Health Professional's Perspective on the Health and Wellbeing of Children with a Parent or Caregiver in Prison. A Descriptive Qualitative Study

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Abstract

Health professionals working with children, particularly those working in the community, will recognise that a significant number of children have a parent or caregiver in prison. This group of children are likely to face different challenges than other children their age, having the potential to impact their overall health and wellbeing. Health professionals have an opportunity to positively impact the lives of these children and their families; therefore, it is important that our research around this topic is up to date and relevant. This research study explores the accounts of six healthcare professionals who work with these children in their everyday practice. The data collected aims to add to our knowledge and understanding of the literature about these children's health and wellbeing, working towards improving outcomes. This study is based on a qualitative descriptive analysis of six semi-structured interviews with health professionals who work with children that have had a parent or caregiver in prison. The study identifies two overarching themes of "The child as a whole" and "It takes a village" that participants demonstrated were significant to the overall wellbeing of a child that has a parent or caregiver in prison, concluding with recommendations for clinical application.

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Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

Candice Roth

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Chapter 1: Introduction

Interest in the topic

I walk up the three flights of stairs because the lift is broken, and knock on the door loudly, hoping they can hear me over the music. They do not. Someone whistles and calls out. This is not uncommon. I repeatedly knock until a little face pops out, followed by a smile and welcome in as they recognise a familiar face. It is always hectic here, and I need to move things to make room to sit. Before I even open my bag to grab a pen, the child's mother bursts into tears. I try to comfort her, but she has so much to say.

When I first started working with this family, there were many issues and concerns about meeting her child's needs. As a nurse, I supported the mother as she overcame many struggles of losing a husband and father to prison. She navigated a loss of income, so we supported her by providing physical necessities like food parcels, blankets, and clothes for the children. In addition to this, support with accessing essential services such as in-home vaccination services, support with enrolment into a GP (General Practitioner) practice, and transport to appointments was also organised for this family.

On this day, the mother was feeling overwhelmed that her partner was due to come out of prison in the next few months, and she was scared about how this would impact the child and the family's new life, routine, and safety. This mother knew that her partner, also the father of her child, being in prison had a significant impact on her child's overall health and wellbeing. She knew that to provide better outcomes for her child, she needed to continue to further engage with health professionals who could continue to support her in her journey. In my experience, health professionals working with families have the potential to create a long-lasting positive impact on children's health and wellbeing. however, it is not always easy to achieve this as not all families are engaged and understand what is needed, making it harder for the child to deal with the situation.

I became interested in this area for my research topic as I have worked with a wide variety of children and their families in my capacity as a health professional and have noticed the lack of knowledge around supporting children who have lost a parent to prison.

New Zealand has a disproportionate imprisonment rate, with 23 more imprisonments per 100,000 people than the OECD average (Ministry of Justice, 2023). This issue has resulted in approximately 23,000 children and young people that have a parent in prison in New Zealand at any time (Ministry of Education, 2019). As there are a number of ethical concerns relating to studying and research using children, resulting in a noticeable gap in research (Morrow & Richards, 1996). These children can often be referred to as invisible or lost in the system and are missing from support and planning conversations when a parent is in the justice system (Bourgeois et al., 2022). Despite this gap in the literature, as a health professional working with these vulnerable families, it has become clear to me that these children face many different challenges and barriers that other children do not face, affecting their health and wellbeing during childhood.

What does it mean to be a child?

Everyone has experienced being a child and commonly feel they understand it. However, these are just memories of our own experience. These memories can influence our ideas and conceptions about what this experience should be like for others. This means that notions of what a childhood should look like are culturally embedded, potentially influencing the formation of our memories (Norozi & Moen, 2016) This may mean that the idea of childhood was constructed by adults, made up based on an array of thoughts, and ideas, rather than an actual state of being.

This idea is reflected in Walther’s (1979) writing, who noted that "childhood, the invention of adults, reflects adult needs and fears quite as much as it signifies the absence of adulthood. Throughout history, children have been glorified, patronised, ignored, or held in contempt depending on the cultural assumptions" (p. 64). Here, Walther explains that the idea of childhood has been created, and the perceptions of what it is are held by adults, who all have different experiences and expectations that influence their perceptions.

The idea that children have a different, special status from adults is evident in society's actions and attitudes toward children. Thus, a child can be described as an individual in the process of development (Schapiro, 1999). Since children are not fully developed yet, we tend to treat them in a more controlled and paternalistic way than we treat other adults. This can be seen in the way adults control the type of education, nurture, protection, and discipline available to the child and their experiences, regardless of whether they agree to it or not (Schapiro, 1999).

Despite society trying to create an image and conceptualise what a child or childhood is, many children do not fit this perfect or innocent image of what it means to be a child. Factors such as neglect, household dysfunction, violence and other ACEs (Adverse Childhood Experience) all have the potential to influence childhood (World Health Organization, 2020). Children with a parent or caregiver in prison are likely to face many of the challenges listed above, impacting their childhood experience, and affecting their overall health and wellbeing as a child. For this research, a child will be defined as an individual under the age of sixteen.

Childhood trauma

Childhood trauma can be defined as a "scary, dangerous, violent, or life-threatening event that happens to a child" (Northwestern University, 2023, para.3). According to the Centers for Disease Control and Prevention (2021) in the United States, parental incarceration is considered an ACE or a potentially traumatic event that occurs in childhood. It, therefore, can be expected that many children could be experiencing trauma from this event. Childhood trauma can lead to a persistent fear state, memory disturbance, difficulty with emotional regulation, and rejection of positive experiences (Goodfellow Unit, 2018b). These states can present in many ways with a combination of externalising or internalising signs. Externalising signs may be more noticeable, including difficulty regulating behaviours, aggression, lying, and stealing. In comparison, internalising signs may be less obvious and can include sleep disturbances, health complaints, toileting issues, and zoning out (Goodfellow Unit, 2018a). Many of these behaviours could lead to the child being perceived as naughty or uncooperative and may mean that the child has difficulties with learning, concentrating, and forming relationships at school (Goodfellow Unit, 2018a).

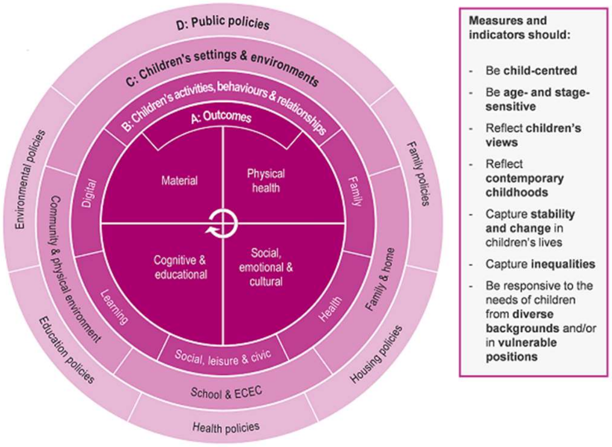
In addition to the signs and behaviours listed above, visible changes in children's brains can be identified in brain imaging. (Goodfellow Unit, 2018a). When children have repeated stressful or negative experiences, their body produces hormones to protect them, aiding their coping ability. However, over time the brain cannot tell if a situation is stressful or not, meaning that children who have had these repeated stressful or negative experiences may react to situations that are non-threatening in a stressful manner (Goodfellow Unit, 2018a). Neural pathways influence how a child interprets and responds to the world, which are shaped by experiences, determine how one interprets and responds to the world. This may result in children solely focused on survival, guarded and hypervigilant, which can be displayed in the behaviours detailed above (Goodfellow Unit, 2018a).

Health and wellbeing

There are many ways to measure health and wellbeing as it is a multifaceted, complex idea that is perceived differently depending on the individual's perception, age, and experience (De Jong et al., 2020). The OECD (Organisation for Economic Co-operation and Development) has created a framework, presented here in Figure 1 below, highlighting the aspects of children's lives that they have identified as the best measure of wellbeing. The middle of the framework has four main dimensions for wellbeing, including children's material living standards, physical health, social and emotional outcomes, and their learning and educational achievements. The next layer looks at the children's school, family, neighbourhood, and communities that all support their wellbeing with opportunities, resources, and security (OECD, 2021).

Figure 1

OECD Measures of Wellbeing



Measures and indicators should:

- Be **child-centred**
- Be **age- and stage-sensitive**
- Reflect **children's views**
- Reflect **contemporary childhoods**
- Capture **stability and change** in children's lives
- Capture **inequalities**
- Be responsive to the needs of children from **diverse backgrounds** and/or in **vulnerable positions**

(OECD, 2021)

This model can be compared to a New Zealand specific model titled "Te Whare Tapa Whā" (Durie, 1994). This model looks at the four cornerstones of the health and wellbeing of Māori, the indigenous people of New Zealand.

Within the Te Whare Tapa Whā model, taha tinana (physical health) looks at physical growth and development, identifying that good physical health is needed for optimal development. It explains that an individual's physical being shelters them from the physical environment and supports their essence. Secondly, taha wairua (spiritual health) is identified as the capacity for more comprehensive communications and faith; it is related to unspoken and unseen energies. It helps to determine who and what the individual is, where they have come from, and where they are going. Next, taha whanau (family health) is the capacity to care, belong, and share where individuals are part of a more comprehensive social system, linking ancestors to the past, present, and future. Finally, taha hinengaro (mental health) focuses on the capacity to think, communicate, and feel and is related to the assumption that the mind and body are inseparable (Ministry of Health, 2017).

Figure 2

Te Whare Tapa Whā

(Ministry of Health, 2017)

This model is precious and relevant in New Zealand, particularly when looking at the health and wellbeing of children with a parent or caregiver in prison because each of the elements is potentially disrupted by experience of having an incarcerated parent.

Both models look at the broader picture and identify that it is not just the absence of disease that affects one's health and wellbeing but many varied factors that influence one's environment. Although these models have the potential to serve different purposes, it is important to capture what is important to the overall health and wellbeing of the user. Both models, created by adults to understand health and wellbeing, may or may not directly correlate with children's perceptions of health and wellbeing.

The understanding of a child's wellbeing may change over time as their identity and the world around them changes. For example, parents and the wider society tend to measure a child's wellbeing by the achievement of certain predetermined milestones, such as their progression through the educational system (Fattore et al., 2007). Again, wellbeing is a personal experience, meaning it can be challenging to identify if wellbeing is "achieved" or not, as the ways of assessing it can be so different.

