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The needs of mothers with an addiction who have had children removed from their care

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PhD thesis by alternative format
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Abstract

This thesis brings together three key papers that each contribute to the understanding of the needs of mothers with an addiction who have children removed from their care.

The first paper focuses on child related risk information and recording of such in parents' electronic records. From 736 services users, 62.8% were parents with 38.3% of those having children aged 16 years and under. 78.4% of female service users were mother yet 54.7% of male service users were fathers. Of the 913 offspring, 32.1% were either in or had been in local authority care, the majority were in kinship care - 17.6% of offspring sample and 54.9% of the offspring in local authority care. Seven (0.8%) offspring were deceased, a two-fold increase in mortality rate compared to the general population. In the records of 53 parents (11.5%; 68 children) there was a discrepancy between the electronic records and staff knowledge.

The second paper focuses on parents and gender differences in child removal. Mothers in the Alcohol and Drug Recovery Service were more likely to have children removed than fathers (56.6 vs. 17.7%, $p<0.001$), had more children removed than fathers (2 vs. 1, $p<0.001$) and were more likely to have a series of individual child removals (22.5 vs. 4.3%, $p=0.014$). Female gender, younger age, drug use, mental health issues and a history of suicide attempts were associated with child removal from parents in the service. Mothers who had children in their care were less likely to have made an attempt on their lives than mothers who had children removed or women who were not mothers.

Paper three is a qualitative analysis of 12 mother's lived experiences of child removal and contact with services – before, during and after child removal using Interpretative Phenomenological Analysis (IPA). Four themes were identified – 'safe/unsafe', 'changing identity', 'loss', and 'no way to win'. Services that can develop a sense of safety in their client through continuity in workers, clarity and consistency about boundaries and communication with other services and supporting mothers to feel respected and validated as a person and as a mother, regardless of whether their child/ren are removed, are more likely to engage their clients and achieve better outcomes.

The findings of these three papers resulted in three key messages: (1) the prevalence of parenthood and child removal is high in Alcohol and Drug Recovery Services, particularly of female parents, (2) mothers with substance use issues who have children removed have unmet support needs before, during and after removal, but it is impossible to understand these needs without

understanding them in the context of their children's needs and the needs of the family unit, and (3) services need to consider how to make services feel safer for mothers and to improve connections and relationships between mothers and clinicians which could lead to better engagement and outcomes for mothers and their children.

The findings of these studies add to the knowledge and understanding of the needs of this group of mothers. Recommendations are made for services working with these mothers included:

- All service users in Alcohol and Drug Recovery Services need to be asked whether they have children, where those children live, and what level of contact they have with their own and any other children. This needs to be repeated regularly as circumstances can change.
- Services need to be aware of the role of gender in parenting and child removal, especially in younger mothers with mental health issues.
- Clinicians need to be aware of the link between child removal and suicide and provide increased support immediately after removal and for a period of time afterwards.
- Clinicians need to understand the concept of disenfranchised grief, how it applies to child removal and offer support for this loss and the subsequent grief response.
- Mothers suggested changes that services need to make them feel safe, such as consistency in staffing, clarity about roles, boundaries and information sharing, especially with child welfare services, and for staff to be persistent and provide outreach.
- Services need to consider and develop 'soft' skills such as compassion and authenticity in their staff teams.

Recommendations for researchers included:

- Further research into the high mortality rate in offspring, including the causes of these deaths and whether this is associated with parental substance use.
- Strengthen our knowledge about these constellations of parental risk factors to allow for the identification of mothers at risk of the removal of children and to aid service development and provision of support.
- There is a need for a better understanding of evidence-based treatment for women and mothers with substance use issues, as gender factors may have been overlooked in previous research.
- There is a need for co-production research with this group of mothers who are keen to have their voices heard.

