message that their parent was safe and being well cared for, and which parents felt was reassuring and pleasant for their children. For younger children toys were important, not just because play is what children do, but also in giving the message that they were welcome – old and broken toys suggest that children are not valued – and creating opportunities for interaction with their Mum or Dad. Activities were less important to older children, but they also welcomed the option of ‘doing something ordinary’ with their parent such as looking through magazines or doing word puzzles.

While patients were generally positive about the overall support they received from hospital staff, views varied on the adequacy of support around children visiting. Patients described contact arrangements as being their responsibility in negotiation with their families. Some patients felt they needed more help preparing and managing visits and questionnaire respondents commented on child-unfriendly attitudes they had encountered:

- *I was made to feel the children were in the way.*
- *I was told if I couldn’t keep him quiet, he wouldn’t be allowed to visit again.*

It was felt that there was sometimes very little understanding of the needs of children, or of the inevitability of a young child being over-excited at seeing a parent after a gap of a week or more.

While most staff were happy with the informal nature of their contact with patients’ children, and were confident that they were approachable if children wanted to speak to them, the majority of parents interviewed did not think their children would know how to approach professionals for help or information.

It was also clear that the biggest barrier to children and parents having positive contact while a parent is in hospital is the continuing stigma of mental illness and ‘mental hospitals’. Some patients were unwilling to let their children see them in, or the other parent did not want the children to be exposed to, such a context. In some cases children had not been told that their parent was in hospital.

Appropriate, family-friendly facilities are clearly necessary, but not sufficient, to overcome the reluctance of parents, carers and children to spend time together in hospital.
Children’s perspectives

Children and young people responded to the review with a range of experiences. While their verdicts on family visiting facilities were never better than ‘OK’, their experiences of staff ranged from ‘brilliant’ to ‘awful’.

I could ring up at anytime if I was worried about Mum. I rang up everyday when I was away on holiday and that was brilliant.

Nobody talked to you…and the nurse was quite snappy with us…I just wanted some questions answered about my Mum’s illness.

Children expressed their needs for clear and specific information. They found it particularly difficult not knowing when their parent was moving wards or when they were likely to come home. It seemed that young people often felt ‘fobbed off’ by well intentioned but vague statements such as ‘Your mum needs some help at the moment’ or ‘Mum needs to feel happier’.

The family visiting issue that spontaneously arose most often from parents and children responding to this review was that of greater privacy. Children in particular wanted to see their parent away from other patients, and if a staff member had to be present they needed to understand why. If at all possible they wanted to see their Mum’s room:

It would have really helped if I could have just seen her room, seen where she was sleeping.

I’d have liked a nicer, more friendly room away from the other patients who could scare me as they were sometimes quite aggressive.

Children eloquently described their powerlessness in not being able to visit their Mum or Dad when they needed to:

I had to rely on someone taking me there as there was no other way of getting there. Sometimes we didn’t have time to go as visiting times were limited and the person who took me had to work late.

I’d go from school. I’d have had nothing to eat. If the traffic was bad I’d just get there and it would be time to leave.

More flexible visiting times, and access to snacks, were small practical improvements requested by young people that would make a big difference to their experience of hospital visiting.
Promising practice

This review included a call for examples of promising practice relating to projects and initiatives aimed at improving the experience of parents in hospital and their children. Information was received about the development of a small number of family rooms, resources for direct work with children, and resources aimed at raising awareness amongst professionals. Most examples were at relatively early stages of development.

In England, the most established work to promote family contact when a parent with mental health difficulties is in hospital has been undertaken by the Keeping the Family In Mind, a Barnardo’s project, working in partnership with Mersey Care NHS Trust. The critical success factors for this work appear to be:

- It was driven from the ‘bottom up’ with service users and their children directly involved. Young carers were particularly active in influencing change.
- As an initiative it is fully co-owned between a MH Trust and a voluntary organisation representing children and young people.
- It has effectively used the concrete issue of a ‘family room’ to promote more ‘family focussed’ services and impact on professional practice in in-patient services.
- It has been championed and mainstreamed by staff at ward level.