One of the most accepted conventions in the history for children's health and wellbeing was created by the United Nations, titled "The United Nations Conventions on the Rights of the Child" (1989). This set of rights details a government's obligations with regard to ensuring that children aged zero to 18 years can grow, survive, participate, and meet their full potential. The rights are applied equally to all children regardless of gender, religion, or ethnicity. In addition to this, it discusses the responsibility of parents and the children themselves to make sure that all rights are met. Some of these rights include freedom from abuse, being raised by their parents, to receive education, health care, social security, and an appropriate standard of living. As a health professional, I have first-hand experience that even in a first-world country like Aotearoa New Zealand, many of these rights are not being met, limiting children's ability to live a safe, nurturing life and allows them to live to their full potential. This is particularly true for children who have a parent of caregiver in prison, as will be discussed throughout this dissertation. For the purposes of this research, health and wellbeing is described as not only the absence of illness or injury but also the child’s physical, mental, and social state, helping them live a positive and functional life.

Children who have a parent in prison often come from families that have many pre-existing risk factors that are generational and apply to families worldwide, creating an enormous negative impact on their lives. This may include long-term poor health, negative social and educational outcomes, and an increased likelihood of being incarcerated themselves. (Social Policy Evaluation and Research Unit, 2015). Despite this, there are occasions when parental incarceration may stop or reduce exposure to substance abuse and family violence, ultimately resulting in a better outcome for the child (Social Policy Evaluation and Research Unit, 2015).

Parent and caregiver

A caregiver is a broad term that includes any person the child lives with and provides daily care to (Better Care Network, 2022). This may or may not be a biological parent. For this study, the parent or caregiver in prison must have had some contact with the child before or during incarceration.

Structure of the dissertation

This dissertation will be divided into four chapters. The first chapter has provided an introduction to the selected topic and given insight into the research project created for this research. The second chapter provides an overview of the current literature. The third chapter discusses the methodology and methods used to conduct this research, while the fourth discusses the research findings as well as a discussion of the study and recommendations for practice.

Chapter 2: Literature Review

Literature review

This chapter reviews the literature relating to health professionals who work with children with children and their families that have a parent or caregiver in prison, looking to understand how this can affect their health and wellbeing. It first describes the approach used to identify relevant studies and then summarises and discusses significant findings from these studies that look to understand the health and wellbeing of children with a parent or caregiver in prison from a health professional's perspective.

Search strategy

To find the most relevant research on the selected topic, an in-depth search of studies was completed before the data collection for the research commenced. The database Scopus was utilised as a search engine for this dissertation as it provides a broad range of global data that is high-quality and comprehensive, specialising in the relevant subject areas of medicine, social science, and humanities (Elsevier, 2023). The engine includes specific analytic tools required to complete the literature review at a high standard.

The terms used for the database search are listed below. The search parameters were set to show studies published between 2018 and 2023.

(TITLE-ABS-KEY (teen* OR adolescen* OR "young adult*" OR highschool* OR "high school*" OR child*) AND TITLE-ABS-KEY (mother* OR father* OR parent* OR caregiver* W/3 incarcerat* OR prison* OR jail*) AND TITLE-ABS-KEY (health* OR wellbeing OR "well being" OR "health outcomes")) AND (LIMIT-TO (SUBJAREA , "NURS") OR LIMIT-TO (SUBJAREA , "HEAL") OR LIMIT-TO (SUBJAREA , "MEDI")) AND (LIMIT-TO (PUBYEAR , 2018) OR LIMIT-TO (PUBYEAR , 2019) OR LIMIT-TO (PUBYEAR , 2020) OR LIMIT-TO (PUBYEAR , 2021) OR LIMIT-TO (PUBYEAR , 2022) OR LIMIT-TO (PUBYEAR , 2023)) AND (LIMIT-TO (EXACTKEYWORD , "Child Health") OR LIMIT-TO (EXACTKEYWORD , "Parental Incarceration") OR LIMIT-TO (EXACTKEYWORD , "Wellbeing") OR LIMIT-TO (EXACTKEYWORD , "Incarcerated Parents"))

The articles generated by this search strategy were then reviewed for appropriateness for this study, starting with 63 different articles. Only studies that were free or fully accessible through AUT library and were written in English were considered for inclusion. Also, only literature from the last five years in the subject areas of nursing, health professions, and medicine, as well as parental incarceration, wellbeing, and incarcerated parents was considered.

Inclusion Criteria

These search terms initially resulted in 59 different articles. Using the criteria below, this number was further reduced to a manageable number to review:

-An average age of children under 18 years old;

-A focus on the child's wellbeing rather than the parent;

-Needed to specifically explore parental incarceration rather than ACES in general, children in foster care, or wellbeing post-incarceration;

-Letters and notes were excluded;

-Be primary research.

This chapter presented a synthesis of the findings of the literature review on the health and wellbeing of children with a parent or caregiver in prison. It highlighted and discussed the significant findings from relevant literature on the experience of children's health and wellbeing that have a parent or caregiver in prison.

Overview of the Literature

Various aspects of parental incarceration have been studied mainly from pre-existing datasets, particularly those collected western countries such as the United States of America. Most of the research was completed in English; only one qualitative study considered here was translated from Tamil to English. Almost all of the studies were completed using quantitative methods, presumably due to the ease of accessibility of data sets that looked at various variables. This allowed researchers to select the variables relevant to their research without having to collect their own data. Most studies found in the literature search had many participants, meaning that generalising the study findings to the broader population was appropriate. In the future, researchers should consider using a qualitative approach in order to gain a more in-depth understanding of these children. It may also be helpful for researchers to create their own datasets by devising the questionnaires or conducting interviews themselves, so that insights can be gained from more recent data to ensure that the insights gained are current and reflective of the present situation in the country that is being explored.to provide insights in the current situation of children with incarcerated children around the world.

Key Topics from the Literature

Four key topics were identified from this review of relevant literature: resilience/risk, physical health, home and family, and mental health. Each of these critical topics will be discussed in this chapter.

Resilience/Risk

One theme that was consistently explored in the literature was the resilience of the children and the risk factors that can be used as indicators to predict their overall health and wellbeing. Resilience can be described as the ability that an individual has to adapt to a difficult situation (Wu et al. 2013). It can be improved with an increased number of protective factors (Benzies & Mychasiuk, 2009). A protective factor can be defined as a condition or attribute in a person, family, community, or broader society that helps individuals manage stressful events or eliminate risk more effectively (Child Welfare Information Gateway, 2020).

Children experiencing PI (Parental Incarceration) may be going through a highly stressful time in their lives, and how this stress is managed may affect their overall health and wellbeing. The importance of protective factors was highlighted in a study by Boch and Ford (2021). The

American based study was completed using the 2016–2019 National Survey of Children's Health, looking at 893 black youth aged 6–17 years exposed to parental incarceration. The study aimed to predict the associations between protective family, school and community factors of overall health and flourishing in youth that are black and exposed to parental incarceration. Protective factors of interest included family resilience, family connectedness, neighbourhood support, safe neighbourhood, and school safety. Covariates included age, sex, prematurity, and the number of ACES the child has experienced. The adjusted results demonstrated that a high level of family connectedness was associated with greater odds of having a good health status for the child (adjusted odds ratio = 2.37, 95% confidence interval [1.35, 4.18]). In addition, youth born prematurely, and each additional ACE were associated with worse odds of overall good health. In contrast, the results show that good caregiver physical health and the presence of an adult in a household with a college education were associated with higher odds of good youth health. This is important as families who have lost a parent to prison may find that the remaining parent has more responsibilities and less of a presence, potentially impacting their ability to achieve over good health and wellbeing.

The other part of Boch and Ford’s (2021) study looked at the flourishing model, a three-part questionnaire designed to assess the child’s curiosity and discovery about learning self-regulation and resilience. The results showed that higher levels of family connectedness were strongly associated with greater odds of youth flourishing (adjusted odds ratio = 5.49, 95% confidence interval [2.50, 12.06]). This is a significant finding as many families that have lost a parent or caregiver may experience a form of family disconnection, potentially impacting their "flourishing" or health and wellbeing. Interestingly the results also showed that older youth and a reporting female caregiver (compared to male caregivers) were associated with greater odds of meeting the flourishing criteria. This is important to note as children who have a mother who is incarcerated may not have a female caregiver or parent around, potentially impacting their flourishing, health, and wellbeing. Finally, the study also highlighted that being male and prematurely born were associated with lesser odds of flourishing across all models after adjusting for the covariates and protective factors. No statistically significant patterns were found between other neighbourhood or school protective factors and overall good child health or flourishing. This is an exciting finding as most of the relevant literature adjusts for different aspects of socioeconomic status, and where an individual resides, and their community is part of their socioeconomic status. Thus, Boch and Ford’s (2021) study has linked in clearly with the theme of resilience/risk as it has pulled apart the different protective factors linked to improved resilience as well as the risk factors relating to socioeconomic status and how these directly relate to the outcomes for children who have a parent that is incarcerated.

While Boch and Ford's (2021) investigation of the database suggested that schools and teachers do not have a significant impact on the health and wellbeing of children with incarcerated parents, Ashmitha and Annalakshmi's (2022) study of 312 school students aged 12-16 came to a different conclusion. Their study looked at developing a tool that measures risk and protective factors among children experiencing PI in four significant domains: individual, family, school, and community. Participants in this studied included prisoners, caregivers of children with PI, teachers of children with PI, and prison authorities. The research started with qualitatively with interviews, then had an aspect of quantitative research where participants had to respond to a questionnaire. The questionnaire had two subscales: protective and psychosocial risk factors. The psychosocial risk factor scale had four domains: disengagement, insecure attachment with parents, maternal distress, and neglect. The psychosocial protective factors scale had seven domains: prosocial behaviour, maternal responsiveness, paternal responsiveness, support from teachers, support from peers, support from the community, and emotional support from extended family. Emotional and behavioural problems were explored using the "Youth Self Report Score." Wellbeing was measured using the "Adolescent Wellbeing Scale" as well as "EPOCH Measure of Adolescent Wellbeing Score" and the “Positivity Scale." Finally, "Bell's Adjustment Inventory" was used to measure the life of the adolescents' adjustment issues experienced by the individual at various levels. This study found that teacher support helped with behavioural difficulties, increased competence, reduced attachment issues, and correlated with perseverance, $r(312) = 0.15, P < .01$.