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Acknowledgements

Firstly, and most importantly, I want to thank the 12 mothers that shared their stories with me. I am eternally grateful for your time and courage, and I am in awe of your strength and resilience. Your desire to not only have your story heard but to do this so you could help the mothers that came after you was inspiring. Your tears, sadness and anger stayed with me, but so did your humour. There was laughter and quite a lot of swearing in those interviews! I hope I have represented you well. I also want to acknowledge the three mothers who are no longer with us and hope that this can be a small legacy that allows your voice and story to continue to be heard.

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Sara, Becky and Alison have been cheerleaders and provided unbelievable amounts of emotional support. It is amazing to have friends who celebrate the publications, had unwavering belief that I could complete this PhD and that it would make a difference. It's time to finally celebrate submission.

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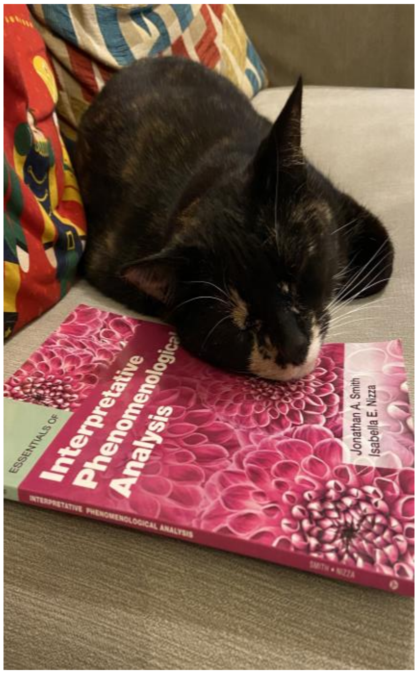
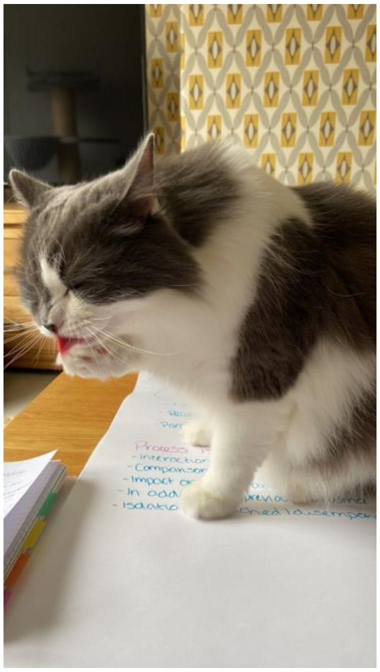
Finally, this PhD would not be possible without the cats – Maud and Alfie. There have been multiple suggestions that it should really be joint authorship. Thank you for sitting on transcripts, moving post it notes during my analysis and the reminders that there are other things to focus on at times – like feeding cats, playing with cats and giving cats more attention than the laptop. Thanks for all those times you walked over the laptop and that time you almost send Helen an email with rows and rows of the letter R. All the fuzzy cuddles are worth it.





List of papers

Paper 1: Published

Russell, L., Gajwani, R., Turner, F. & Minnis, H. (2023) Where Are the Children?: Addiction Workers' Knowledge of Clients' Offspring and Related Risks. *International Journal on Child Maltreatment*, 6, 675-686. doi:10.1007/s42448-023-00158-9.

Contribution statement:

LR fully responsible for: Data curation, investigation, project administration, visualisation and writing the original draft.

LR responsible for with feedback from RG, FT & HM: Conceptualisation, formal analysis, methodology and writing review and editing.

Paper 2: Published

Russell, L., Gajwani, R., Turner, F. & Minnis, H. (2022) Gender, Addiction, and Removal of Children Into Care, *Frontiers in Psychiatry*, 13:887660. doi: 10.3389/fpsyt.2022.887660.

Contribution statement:

LR fully responsible for: Data curation, investigation, project administration, visualisation and writing the original draft.

LR responsible for with feedback from RG, FT & HM: Conceptualisation, formal analysis, methodology and writing review and editing.