It is not often that children’s organisations work closely with specialist mental health trusts. In this case the collaboration has resulted in two services with accessible, child-friendly family visiting rooms which are well used and appreciated by patients and their children, in which staff recognise the importance of patients parenting role, are very supportive of family contact, and are beginning to undertake pro-active work with families.

The impact of the first family room has been the subject of a detailed internal evaluation which describes benefits greater than the outcomes envisaged at its inception. It is clear that ‘the room’ provided a tangible focus that made families far more central to the mental health agenda and encouraged staff to start talking to patients about family issues. The room’s development “has lead to a feeling of optimism that acute wards can change and that the process need not be as ‘painful’ as envisaged nor have heavy resource implications.” (Wardale and Johnston, 2004).

Over the last few years there has been some progress in the development of other family rooms, but these have rarely been accompanied by a strong strategic commitment to providing more family focussed adult mental health services, and to increasing the involvement of service users, their carers and children in service design and development. The KFIM/MerseyCare initiative had no dedicated ‘family link’ worker, rather it focussed on influencing the practice of those in day to day contact with in-patients and their children and in maximising their ownership of change. However, it was part of a wider plan to support all Merseyside mental health service users who are parents – a factor which has supported its sustainability.
What services need to do

The stigma surrounding mental illness and mental health services often arouses intense feelings in all members of a family trying to cope with a parent in hospital. Families are unlikely to overcome these feelings and transform parent-child contact into a positive, therapeutic experience on their own. Staff need to undertake pro-active work to address stigma directly and dismantle the barriers to positive contact for the sake of parents and their children. The apparent complacency of staff in relation to current practice needs to be challenged.

- It is clear from this review that many Mental Health Trusts need to address a significant gap between their policies on family visiting and the practice in in-patient services. All Trusts should review their practice in line with their policy, and in collaboration with other stakeholders (user groups and children’s services in particular) develop a strategic approach to supporting all mental health service users who are parents, their carers and their children.

- Contact between parents and children when a parent is in hospital needs to be actively encouraged by staff.

- Staff need information and training to increase their:
  - knowledge of the benefits to parents and children of contact,
  - confidence in addressing family issues with patients,
  - skills in communicating helpfully with children and young people,
  - ability to challenge the stigma of mental illness and the barriers that creates between parents, carers and children.

- Family visiting rooms which are accessible, warm, clean and well-equipped should be available in all in-patient units/hospitals.

- Patients, carers and their children should be actively involved in the development of family visiting rooms.

- All new-build facilities should incorporate family visiting rooms in their design.

- In addition services should address the following 10 messages to mental health professionals written by a group of children and young people in Liverpool (Barnardo’s, 2005).

  These are 10 messages we would like you to think about next time you come into contact with children and young people

1. Introduce yourself. Tell us who you are. What your job is.
2. Give us as much information as you can.
3. Tell us what is wrong with our parents.
4. Tell us what is going to happen next.
5. Talk to us and listen to us. Remember it is not hard to speak to us. We are not aliens.
6. Ask us what we know, and what we think. We live with our parents. We know how they have been behaving.
7. Tell us it is not our fault. We can feel really guilty if our Mum or Dad is ill. We need to know we are not to blame.
8. Please don't ignore us. Remember we are part of the family and we live there too!
9. Keep on talking to us and keeping us informed. We need to know what is happening.
10. Tell us if there is anyone we can talk to. MAYBE IT COULD BE YOU

References


HSC 1999/222:LAC(99)32 Mental Health Act 1983 Code of Practice: Guidance on the visiting of psychiatric patients by children

Hugman, R and Phillips, N (1992) ‘Like Bees Round the Honeypot’ Social work responses to parents with mental health needs’ Practice 6(3)

Jones, A, Jeyasingham, D and Rajasooriya, S (2002) Invisible families: the strengths and needs of black families in which young people have caring responsibilities Bristol: Policy Press

Shah, R and Hatton, C (1999) Caring Alone: Young Carers in South Asian Communities Ilford: Barnardo’s