Ashmitha and Annalakshmi’s (2022) study also found that teachers' support and good quality child-teacher interactions reduce aggression and improve self-regulation. A large portion of a child's life is spent at school with their peers and teachers; therefore, it is essential to consider their impact when looking holistically at a child's health and wellbeing. As expected, risk factors positively correlated with adverse outcomes, and prosocial factors negatively correlated with home maladjustment. Almost all the protective factors correlated with positive outcomes, with a key finding being that good relationships at home and school can be identified as protective factors, therefore resulting in improved resilience and health outcomes.

This study also demonstrated that peer support was shown to promote academic motivation, classroom engagement, and school belongingness and it was found to influence their decision-making process. On the other hand, a lack of peer support correlated with academic adjustment issues. Ashmitha and Annalakshmi’s (2022) study have found that community resources help with the satisfaction of life and posttraumatic growth; this can also be contrasted to the study mentioned above (Botch & Ford, 2021), where no correlation was found between flourishing or overall health and wellbeing and neighbourhoods. This could be due to the different ways the studies defined the meanings of community and neighbourhood, as a community may be significant, such as churches and schools. In contrast, a neighbourhood may be the physical streets around them. The family also proved to be a significant protective factor, with the extended family providing support with financial hardship (Ashmitha & Annalakshmi, 2022).

Maternal responsiveness, a protective factor, was found to reduce emotional problems and adjustment issues, promote intellectual growth, and create a sense of trust and security. An additional protective factor identified was paternal responsiveness (Ashmitha & Annalakshmi, 2022). This was shown to guide socialisation and learning processes, improve assertiveness, and reduce substance abuse (Ashmitha & Annalakshmi, 2022). The reduction of substance abuse with increased protective factors showed similar results in a study examining the use of all tobacco products and different protective factors (Parks et al., 2020).

While risk behaviours are more common amongst this population, there are protective factors that can support better outcomes; for example, while the likelihood using tobacco is higher for children with an incarcerated parent, the rate was lower for those whose peers and parents were strongly opposed to smoking (Parks et al., 2020). In their study, Parks et al. (2020) explored how PI relates to a range of tobacco products such as cigarettes, non-cigarettes combustible products, smokeless products, e-cigarettes, and use of multiple products. Their extensive study had 11091 participants with an average of 14.8 years old. Not only did it explore the use of tobacco products, but it also looked at the protective factors that made children less likely to use tobacco product. The results demonstrated that youth with current PI used all of the products with a higher frequency than youth with previous PI or no PI. Use with current PI was 26% for e-cigarettes (CI 95% = 24.1-27.8), 20.8% for multiple uses (CI 95%= 19.1, 22.5), 17.8% for cigarettes (CI 95%= 15.8-19.0), 17.4% for non-combustible cigarettes and 9.9% for smokeless cigarettes (CI 95%= 8.6-11.2). Youths with current PI were at the highest risk for tobacco use, and youth with current and past PI both had significantly higher rates of tobacco use than those without PI. Protective factors included strong anti-smoking norms among peers and parents and internal developmental assets. Race, number of ACES, positive teacher engagement, and socioeconomic status were accounted for. Almost all protective factors were significantly negatively related to using all products, regardless of experiencing PI. In addition, solid anti-smoking peer norms had a strong negative relationship with all forms of tobacco use. As mentioned previously, children spend most of their time at school with their peers, meaning that ensuring education around health promotion must be considered in schools to help improve outcomes for vulnerable children.

Socioeconomic status looks at the position of an individual in society and is determined by different economic and social factors (Baker, 2014). The theme of socioeconomic status affecting health outcomes, as a resilient or risk factor, has been highlighted in almost all the data (Branigan & Wildeman, 2019; Jackson et al. 2021a; Testa & Jackson, 2021b), particularly in the quantitative studies, where numerous covariates of socioeconomic status have been identified and controlled for in the findings, demonstrating the significance in the results. This can be seen in Jackson et al.'s (2021) work who controlled for many covariates that were related to socioeconomic status. The results of their study demonstrated that non-white children exhibited fewer mental health challenges than white children, and households living above the poverty line also showed fewer health difficulties, yet poverty levels were not related to chronic physical conditions and developmental disorders. Similar findings were demonstrated in a study on school readiness completed by Testa and Jackson (2021b). This study found that average scores on all covariates included significantly varied by whether or not the child was experiencing PI. Examples of the results show that children experiencing PI are more likely to be non-white, living below the poverty line, having native-born parents, younger mothers, and less educated parents. This finding is significant as it demonstrates that the children experiencing PI are also likely to be experiencing other strains of hardship due to their socioeconomic status.

An example of this would be living below the poverty line; this may create other barriers to achieving good health and wellbeing and should be considered when working with these children to help reduce the impact of the stress that they are experiencing. This finding is also identified by World Health Organization (2018), in an article which indicated that the lower the socioeconomic status of a person, the higher the risk of poor health. Discussions of the influence of socioeconomic factors of children experiencing PI has also highlighted that highlight that risk factors can be identified when working with these children and their families that indicate a need for more intensive care or support. This intensive care or support may reduce the barriers to achieving optimal health and wellbeing.

Throughout the literature examined, a clear pattern emerged that suggests that protective factors in children boost their health and wellbeing outcomes and that protective factors in children exert a positive influence on the children's health and wellbeing outcomes.

The findings related to paternal protective factors, positive and negative protective factors, are important to consider as there is a disproportionate population of men compared to women in prison, meaning that many children would be missing their fathers. In addition, the school environment, including peers, teachers, and the wider community, comes up frequently as a protective factor and should be considered when working to improve the health and wellbeing of children, particularly those experiencing PI. It can positively influence children's overall health and wellbeing when protective factors are uncovered and enhanced. Healthcare professionals and others working with these families should be aware of children's protective factors, creating a strength-based approach that focuses on what they do have compared to what they do not.

Physical Health

Physical health describes the condition of an individual's body, and the literature on children experiencing PI clearly shows multiple impacts on the physical health of these children.

One of the quantitative studies identified as relevant for this project looked at the National Survey of Children’s Health, conducted from 2016-2018 in America, to look at 99,962 participants aged 0-17 years, including those with and without a parent in prison (Testa & Jackson, 2021a). The study examined the association between PI and children's oral health, accounting for household socioeconomic factors, healthcare insurance, and using oral healthcare facilities for treatment and prevention. The results from this study found that children who were experiencing PI had significantly worse oral health outcomes than those whose parents were not in prison, with more of the PI group having poor or fair teeth condition (OR=2.71, 95% CI =2.23-3.29), toothaches (OR=1.72, 95% 1.36-2.18), gum bleeding (OR= 2.12, 95% CI=1.52-2.94), cavities or decay (OR=1.50 95% CI= 1.26-1.77) as well as unmet dental needs (OR=1.78 CI= 1.28-2.46). Attenuation analyses showed that household material hardship and health insurance could partially explain this correlation. Although this finding may be relevant for some countries, it does not entirely apply to children in New Zealand as oral health care is free for children under 18. However, the study also explored the factors that prevent children from accessing oral healthcare, such as transport, transiency, and lack of knowledge around the service, resulting in unmet dental needs and costly fees for orthodontic treatment, creating inaccessibility for some. This finding can be generalised to healthcare in New Zealand, which for children is most often free, there are still some families that encounter similar barriers to accessing the services. These findings suggest a need to increase oral health literacy among children experiencing PI and their families as well as generally to provide more support to help families achieve better health outcomes. This could be completed by supporting families with transport to appointments as well as educating families on the importance of attendance and how the healthcare system functions.

Jackson et al. (2021) found a similar correlation between PI and poorer physical health. Their study, which considered data on 102,341 children aged 0-17 from the National Survey of Children's Health in the US, looked at children exposed to PI compared to children who were not exposed to PI but other family stressors of adversities, specifically ACES. The study examined health difficulties, chronic physical conditions, development disorders, and mental health conditions. Covariates included age, sex, race, household poverty ratio, neighbourhood disorder, maternal age at birth, parent education, parent marital status, immigrant status, and insurance status. Results showed that PI is associated with increased health risk among all dimensions, particularly with multiple health challenges in each dimension. For example, the researchers found a 57% RR of multiple health difficulties (relative to none), a 26% increase in RR for multiple chronic physical conditions (relative to none), a 58% increase in multiple developmental disorders (relative to none), and a 130% increase of multiple mental health conditions. Children from neighbourhoods with more significant disorder reported more health challenges in each dimension, and children above the poverty line showed fewer health difficulties; both of these ideas are also reflected in the studies mentioned (Jackson et al., 2021).

Moreover, in Jackson et al.'s (2021) study, children with PI have shown a 30% higher rate of health conditions across all dimensions compared to those without PI; however, compared to children with other ACES, the results are very similar and not statistically significant. PI was also associated with worse outcomes than other reasons for removal of a parent, potentially because, "unlike separation due to parental death, divorce or hospitalisation, the stigma associated with incarceration may discourage parents and caregivers from discussing the nature of the parent's absence with children and undermine children's access to social support." (Johnson & Easterling, 2012, as cited in Jackson et al., 2021, p.12). This quote indicates that there may be a correlation between incarceration rates being higher in lower socioeconomic groups. Jackson et al. (2021) suggested that, instead of focusing on reducing PI, funding should be increased to generally improve access to healthcare and education in lower socioeconomic neighbourhoods as this would also make the children more resilient to negative influences should they experience PI. This demonstrates how important it is to truly understand the needs and hardships that the children and families that health professionals are working with are experiencing; care should be holistic and wrap around to help improve outcomes for these children.

In contrast to the studies above, where losing a parent to PI had a negative impact on the aspects of physical health examined, Branigan and Wildeman's (2019) study found a positive impact on having a parent that is incarcerated. Their study looked at 2,142 nine-year-old children from the Fragile and Child Wellbeing Study to explore whether the rates of obesity and PI correlated, specifically whether obesity was related to the mother, the father, or both being incarcerated. The study controlled for race, sex, parental socioeconomic status, maternal obesity, parental impulsivity, and child temperament. It found that the odds of being overweight were significantly lower if a child's mother was the only parent ever incarcerated (adjusted odds ratio [aOR]=0.43 95% CI=0.22-0.83) or if both parents were ever incarcerated (aOR=0.58 95% CI=0.380-0.87). Although research often links parental absence and PI with adverse effects, changes in the environment due to PI can be relevant for the BMI (Body Mass Index) in young children that have their food and physical activity controlled by adults. At the same time the results may indicate a potential for maternal neglect, where mothers are not attending to children’s nutritional needs, resulting in obesity. Overall, the study demonstrated that PI is not a blanket term and can be very dependent on whether a child's father or mother is incarcerated; this is not a separate finding as other studies within this literature review have made similar observations (Branigan & Wildeman, 2019).