Paper 3: In preparation for submission to Youth and Children's Services Review.

Contribution statement:

LR fully responsible for: Data curation, investigation, project administration, visualisation and writing the original draft.

LR responsible for with feedback from RG, FT & HM: Conceptualisation, formal analysis, methodology and writing review and editing.

Additional papers resulting from this work

Paper 4: Published (Link in Appendix 10)

McFarline, S., White, N. & Russell, L. (2023) The Experience of Alcohol and Drug Recovery Staff Working with Mothers Who Have Had Their Children Removed. *Health & Social Care in the Community*, 2023, 2983040. doi: 10.1155/2023/2983040.

Abstract of paper:

Parenting can be impacted by substance misuse, and children can be at risk of maltreatment, leading to their removal from their mothers. Successful treatment of substance abuse relies on these women gaining effective support from services. Previous research has demonstrated the impact working in this field can have on staff, including high staff turnover, vicarious trauma, and burnout. The present study further explores the experience of staff members working in a Drug and Alcohol Recovery Service in Scotland who work with mothers who have had their children removed. Six interviews with nurses and social care workers were analysed using interpretive phenomenological analysis (IPA). Two superordinate themes were developed from the data: (1) complexity and tension within working relationships and (2) emotional experiences and attempts to resolve them. Participants described the complexity of their roles, including the dual role of supporting mothers while also being involved in the child removal process by providing reports and evidence and how they respond and work with mothers after removal and conflicts with the wider system. They also highlighted their attempts to cope with the emotional impact of being part of this process and the empathy they have with mothers, especially when they are parents themselves, and described the complexities of trying to cope and manage when working in this challenging area. Clinical implications, including training needs and requirements, are discussed.

Contribution statement:

LR fully responsible for: Conceptualisation, data curation, investigation and methodology

LR and SM responsible for: Project administration

SM responsible for with feedback from LR and NW: Formal analysis and writing review and editing.

SM responsible for: Visualisation and writing original draft

Paper 5: Published (Link in Appendix 11)

Crawford, K., Russell, L., Graham, S. & Turner, F. (2023) Helping themselves and helping others: how the passage of time influences why mothers with addictions take part in research. *Frontiers in Psychiatry*,14:1204882. doi: 10.3389/fpsyt.2023.1204882.

Abstract of paper:

Introduction: Women with addiction issues are under-researched, despite previous evidence that women's needs are less understood than men's and that services can overlook gender-specific issues. The majority of women in treatment are mothers and a significant number have contact with child welfare services. The voices of these women are needed to shape and influence evidence-based treatment and service development.

Aim: To examine reasons and rationale for participation in research in mothers with addiction issues and involvement with the child welfare system.

Method: Reflexive thematic analysis was used on interview transcripts from two qualitative studies. Individual themes from each study were combined and analysed to develop themes covering both studies and at different timepoints in process of child welfare assessment or removal of child/ren.

Results: Three themes were identified (1) altruism; (2) personal benefit; and (3) empowerment. These mothers wanted to help with research. However, they also participated with the hope that this might facilitate the return of their children or help them to access support or services. A change over time was evident and, in those further down the line from child removal, there was a stronger want for their voices to be heard in order to advocate for other women and create change in services.

Contribution statement:

LR and KC responsible for separate components of the overall project and the contribution statement is a reflection of this.

LR, KC and FT jointly responsible for: Conceptualisation, data curation, formal analysis, investigation, methodology, project administration and writing – review and editing.

LR and KC jointly responsible for: visualisation and writing original draft.

Contribution statement from publication:

LR, KC, and FT contributed to the conception, design, and data analysis. LR and KC wrote the first draft of the manuscript. SG wrote a section of the paper and provided reflections as an expert by experience. All authors contributed to the article and approved the submitted version.