Home and Family

The incarceration of a parent is a traumatic event that is likely to have a fundamental impact on the family's home life. Thus, can increase financial hardship and the workload for other household members; this added pressure can make it difficult for the family involved (Gordon & MacGibbon, 2011). These time constraints also have the potential to reduce the parent's educational involvement, such as attendance of parent-teacher interviews and home-based schooling activities like helping with homework.

Testa and Jackson’s (2020) study examined the relationship between PI and school readiness among three to five-year-olds. It had 15,402 participants and used data from the 2016-2018 US National Survey of Children's Health. It looked at four domains of school readiness, including early learning skills, self-regulation, social-emotional development, and physical health. The study controlled for child age, race, sex, firstborn, poverty, parental education, and schooling status. The results showed that children with PI are significantly less likely to be on track across all four domains (t=8.73. P<0.1) and were more likely to be on track for only two or fewer of the domains (t=12.28 P<0.1). Furthermore, oncer controls were adjusted for, the risk of being on track for none of the domains was elevated (Relative risk ratio=3.82 CI=1.78-7.78). Thus, their findings suggested that the probability of being on track for all four domains was 0.40 for children without PI compared to 0.22 for children with a PI. On average, all the covariates were significantly varied by PI; children affected were more likely to be older, non-white, firstborn, have a lower socioeconomic status, English as their first language, native-born parents, younger mothers, less educated parents, unmarried, and non-parents as their caregivers. As previous studies have mentioned, it was suggested that health outcomes could be improved by reducing risk factors for these children. Unlike other relevant literature, Testa and Jackson (2021b) suggested the need for home-visiting programs and nurse-family partnerships to enhance cognitive and socio-emotional skills in children. When a child and their family are visited in their home, many barriers to access are reduced, which improves the families' engagement with the healthcare provider.

Family and home life can be significantly affected by different cultural views and aspect of parental incarceration, resulting in significantly worse outcomes for children. This was highlighted in a Chinese study conducted by Xia and Lam (2018) which explained how, similar to New Zealand, extended family plays a significant role in looking after its members. However, according to the Chinese belief system, the families of those incarcerated should also be punished as a whole, and therefore, children are not entitled to any support from the government as they would be in a more western country. Xia and Lam (2018) found that the children of incarcerated parents (or one and one not alive) are not accepted by their extended family members due to shame, dishonour, and limited resources. Qi-qi, one of the seventeen children interviewed in this study, noted that "my paternal aunts just did not care, neither did my maternal aunts, none of them cared. Does anyone care about us? No one!” (Xia and Lam, 2018, p. 197). One of the themes identified in this study was entitled "I am an extra burden to others", highlighting that many of these children who are being passed around to others felt that their presence was a burden, creating feelings of guilt and shame. This study helps remind professionals that different cultural backgrounds and belief systems prevalent in a family may affect the way that PI is managed. This may have the potential to affect how children are able to cope with the situation and get on with everyday life. These children may not have a standard home or family and it is therefore important to consider how this may affect their overall health and wellbeing. Fortunately, although poorer school attendance for children experiencing PI has been noted in New Zealand (Social Policy Evaluation and Research Unit, 2015), they may not experience shame as intensely as the children interviewed for Xia and Lam's (2019) study, allowing them to attend school and other activities without fear of social ostracization.

Mental Health

According to the World Health Organization (2022), mental health can be described as a state of mental wellbeing that helps people deal with life's stress, learn, and work well, contribute to their community, and understand their abilities. It is an essential aspect of an individual's health and wellbeing that allows one to make decisions, understand the world that we live in, and build relationships with others (World Health Organization, 2022). A person's mental health is shaped by different experiences they have had as well as by genetics. Risks during vulnerable stages, particularly childhood, can harm an individual's mental health (World Health Organization, 2022).

A quantitative Irish study looking at associations between PI and children's emotional and behavioural development consisting of 8,568 participants conducted by Bradshaw et al. (2020) looked at children at ages nine and 13 using a dataset from the first two waves of the National Longitudinal Study of Children. The results controlled for age, gender, ethnicity, the highest level of parent education, if the parent or caregiver was biologically related, and the percentage of the income. The results demonstrated that children experiencing PI are more likely to come from socially disadvantaged homes and likely to have also experienced other stressful events in life. It compared a matched sample of children who did not experience PI compared to those that have, finding that nine-year-old children experiencing PI reported higher levels of anxiety (mean difference 1.31, 95% CI= 0,28,2.34, p=.01) as well as lower levels of happiness at 13 years of age (mean difference -.88 95% CI= -1.51-0.25, p=.007). Despite the finding of poorer mental health for children experiencing PI, there was no statistical significance in mean levels of internalising or externalising difficulties in the two different tests completed. However, there was a significant finding in the first wave indicating that children who had experienced PI had lower levels of freedom from anxiety in comparison to those without controls (mean difference −1.23, 95% confidence interval [−2.43, −0.03], p = .049). This was then supported with results in wave two, when the children were 13 years old, where those who had experienced PI demonstrated higher levels of emotional symptoms compared to the children who had not (mean difference 1.31, 95% confidence interval [0.28, 2.34], p = .01). The study noted that caregivers can experience a great variety of stress that can affect the child's environment (Bradshaw & Muldoon, 2017; Bradshaw et al., 2020). These stressors can mean that the caregiver has less time to spend with children, with the result that needs may not be met, thus negatively impacting their mental health.

The effect that PI has on mental health was also explored in terms of behavioural problems and cognitive ability. Branigan and Wildeman's (2021) study consisted of 3246 participants aged nine years old and examined the relationship between bedtime schedules and the regulation of sleep. Research suggested that having a set bedtime routine managed by a caregiver was associated with longer sleep duration and better sleep quality. Longer duration and better-quality sleep can lead to a lower likelihood of behavioural problems and, therefore, was significant for Branigan and Wildeman's (2021) investigation. This study considered socioeconomic controls of child sex, race, ethnicity, household income, education, and age of the child's parent at birth. The results of this study showed that there were no statistically significant differences of PI status in bedtime schedules (odds of having a set bedtime, timing of bedtime, or having a routine). However, the results did highlight that having a father with a history of PI was associated with lower odds that a child would consistently adhere to a set bedtime (OR 0.83 95% CI = 0.70-0.98). This means children with a father in prison but not a mother at home where they were less likely to have good sleep and less likely to have an inconsistent bedtime. In addition to this, these children indicated that they got around 10% less sleep per night, meaning that these children were also more likely to have a shorter duration than the National Sleep Foundation requirement net controls (OR 1.23 95% CI= 1.03-1.47), which was slightly reduced when a consistent bedtime was accounted for. The idea that a child's experience can be affected by which parent is incarcerated was also mentioned in the literature looking at physical health and the relationship between PI and obesity above (Branigan & Wildeman, 2019).

That children with a history of PI were less likely to follow a set bedtime was a significant finding as inconsistent bedtimes were related to behavioural problems with worse cognitive performance in children. These behavioural and cognitive difficulties may present themselves in different ways, such as acting out or poor performance at school (Goodfellow Unit, 2018a). However, it was also discussed that children experiencing PI are likely to be experiencing numerous additional challenges that could interrupt sleep and should be considered when trying to understand the behaviours that these children display.

Chapter 3: Methods and Methodology

Methods and Methodology

This chapter looks at the aim of the study, the research title, the design, the paradigm, and the methodology. The data collection and analysis method, as well as ethical considerations and risks, are also discussed.

Research questions are a way of expressing your interest in a select topic (Agee, 2009). Qualitative research narrows down the type of data that is collected, looking at the topic of interest and questions the population that is experiencing or has experience with this selected topic (Flick et al., 2004). The selected topic is portrayed in the research title "Health Professionals' Perspectives on the Health and Wellbeing of Children with a Parent or Caregiver in Prison. A Descriptive Qualitative Study". This title identifies that the participants will be health professionals with experience working with children and their families who have a parent or caregiver in prison. It highlights that the topic of interest is the health and wellbeing of these children.

Research Paradigm

A paradigm can be described as a person's worldview or perspective of their being in the world (Mackenzie & Knipe, 2006). An individual's paradigm can influence how research is completed as their views may affect the way they understand and analyse data. As each person's experience and understanding of their research topic will differ, they will approach their research, methods, and discussions differently (Creamer, 2017). Researchers will often select a paradigm to approach their research and topic of interest, allowing them to decide on what is genuine, legitimate, reasonable, and essential (Williams, 1995).

The paradigm chosen by the researcher is an interpretive paradigm. This paradigm was chosen because the researcher acknowledged that each healthcare professional working with these children and their families had had different experiences, outlooks, ideas, and perceptions of a potentially similar experience. This paradigm is based on the assumption that reality is subjective and socially constructed (Putnam & Banghart, 2017). This allows the researcher to gain insight into the viewpoints of the participants and the thought processes behind their thinking rather than the researcher's viewpoint (Kivunja & Kuyini, 2017).

Research Design

The research design refers to how the researcher intends to collect suitable data to answer the research question (Aparasu & Bentley, 2014). To adequality discuss this research topic, a research design was created to capture the participant's experience and expertise in this specialised practice area.

Methodology

The methodology allows the audience to understand how the design has come about from the paradigmatic stance of the researcher. The methodology chosen for this research is qualitative descriptive. Understanding the method is important as it helps provide a rationale for how the researcher has chosen to collect and analyse data. Understanding the methodology is essential for readers, allowing acknowledgment and understanding (Newhart & Patten, 2023).

Qualitative research allows an individual's ideas and views to be shared (Sutton & Austin, 2015). In this sense, a qualitative approach is helpful to gain insight into health behaviours and experiences with illness and create health interventions and that are fundamental for improving healthcare provisions (Renjith et al., 2021). The main goal of qualitative descriptive research is to concisely describe an event that may be either poorly understood, or to explore phenomena that may be well understood using a different paradigm (Kim et al., 2017). It helps researchers to understand a topic better through the perspectives of the relevant participants using their language (Malagon-Maldonado, 2014). The qualitative descriptive approach aims to answer truthfully how a particular group feels and responds to a select topic (Malagon-Maldonado, 2014). Qualitative research is often utilised in the health industry as it provides a personal perspective on the interactions and the care that health professionals provide in their everyday practice. It can help to explain complex and sensitive subjects keeping participants and researchers safe while allowing all ideas to be considered and presented in a thoughtful and relaxed manner (Silverio et al., 2022). Thus, considering the aim of this research is to explore the issues encountered by children with a parent in prison to identify ways to better support them, the qualitative approach matches the study's goals the qualitative description approach can be deemed suitable to fulfil the study's goals.