Chapter 1

Motivations for doing this research

This research was motivated by several factors. Firstly, a longstanding interest in gender-based research. My MSc research was a qualitative study exploring how women made the decision to use or not use condoms and my DClinPsy research investigated the links between metacognitions, bonding and OCD in new mothers. In addition, when I started working as a clinical psychologist in the Alcohol and Drug Recovery Service, I shared an office with the specialist team who worked with parents who had social work involvement. These colleagues raised concerns about the parents they worked with, but especially the mothers, and mentioned the lack of support and services available for mothers who were involved with social work. They also discussed the significant impact of child removal on parents, noticed a pattern of repeated pregnancies and removals in some mothers and worried about their skills and knowledge due to the lack of training available in this specialist area.

Initially we planned to do a small piece of in-service research to get some data about our service users and their children, to do interviews with mothers about their experience of child removal and contact with services, and to interview staff about their experiences of working with mothers who had children removed from their care. However, after discussions with management and research and innovation team in NHS Greater Glasgow and Clyde, it was agreed that this research should be prioritised and funded by the service. At this point, Professor Helen Minnis became involved with the study and suggested adapting the initial proposal to become a part time PhD to give the time and space needed to fully do justice to this group of mothers.

Overview of thesis

Chapter One discusses the motivations for this research and gives an overview of each chapter.

Chapter Two provides additional information about methodology and methodological considerations for the introduction chapter and the three empirical papers and includes information and reflections that were not covered in the original papers due to word count limitations.

Chapter Three is a review of the current literature in the area of parental substance use, including prevalence and impact on children; parental substance use and child welfare; impact of child removal on parents; disenfranchised grief; mental health and child removal; multiple removals; interventions; and policy context.

The following three chapters are the empirical papers. Chapters Four and Five are published qualitative papers using routinely collected data from an Alcohol and Drug Recovery Service in Scotland to get a better understanding of parental substance use and child removal in the service. Chapter Six is a qualitative paper interviewing mothers in the service who had children removed. It has been prepared for publication and is due to be submitted to Children and Youth Services Review.

Chapter Four is a published paper which focuses on the children of service users in an Alcohol and Drug Recovery Service in Scotland. It provides information about prevalence of parenthood in service users, residential status of offspring and Local Authority involvement, prevalence of other children in the home of service users, offspring mortality rates and staff awareness of service users children and accuracy of reporting. This paper is presented first as this fitted better with the narrative of the thesis generally but was published after the paper in chapter 5. As a result, it references the paper in the following chapter, and some methodological information was excluded from this paper as it had been included in the other paper.

Chapter Five shifts the focus from children to parents and explores gender differences. It details the overall prevalence and pattern of child removal from parents in an Alcohol and Drug Recovery Service and if there are gender differences in these prevalence and patterns. Associations between parent factors such as age, gender, substance use, mental health and suicide and child removal were explored. Finally, this paper looks at the prevalence of suicide attempts and child removal in mothers.

Chapter Six is a qualitative paper focusing on the experience of child removal and contact with services in 12 mothers who were accessing the Alcohol and Drug Recovery Service. It discusses the process of analysis and development of four themes – ‘safe/unsafe’; ‘changing identity’; ‘loss’; and ‘no way to win’. A model was then developed to understand these mother’s experiences of removal and services and could be used by services when thinking about working with mothers who have children removed or those services who are considering service development for this population.

Chapter Seven is a discussion and conclusion summary for chapters Four, Five and Six. It provides three key messages for this thesis and includes recommendations for services and researchers.

Chapter 2

Methodology and methodological considerations

This chapter will discuss methodology and methodological considerations for chapters Three, Four, Five and Six in more detail given the limitations with word count in the published papers. As Chapters Four and Five used the same sample, recruitment and methodology then they shall be discussed together.