Method

A research method consists of the researcher's approach to the topic, such as the techniques and procedures used to collect, analyse, interpret, and share the collected data (University Libraries, 2018). The same topic may be researched by different people in different ways; the researcher's experience and understanding of the topic shape the way it is completed and the audience for whom it is being written (Creswell & Creswell, 2017). The sampling, recruitment, exclusion, and inclusion criteria, data collection, and analysis will be discussed in this section.

Sampling

Sampling is how the researcher identifies the participants that will partake in the study (Martínez-Mesa, 2016). This will be determined by the topic that the researcher has chosen, their design, the number of participants, and the methodology selected. Due to the nature of qualitative research to gain in depth insights from often only a small set of participants, these participants need to be selected with care.

The type of sampling used for this research consists of non-probability sampling using self-selection sampling. This type of research relies on participants who volunteer to be part of the research (Sharma, 2017). In addition to meeting specific criterion (Alvi, 2016), participant sample size was discussed with the supervisor and the Chair of university's ethics committee deemed the approach as realistic for a Master's project; as the goal was description and not generalisability, the sample size was sufficient to include a variety of different perspectives from which instructive data is possible (Boddy, 2016).

Using self-selective sampling means extending an open invitation to a particular group of people who are likely to have experience with the issue under investigation. Those who express an interest in participating in the study are then matched against the selection criteria so that only those who fit the profile are included in the study (Lund Research, 2012). In this study, an advertisement (Appendix C) was put onto a social media network for healthcare workers, including those who had the potential to have worked with children and their families that have a parent or caregiver in prison. In most qualitative studies, the sample size tends to be smaller; this study has a sample size of six participants as the focus was to obtain in-depth and information-rich data about the selected topic. While the small sample size may reduce the research's generalisability to a large population, it allows the researcher to spend more time with each participant, ensuring that their opinions and experiences are genuinely heard and considered expert knowledge. The first data collection plan aimed for only three participants, but this was changed to six during the early planning stages in order to ensure a more extensive range of data could be collected.

Recruitment

The recruitment of this study was completed by posting an advertisement for the study on the page of a healthcare group on a social media network. The advertisement posted had general information about the study, such as the title, topic, ethics approval information, duration of participation, as well as contact information for the researcher and supervisor.

Interested participants contacted the researcher via email, text, or in person. This allowed any questions about the study to be answered. Potential participants were given the information sheet (See Appendix B for the information sheet), which included the inclusion and exclusion criteria and purpose of the research, allowing them to decide whether or not they would like to participate; the sheet was offered in person or via email. If a potential participant agreed to participate in the study, a consent form was sent via email or handed over in person, and then a mutually agreed date and time were established for the interview. The interviews were offered at a booked meeting room at any AUT campus or in the hospital setting, allowing privacy and confidentiality to be maintained.

Inclusion Criteria

The health professionals included in the study needed to have had recent experience (last five years) working with children and families with a parent or caregiver in prison. For the purpose of this study, anyone working in healthcare, including but not limited to, nurses, doctors, physiotherapists, cultural support workers, and social workers, are considered health professionals.

Exclusion Criteria

Those interested in participating who have a child or family member in prison were not interviewed as the study focuses on a professional rather than a personal experience. This criterion was necessary as the study aims to understand the perspective of health professionals working with children and their whanau that have a parent or caregiver in prison.

Risk

Careful consideration and ethics approval had to be sought for this topic due to its complex and sensitive nature, which will be discussed later in this chapter. Even though the questions used in the interviews were aimed at participants' professional rather than their personal experience, it was acknowledged that participants may experience some emotional discomfort if, during the interview, a memory or experience they had encountered is triggered by the questions in the interview. After all, the study looked to interview experts on potentially traumatic but routine events in their everyday work experience. Therefore, the inclusion and exclusion criteria were important to ensure participants could provide relevant, up-to-date, and protective insights on the situation of children experiencing PI in New Zealand.

Setting

The interviews were conducted in a large public hospital interview room or any available interview room at one of the AUT campuses. This was done to ensure the privacy and confidentiality of participants, allowing a relaxed environment where participants felt comfortable sharing their experiences (Kaiser, 2009). As qualitative research requires an in-depth collection of data, the relationship between the researcher and participant must be trusting and robust, ensuring participants feel comfortable to truthfully share their experience of the selected topic (Guillemin et al., 2018).

Data Collection

Data was collected during June 2023 using the chosen research methodology of a semi-structured interview approach, with interviews being conducted one-on-one and face-to-face. A semi-structured method was selected as it involves participants answering preset open-ended questions, providing significant insight into the selected topic (Jamshed, 2014). In addition to this, a semi-structured approach creates reciprocity between the participant and the researcher as it allows a give-and-take environment where the researcher can ask for clarification and probe further into the participant's responses (Galletta, 2013). In addition, the semi-structured approach allowed participants to talk about their experience of the chosen topic and express accurate and relevant details (Al Balushi, 2016).

While participants were given the choice if they wanted to conduct their interview in a meeting room at any of the three AUT campuses or at the hospital setting all participants opted to have their interviews completed in the hospital setting. This ensured accessibility, privacy, and confidentiality by offering the meetings away from their clinical space, reducing the stressors of sharing personal information. Before the interview, the researcher again discussed the inclusion and exclusion criteria, offered to answer any questions, and confirmed with the participant that they wanted to participate, reminding them that it was not compulsory and that they did not have to partake. They were also informed that they could withdraw from the study at any stage before the end of the data analysis without any disadvantage. Participants were given the contact information on the information sheet to access support offered through Auckland University of Technology should they require any follow-up support post-interview. The interviews were conducted by the primary researcher and, with the participants' consent, were recorded on a recording device. Participants were then asked predetermined and follow-up questions on the selected topic (see Appendix E for the interview schedule). The follow-up questions allowed the researcher to extend participants' answers and discuss in-depth their experience around the selected topic (Turner, 2010). These questions were selected as the researchers felt they provided significant insight into the topic, working towards understanding current practice and how this could be improved for the future.

Transcription

The interviews were transcribed from audio to written text. The audio was transcribed by the researcher and rechecked twice to ensure that the audio and written text accurately represented one another. The transcribed data was stored on a secure USB, separate from the consent forms, stored in a locked drawer within the AUT North Campus.

Data Analysis

Analysing qualitative data requires organising, structuring, and giving meaning to the data collected from participants. It is done to make sense of the data (Ngulube, 2015), allowing the researcher to understand the selected topic and the unique experiences from the participant's point of view. The data was analysed using a descriptive method allowing the data to stay as close as possible during the analysis stage, creating an actual transcription of the participant's responses (Sandelowski, 2000).

The data was analysed using a thematic approach as it allows general patterns and themes summarise essential aspects of the data relevant to the research topic that to be pulled from the data (Alhojailan & Ibrahim, 2012). This method was selected as it follows a step-by-step approach to working with qualitative data collected from the participants (Braun & Clarke, 2006). These themes are created from small meaningful ideas that carry the same understanding throughout a large amount of data, creating connections throughout the whole data set (Maguire & Delahunt, 2017). This type of analysis fits well with the selected topic as it provides a framework to identify common themes from the accounts of health professionals on the health and wellbeing of children and their families with a parent or caregiver in prison. This type of analysis utilises identifying and coding patterns across the whole data set, allowing an overarching thematic story to be created without losing the richness of the data (Maguire & Delahunt, 2017).

Braun and Clarke (2006) outlined six phases in the thematic analysis process.

First Phase- becoming familiar with the data set by reading and rereading transcripts, listening to the audio recording, and ensuring the accuracy of the transcriptions. This allows the researcher to engage with the data, looking for exciting findings, connections, or other important ideas. It is the foundation of the analysis process as it means that the researcher notes ideas and codes specific items from the whole data set.

Second Phase- the researcher begins to code and label aspects of the data set relevant to the research. These codes are the basis for analysing the data set, allowing the organisation of groups for analysis, and meaning and patterns to arise from the whole data set. This coding must be applied consistently throughout the entire data set, highlighting meaningful units to be identified as relevant to the research topic. When these codes are separated into subgroups, also called themes, a straightforward narrative can be produced of the specific data set. These themes are created from the analysis of the data set, and they highlight bold patterns that are relevant to the selected topic.

Third Phase- Once themes are formed, the researcher reviews the themes and refines them in relation to the whole data set, ensuring that all themes reliably adhere together, creating a pattern.

Fourth Phase- A thematic map can be created to review the data, using the relationship between the potential themes and the entire dataset, to help the researcher identify an overarching story from within the data. This story creates an understanding of the concepts and boundaries of each theme, subtheme, data extract, and code that serves to answer the research question.

Fifth Phase- The themes are then named and defined. Themes are defined by assigning a central working idea of the theme and marking its boundaries. This stage helps to clarify each theme's scope and meaning. Following this, names are given to themes that capture the reader's attention towards the content and scope of the analysis. Using this, the researcher then writes an analytic narrative, telling the story within the data, ensuring that each theme relates to its extracts precisely and cohesively.

Sixth Phase- A report is produced where the themes are analysed, and an in-depth account of the story is created from the data. The researcher analyses the research question, then the themes are tested against this. The data and the analysis are discussed in relation to the broader literature to help answer the research question. This final report shows the researcher's logical data analysis in relation to the research question and the literature about the selected topic.

During the analysis process, each phase was discussed with the researcher's supervisor, allowing the information to be assessed by an experienced researcher. This provided guidance and feedback for the researcher to utilise in the process as well as ensured the quality of the data analysis presented in chapter 4.

Validation

Participants were asked if they would like to confirm the accuracy of their transcripts via email. The purpose of this is to ensure that the data captured the participant's experience accurately. Only some of the participants opted to complete this.

Ethical Considerations

Ethics approval from the Auckland University of Technology Ethics Committee (23/144) was sought before starting this study (see Appendix A for the letter granting Ethics Approval). This was completed to ensure that all ethical aspects of the study were considered and well thought through because the study involves human participants and focuses on what can be considered a sensitive topic. This research design recognises participants as experts in the subject area, allowing them to share their perspectives and develop a partnership with the research, who has also worked in this field. This collaborative approach is likely to result in accounts that have the potential to deepen our understanding of the field of practice. The interviews were conducted in a non-judgemental atmosphere and any information that could potentially lead to participants being identified were redacted from inclusion this thesis or other publications. This means any information revealing the participant's identity were removed. All participants were informed that their data would be securely transcribed on a password-protected laptop, having the consent forms and the transcripts stored separately on

USB and destroyed after six years. This information will be stored securely within the AUT North Campus.

The research was completed in a way that is mindful of findings pointing to overarching systemic issues rather than individual faults. The Treaty of Waitangi obligations were considered in the design, in particular article three, the promises of the Crown. This article emphasises equity, royal protection, and benefits to Māori (Waitangi Tribunal, 2021). Its purpose is to create equitable outcomes for Māori and non-Māori, which, as mentioned previously, is not occurring in our society today considering the high imprisonment rate of Māori people in New Zealand. Although this research was not focused on the ethnic background of the children discussed, it is still considered relevant to support equitable outcomes for all and has been considered as part of the ethical consideration.

In addition, all questions and concerns about the research were answered openly and honestly, allowing participants to make informed decisions regarding their participation in the study. To ensure that participants understood this information, information sheets and consent forms were given out and completed before the interview (see Appendix B for the participant sheet and Appendix D for the consent form). Participants were also reminded throughout the process that they could withdraw from the study at any time before the end of the data analysis without any disadvantage.

Summary

This chapter has explained the research design and method as well as given rationale and explained the appropriateness of the methodology chosen in relation to answering the research topic. It described the methods for how participants were recruited, the setting of the research as well as data collection and analysis. It explored the ethical implications associated with the research topic. The next chapter will discuss the main themes identified in the analysis process.

Chapter 4: Findings and Discussion

Findings

This chapter presents the findings of this dissertation, looking at health professionals' perspectives on the health and wellbeing of children with a parent or caregiver in prison. The identity of the participants is protected by using pseudonyms that have been randomly selected, removing any details that may identify the health professional or their workplace. Omissions are marked by the symbol "..." .

The six participants interviewed were all health professionals working with children with a parent or caregiver in prison in the last five years. As this study focuses on the professional perspectives of health professionals rather than their lived experience, participants do not have a family member in prison. Within the data set, three out of the six participants were in senior roles. The process of analysing the data has been described in the previous chapter. The three main themes that were identified in the data are discussed using participants' quotes to provide examples and shed light on their experiences.

The process of analysing the data has been described in the previous chapter. Two main themes were identified and are discussed here using participants' quotes to give examples and illustrate each.

The two main themes identified from the interviews are "*it takes a village*" and "*the child as a whole*".

It Takes a Village

While none of the participants spoke of 'a village', the phrase is used to capture the ways they described necessary interconnectedness of support to provide a healthy and safe environment for these children. Originally an African proverb, the saying, 'it takes a village to raise a child' has been broadly accepted as a metaphor to express that caring for children is too important to not be a shared responsibility (Reupert et al., 2022). The necessity for less siloed and more participatory approaches was clearly expressed across participants, for example:

> “We have to work in collaboration. It is the community’s responsibility. It is a community obligation that we come together and work in collaboration, the health team, the school, social workers, allied health, everyone comes together to give the support that these children need. And sometimes it’s not easy. But we can try our best. But they definitely need support. Then no one has to miss out and no one is left behind”. [Tania]

All the participants had a strong focus that improving outcomes for these children was not a one-person task. Whether telling stories from their practice or articulating ideas for improvement, a consistent idea was that for families, a range of people needs to be involved in these children’s care. This range of people might include, but is not necessarily limited to, family, nurses, social workers, counsellors, teachers, and Oranga Tamariki. When health professionals felt there was good communication and teamwork between the different teams and sectors, they also felt that the outcomes for the child improved. As quoted above, Tania, a senior health professional, emphasised the importance of collaboration as a “community obligation”. That obligation encapsulates how communities or villages work together for each other.

Similarly, Rita, a registered nurse, stated that to positively contribute to the health and wellbeing of these children, a good support network was required:

> “increased support network through social workers and community health works….good community supports, outreach team,…supporting with dental checks, immunisations at home, transport, taxi chits to hospital appointments and also getting kids enrolled in kindergarten using the 20 free hour service if possible… Family Start to fund kids to be in kindergarten under three years old… the pick-up and drop-off service, a lot of kindies [pre-school facilities] do it so mom doesn’t have to drop off the kids herself, nurse practitioner’s into the home to assess skin and health”. [Rita]

Rita clearly listed practical interventions offered by the multiple teams involved to help families and children. However, Rita also noted how previous stress and trauma, such as "previous CFYS involvement with the mother" and "family violence," can create a barrier to accessing the support required.

A slightly different perspective of a successful team approach was shared by Kim, an experienced health professional who has recently progressed to a senior role. As well as the practical help, Kim noted how changes in context can make the interventions more effective. Telling a story from her practice, Kim described how outcomes were improved for the child when the father was taken to prison. She explained how, in prison, he could undergo counselling and get support for his drug and anger issues, helping the family dynamic overall. Kim told a similar story about of one of her clients:

> "once dad went to prison, … I found that relationship improved, and she really opened up and was happy for supports, and we managed to get him (the child) linked into health appointments that he needed and developmental screening… so I think it gave them to opportunity to start working on themselves".

Kim also said that previously the mother was in "survival and panic mode" but once the father was in prison, she felt "safer". [Kim]

Fiona, a health professional with over two decades of experience, faced challenges with communication between health professionals, students, teachers, and parents in the school environment. Fiona found that these difficult conversations were not always direct, and information may be passed on via other team members to get to her, making communication difficult. She explained:

> "(I) had to have these three-way conversations with the children. That was something that I was starting to see a lot more. That was difficult." [Fiona]

Another concern noted by Fiona was that for the support to be provided, someone needs to be aware that support is required. Fiona felt strongly about this, mentioning it twice:

> "some people don't know how to ask for that support." [Fiona]

and

> "I found that they were parents brave enough to come and approach the nurse, the social worker, (to) come and talk to them… it's a trust aspect, if they felt their children talked highly of the social worker, they found the courage to come in and visit and approach them personally in school. So, I saw that strength in one or two parents and some you know, some parents just avoided you." [Fiona]

The quote above also highlights the rapport that is required to be established in order to obtain successful engagement. This finding was widespread across all participants; including Lila, [provide her little background blurb], who provided a vivid account of the role of trust in providing care for these families:

> "Yeah, it was good and we were quite close in a professional sense there. I got the trust and yeah, if someone couldn't get them to do something, I mean as in attend clinic appointments, because they couldn't reach (them) or didn't have that trusting relationship, they could ask me to go on their behalf, and because I'd established that relationship with the family, they allowed me to do that." [Lila]

Cindy, an experienced frontline health professional, also talked about rapport at a time when care went well for a family that had a parent in prison. Cindy explained how she worked to:

> "understand the family dynamic and building a good rapport and trust with the family and the child and understanding how you can support them." [Cindy]

Throughout the data findings, it was evident that all health professionals who were interviewed felt it was essential to identify where care and support are required and to understand the needs of the family, adopting a family-cantered approach to care. It was also imperative to the health professionals that the support provided to these children and families is through a multidisciplinary approach, and that communication is clear and consistent.

Another idea that aligns with the theme of "It takes a village" voiced by all participants is how the family dynamic or structure changes when a parent has gone to prison. Tania, Rita, Kim, and Cindy all touch on the loss of a parent, corresponding with a loss of time that the remaining parent may have previously had to spend with the children. Tania discussed:

> “while some children may be neglected, some children will probably get abused physically or harmed because there is only one parent. And when they get stressed, they, the other children might get a hiding or something”. [Tania]

Tania also mentioned that because the mother is busy dealing with the children, chores, and everything else, and there is no one to help with the children, so they may often be left alone with devices to keep busy. Kim also mentioned a “changing environment” where everything is put into “what’s the priority”, emphasising how difficult managing as a single parent can be and the vital role that the village plays in these families’ lives.

Another aspect of the village metaphor are the bystanders. Not directly involved with these children, but still making an impact in their lives, bystanders are members of the public and society that create a stigma that affects the children in their everyday life. Both Lina and Rita mentioned this idea of public stigma. Lina noted:

> “I think our society still has a lot of prejudice and bias against prisoners and the prison system. So, I feel like it’s an inequity created for children. If it’s known that they’ve had a parent that’s in jail or prison, I feel like they’re already on the back foot.” [Lina]

This quote from Lina highlights the implications that the village can create, demonstrating that the ‘village’ does not work equally well for all. These children may be judged by society, creating barriers to accessing the required support and care. There is a need for these families to be listened to and understood by all; when a child’s parent or caregiver goes to prison, they may be judged by others who may not know the impact that this may have on the child. This can lead to assumptions that they may end up like their parents or live in an unhealthy or dangerous way.

The Child as a Whole

Children’s health and wellbeing are multifaceted and complex, and having a parent or caregiver in prison adds another layer to the complexity. When a child’s parent or caregiver goes to prison, as mentioned above, a change in environment and family dynamic occurs, affecting the child in many visible and invisible ways. All participants interviewed listed many physical and mental effects that this experience can have on a child, such as bedwetting, anger, behaviour issues and mental health issues. Lina provided the following account:

> "You might see developmental milestone regression as they regained a sense of control back, you know through wetting, fussy eating, or that is the child's way. With the older children, which is what I experienced, it was things like truancy and increased risk-taking, but then it's a sense of them gaining control against trauma or protectiveness… I think because that is a heightened response and you think of the physiological effect, the cortisol pumping through, the adrenaline going through when you're heightened, when you're grieving, when you're worried, I think that leaves your body biologically open to illness, infection, and mental health issues". [Lina]

In this quote, Lina highlighted how the experience of having a parent or caregiver incarcerated can affect the child in multiple different ways. The consequences of having a parent incarcerated may include aspects of physical health, but it can also impact developmental stages and lead to alterations in behaviour.

Fiona also found that these children suffer from many mental and physical issues. Thus, Fiona reported that children who were experiencing PI at the time would often be referred to her for physical issues such as ear infections that uncovered a much bigger picture:

> "if it wasn't a tummy problem, it was a problem. If it wasn't a problem, it was my, my foot hurts or something else hurts. That call, the cry attention? Certainly, that was there. Gosh" [Fiona]

The idea that these children were not brought to the attention of Fiona for having complex social needs but on their own terms because they wanted attention indicates that their needs may have been missed and appropriate support had not been put into place. This finding is significant as it indicates that seemingly innocuous problems may signify more significant holistic needs that are not being addressed.

Rita, Kim, and Cindy all discussed the barriers of access to healthcare and how this can affect a child's physical health. Kim stated:

> "There may be less focus on the child's health development because everything is put into what's the priority, which is safety, of course, but there can be a lot of underlying health concerns that might not be picked up because the parents might be on their own now, doesn't have the time or money to be able to access care in a timely way". [Kim]

Similar to Kim, Rita commented:

> "less time and attention for the needs, development and physical wellbeing of the child and mom has less time to get the child to essential GP appointments, hospital appointments and school education because she has more financial needs or because she is going to do it on her own, doesn't have a car and can't get them in everywhere; also maybe they are funding dad in prison". [Rita]

In the above quote, Rita noted the negative effects of PI on the child's development and wellbeing; she also went on to discuss why this might be, exploring the challenges that losing a parent brings, such as a lack of income and greater demands on the time of the remaining parent, resulting in less time spent with the child, which have the potential to affect the child as a whole.

Tania also talked about access barriers to education, using the example that, sometimes, the single parent may find it easier not to drop the children to school as there is no one to pick them up, and it is easier to stay home. This means that children may miss out on the social interactions and education achieved at school, potentially impacting their education and employment in the future. Tania also mentioned how the remaining parent may not be able to spend much time with the children, meaning that they may be left to play on electronic devices for long periods, affecting their learning and causing other issues such as constipation from holding on.

Both Kim and Cindy talked about the bond lost when a parent is missing. Although Kim did not elaborate, Cindy talked about how this may lead to mental health issues, including "separation anxiety".

Health professionals can see a clear correlation between the direct, visible, and invisible effects that these children carry and display in their everyday lives due to having a parent or caregiver in prison. Health professionals can identify and assess individual physical and mental health issues, the visible and invisible effects of everyday lives of children who have a parent or caregiver in prison; however, it is just part of a bigger picture, the child a whole. A thorough holistic assessment must be carried out to inform health professionals to support and design interventions that cater to the child as a whole to ensure the child and their family are being supported in all ways needed. It is essential for health professionals to complete thorough assessments and understand the whole child, helping them to answer the why questions instead of just treating the presenting problem.

“It takes a village” and “The child as a whole” are two important themes that have been identified in the health professional’s interviews completed for this study. Both have significant findings that can be applied as a recommendation to everyday practice.

Recommendations for Practice

According to Te Whatu Ora (2023), current school-based health services use a positive youth development approach, supporting the mana of young people and working to improve their wellbeing and resilience. It is a nurse-run service that students can request, or nurses are able to reach out to offer support, and that has the authority to refer the children on to other services if required. It is only available in low decile schools, teen parent units, and alternative education sites; however, other schools may choose to pay for their own nurse. Although the literature and research highlight a common theme of financial stress, there are families who may have children attending a higher decile school. This means that these children may attend school where there is no nurse or health service available (Te Whatu Ora, 2023). This may result in difficulty accessing the care and support that the child and their family may need in order to support the child as a whole. The focus population for the school-based health service are Māori and Pacific people, members of the Rainbow community, young people in care, and those with disabilities (Te Whatu Ora, 2023). Although some young children who have a parent or caregiver in prison may be in care, there are many that live at home with immediate or extended family, meaning that this group of children have the potential to be missed or slip through the cracks. This service is advertised or shared with pupils and their families in different ways at each school, with some using newsletters while others rely on word of mouth.

Recommendations from literature and research conducted in this study identify a need for a service that is easily accessible for the whole family, including members of the MDT (Multidisciplinary Team), is low cost or free, and focuses on the vulnerable group of children that have a parent or caregiver in prison.

It Takes a Village

Practice recommendations indicate a need for a reliable village and safety net for these children and their families. This may include implementing a process where health professionals and other multidisciplinary team members are routinely notified when a child has a parent or caregiver in prison. It is understood that sometimes the school or different organisations may not know this information either. However, often, despite this being known, health professionals are only contacted when there is a problem. This process would prevent health professionals from being “the ambulance at the bottom of the cliff” and instead can provide a wrap-around service to prevent adverse outcomes from occurring. It is a well-known fact that health professionals are understaffed and overworked, meaning that care may need to be prioritised. This prioritisation is important as resources need to be focused where the most pressing need is in order to improve outcomes. If health professionals were more aware of these children and their families, they could work to prioritise equitable outcomes for this vulnerable population group. If this approach was implemented, health professionals would need to be aware of their unconscious bias (Oxtoby, 2020). As Lina mentioned, these must be acknowledged and understood to provide optimal care for these children and their families. This indicates a need for education and a better understanding of the impacts that a negative societal stigma related to their imprisoned parent can have on these children.

Recommendations based on this study include:

- A policy agreement between services to inform each other if there is knowledge of a child with a parent in prison;
- Education within services across multiple sectors on prejudice, common findings affecting the health and wellbeing of these children and their families, and how these can be minimised as well as what services are available for referrals to support these families;
- Champions within different services who can be the go-to people for support and questions as well as facilitate education updates.

The Child as a Whole

This study has highlighted the significance of genuinely understanding these children and their families' needs. The information presented in this study highlights that health professionals need to whakarongo (listen) to the needs of the children and families they are working with, using a strength-based approach, and listening to the voice of the child. This notion was also expressed in the findings of Reupert et al's (2022) study which noted that, in order to provide a safe environment for children where they are given the ability to flourish, develop, and create goals and dreams, an environment needs to be created where children’s voices are heard and taken seriously.

To give families this opportunity, a safe space or environment needs to be created where they can ask for the support they need. As Fiona mentioned in her interview, asking for help is not always easy. The idea of establishing an actual physical safe space would involve the creation of an environment where parents and children could easily access support for their physical and mental health, encompassing the issues that the child as a whole may be facing. This would be created to address the inequality in overall health outcomes that both the literature review and the research have highlighted. To address the time and transport barriers mentioned in the data by the health professionals, these safe spaces could be facilitated within school clinics or halls before and after school, a private room in the prison, or at local community halls. All locations would be community based and easily assessable. It would be run regularly, allowing these families to feel comfortable having consistent support where a strong rapport can be maintained. This safe space could consist of a nurse, doctor, social worker, cultural support, and other rotating multidisciplinary team members such as a dentist or physiotherapist, acknowledging that health and wellbeing is a complex idea and different members of the multidisciplinary team should be involved. This would be a space where families could easily seek support in a non-judgmental environment. This support service would address financial barriers by providing accessible primary treatment, education and advice for common conditions, and logistic management for support of referrals for more complex circumstances. It could also provide essentials such as food parcels and nappies.

These safe spaces could be promoted to families through advertisements within school newsletters and sent home to families, community pages, and prisons, outlining dates and times. There would be no need to book appointments or register, meaning families could access the service when it worked best for them, without feeling shame or stigma. This idea links back to the notion of the child as a whole as it acknowledges the wide array of different challenges and needs that these children face to achieve optimal health and wellbeing. It allows a safe space for the child’s voice to be heard and another opportunity for professionals to come together in a “single one stop shop” environment where they can ensure that the families’ needs can be met without relying on the idea of an ongoing engagement. It also allows the child and family to seek a key point of contact for support, without having to navigate the complexities of accessing multiple services. The service would use a strength-based approach, focusing on protective factors and what works well for the family, as it was highlighted in the literature that this approach improves and enhances the overall wellbeing of children. This initiative reflects the different elements of the whole child as expressed back to model of Te Whare Tapa Whā (Durie, 1994).

Finally, for this initiative and similar projects to gain traction and funding, more qualitative research on this vulnerable group is needed in order to gain rich insight into their experiences. In particular, more research is needed that focuses specifically on the families, looking at the voice of the child and their village around them. Despite the need for such in-depth research, most of the current research on children experiencing PI takes a quantitative approach, providing minimal insight into individual experiences.

These practice recommendations link back to the research findings as once the time is taken to understand a child's village and the role of a health professional within it, the child as a whole can truly to be understood. Once a child is understood, their village is given the option to come together to help meet the child's needs and help to create an environment for the child to reach their highest potential.

Limitations

There are a few limitations within the study presented here, including time, the scale, and the researcher's experience. This study was conducted as part of a qualification to complete a Master's degree in Nursing; therefore, there were time constraints for each aspect of the research. Despite the small number of participants, there was a consensus agreement on key issues highlighted by participants who have many years of experience between them. However, in order to generalise to different contexts more research is needed. As well as this, the inexperience of the researcher in completing the interviews may play a part in the nature of the data collected. This can be seen in the increased use of probing questions in later interviews, after the researcher has gained more confidence in their role as the interviewer and in the interview process.

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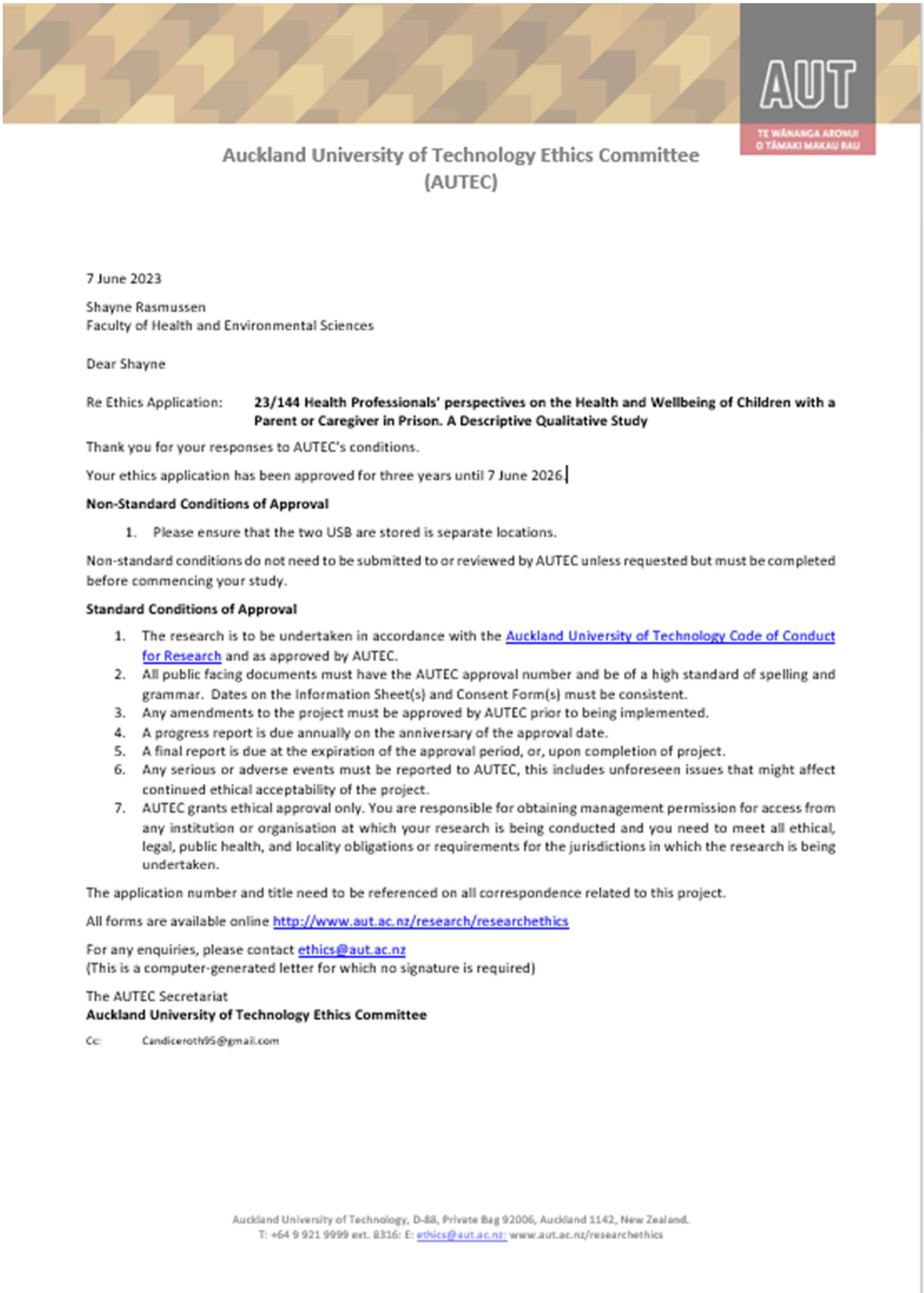
Appendices

Appendix A : Ethics Approval



AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Auckland University of Technology Ethics Committee
(AUTEC)

7 June 2023

Shayne Rasmussen
Faculty of Health and Environmental Sciences

Dear Shayne

Re Ethics Application: **23/144 Health Professionals' perspectives on the Health and Wellbeing of Children with a Parent or Caregiver in Prison. A Descriptive Qualitative Study**

Thank you for your responses to AUTEC's conditions.

Your ethics application has been approved for three years until 7 June 2026.

Non-Standard Conditions of Approval

1. Please ensure that the two USB are stored is separate locations.

Non-standard conditions do not need to be submitted to or reviewed by AUTEC unless requested but must be completed before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC.
2. All public facing documents must have the AUTEC approval number and be of a high standard of spelling and grammar. Dates on the Information Sheet(s) and Consent Form(s) must be consistent.
3. Any amendments to the project must be approved by AUTEC prior to being implemented.
4. A progress report is due annually on the anniversary of the approval date.
5. A final report is due at the expiration of the approval period, or, upon completion of project.
6. Any serious or adverse events must be reported to AUTEC, this includes unforeseen issues that might affect continued ethical acceptability of the project.
7. AUTEC grants ethical approval only. You are responsible for obtaining management permission for access from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

The application number and title need to be referenced on all correspondence related to this project.

All forms are available online http://www.aut.ac.nz/research/researchethics

For any enquiries, please contact ethics@aut.ac.nz
(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: Candiceroth95@gmail.com

Auckland University of Technology, D-88, Private Bag 92006, Auckland 1142, New Zealand.
T: +64 9 921 9999 ext. 8316: E: ethics@aut.ac.nz: www.aut.ac.nz/researchethics

Appendix B: Participant Information Sheet

Information Sheet

Participant Information Sheet

Date Information Sheet Produced:
1 June 2023

Project Title
Health Professional's perspectives on the Health and Wellbeing of Children with a Parent or Caregiver in Prison: A Descriptive Qualitative Study

An Invitation
My name is Candice Roth and I am a postgraduate student who is looking to explore the perspectives of health professionals about the health and wellbeing of children that have a parent or caregiver in prison. I am a Registered Nurse and Nurse Educator working in Starship Community. As part of my work in the community, I am interested in helping in improve outcomes for this vulnerable group of children. This research will also be used to complete my dissertation, allowing me to complete my master's in health science in Advancing Nurse Practice

What is the purpose of this research?
I hope to incorporate your first-hand experience to identify how these children's health and wellbeing may be affected. I hope my findings will ensure our approach to supporting these families and best practice is up to date and effective. I intend to identify and reduce barriers and challenges that may be highlighted by your first-hand professional experience that could prevent these children from having optimal health and wellbeing. I would like to explore situations when care went well for these families and how we can apply these found principles to everyday practice as a health professional. I intend to share my findings with health professionals that are interested or work with children and their families that have a parent or caregiver in prison, as there is a lack of data around these so-called invisible children. I aim to create a piece of work that will help to update policies and guidelines nationwide to ensure that these families are receiving excellent care, providing best health outcomes. In addition to this the findings of this research may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?
You have responded to an advertisement post in social media and have volunteered to take part in this interview. You have confirmed that you have recent experience (last 5 years) as a health professional working with children that have a parent or caregiver in prison.

How do I agree to participate in this research?
You will complete a consent form which is also attached in this email and send it signed back to me.
Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You can withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?
We will find a time and location that suits us both to meet. We can either meet in a booked in a private interview room at Greenlane Clinical Centre or AUT North Campus. I will ask questions in a semi structured interview format. This may take between 30 minutes to an hour. Your responses will be kept confidential to ensure no participants are able to be identified in my findings. These findings will be used to write my dissertation and once completed you will be able to read the final piece. Any information collected will have a pseudonym used and any potentially identifying information will be changed. The data will be kept securely on a USB, after six years the consent forms and data will be destroyed.

What are the discomforts and risks?
When discussing challenging areas of practice, it is possible participants may experience emotional discomfort if questions asked in the interview trigger uncomfortable memories or experiences you may have endured. In addition to this, if you know someone who has been or currently is in prison this may cause emotional discomfort.

Inclusion and Exclusion Criteria:

Participants must be health professionals with recent experience (last five years) working with children and their families that have a parent or caregiver in prison, this helps to keep our research up to date and relevant.
Participants who have a family member in prison are not able to participate in this study as this small study focuses on the professional experience of health professionals and not personal experience, preventing the potential for cross over of personal and professional experience.

How will these discomforts and risks be alleviated?
If participation in this interview causes any discomfort please contact:
AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9292.
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits to the participants?
There are no benefits to you other than supporting my research and the opportunity to share your perspectives. Participating in this study will allow me to complete my Masters in Health Science. It will also provide insight into this area of research, allowing the potential for current practice to be reviewed or provide an indication that more research should be completed in this area.

How will my privacy be protected?
A pseudonym will be used to protect your privacy. Along with pseudonyms, any information that could lead to you being able to identified will be changed in the write up of the study. I will transcribe the recordings myself in a private room on my own password protected laptop.

What are the costs of participating in this research?
There is no cost involved in participating in this study.

What opportunity do I have to consider this invitation?
You have two weeks to consider this invitation, allowing other participants to be involved in the study as an alternative.

Will I receive feedback on the results of this research?
If you have indicated on the consent form that you would like to receive feedback, you will be sent the URL for the final dissertation via email to read at your own leisure.

What do I do if I have concerns about this research?
Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor:
Shayne Rasmussen
0210405182
shayne.rasmussen@aut.ac.nz
Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?
Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:
Candice Roth
Candice.roth@aut.ac.nz
0212117253

Project Supervisor Contact Details:
Shayne Rasmussen
0210405182
shayne.rasmussen@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on *7 June 2023*, AUTEC Reference number *23/144.*

Appendix C: Advertisement

ARE YOU A HEALTH PROFESSIONAL WORKING WITH CHILDREN THAT HAVE A PARENT OR CAREGIVER IN PRISON?

Do you want to talk about your work with these whanau?
I'm looking to interview health professionals who work with children that have a parent or caregiver in prison
For more information on the interview process please contact the researcher at xjs6392@aut.ac.nz
Participants will be asked to participate in a one on one interview lasting around 60 minutes (online or in person)
Privacy and confidentiality will be maintained through out the process

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

AUTEC approval date: 7 June 2023
AUTEC approval number: 23/144

Candice Roth - xjs6392@aut.ac.nz
Shayne Rasmussen - Shayne.rasmussen@aut.ac.nz

Appendix D: Consent

Consent Form

Project title: ***Health Professional's Perspectives on the Health and Wellbeing of Children that have a Parent or Caregiver in Prison.***
Project Supervisor: ***Shayne Rasmussen***
Researcher: ***Candice Roth***

○ I have read and understood the information provided about this research project in the Information Sheet dated 1 June 2023
○ I have had an opportunity to ask questions and to have them answered.
○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
○ I agree to take part in this research.
○ I wish to receive a summary of the research findings (please tick one): Yes○ No○▪

Participant's signature: ....

Participant's name: ....
Participant's Contact Details (if appropriate):
………………………………………………………………………………………..
………………………………………………………………………………………..
………………………………………………………………………………………..
………………………………………………………………………………………..
Date:
Approved by the Auckland University of Technology Ethics Committee on 1 June 2023 AUTEC Reference number 23/144
Note: The Participant should retain a copy of this form.

Appendix E: Interview Questions

Questions for Interview

What is your health profession that brings you into engagement with children with family members in prison? Can you tell me about how you work with these children.

How do you think having a parent or caregiver impacts on the health and wellbeing of children who have a parent in prison? Can you think of any examples?

What do you think are the particular challenges for these children's health and wellbeing?

Thinking about their health and wellbeing, what do you think is different for children who have a parent or caregiver in prison? Why do you think this happens?

As a health professional what do you believe can be done to positively contribute to the health and wellbeing of children that have a parent or caregiver in prison?

Tell me about a time when you worked with a family that had a parent or caregiver in prison, what went well?

Follow up Questions:
Why do you think this happens?
Can you tell me any examples of this?
Can you tell me more about this?