Chapter 3: Introduction

Chapter Three is a literature review covering the content of the thesis generally and is not a systematic review. While there is enough literature to have an overview and introduction to the thesis, it became apparent that there were only small or limited collections of research in each area. Despite multiple attempts at generating a systematic review question or topic area, the limited research in this area made it challenging to conduct a systematic review. These attempts found either too few papers or, when the subject area was broadened, too many papers and a lack of focus to align with the thesis. Following discussions in supervision and in my annual review with my independent research advisors, it was agreed that the options available were to conduct a systematic review in an area that did not align with the thesis with the risk that this would have limited benefit to the thesis itself and take time away from my work on the thesis given my other commitments. Or to conduct a literature review, using systematic searching and screening of papers, which would be updated yearly and would include new research up to the point of submission of the thesis. It was agreed that this was a better option and would be of more value to the thesis.

Methodological considerations

By completing a literature review this chapter lacks the depth and systematic rigour of a systematic review. In addition, no formal bias or quality measure was used to assess the literature given the volume and the heterogeneity of the literature included in the chapter. However, given this was a part time PhD conducted over several years this allowed the literature review to be a living document which was reviewed and updated yearly. Search terms were developed, and databases (OVID and EBSCO) were screened with results being saved to Endnote which could identify duplicates and new papers. The reference sections of relevant papers were reviewed for additional papers and resources. While no formal quality or bias tool was used, all papers were critiqued, and areas of strengths and limitations were identified. Given that this thesis covers several separate areas (parental substance use, child welfare, disenfranchised grief) a wider literature review allowed all areas to be covered while a systematic review would have been limited in focus to one of those areas or potentially an area that was not as directly linked to these areas. By updating the literature review yearly and in the month before submission, it is as relevant and up to date as possible, while a systematic review would have been completed a period of time before submission.

Chapters Four and Five

Methodology

Procedure

This study was conducted within one sector of an Alcohol and Drug Recovery Service in Glasgow, Scotland, with roughly 3,000 active service users although this number can vary due to new referrals, discharges from service and service users disengaging from treatment. To access the service, individuals need to have moderate to severe issues with drugs and/or alcohol and complexity or risk (such as physical or mental health issues, being parents, criminal justice involvement). The data was collected from routinely collected information in service user's electronic records and from interviews with care managers.

We aimed to obtain data on ~25% of service users. Due to the high levels of disengagement from the service, the time needed to review roughly 750 electronic sets of records and the focus on staff knowledge for chapter three, staff were randomized rather than service users. Service users were identified using the caseloads of current staff members. At that time, the service employed 25 nurses and 40 social care workers. The randomization process is described in Table 1.

Table 1: Sampling and data collection process

Stage	Procedure
1	Staff members were excluded if they were currently off work for an extended period of time (such as maternity or long term sick leave), did not have a caseload (such as team leads or students) or were co-workers (such as health care workers, medics and the blood borne virus nurse).
2	Remaining staff were split into two groups of 25 nurses and 40 social care workers.
3	Surnames were entered into two SPSS worksheets.
4	SPSS generated a random sample of 6 nurses and 10 social care workers (~25%).
5	Each member of staff was approached by the researcher and provided with information about the study.
6	All (100%) members of staff provided the researcher with a copy of their full caseloads.
7	Each service user's unique ID number was recorded in an Excel database to prevent duplication.
8	Service users were only included if the member of staff was their care manager rather than a co-worker for a brief piece of work (such as a physical or mental health assessment).
9	Electronic records data were collected before speaking to the worker in all cases.
10	Data from each member of staff's caseload was fully gathered before starting with the next member of staff.
11	Due to varying caseloads (due to role or part time working) and exclusions of service users (as a result of duplication or co-working) the original sampling process failed to generate a sample of ~25% of service users. Staff previously included in the study were removed from the original list of surnames in SPSS and stages 1 to 11 were repeated to generate an additional 2 nurses and 2 social care workers and a sample of ~24.5%.

The initial randomization process identified 6 nurses and 10 social care workers. However, due to variations in role and caseload size this process did not generate a large enough sample of service users. The process was repeated with the original sample of staff excluded and a further two nurses and two social care workers were identified and provided their caseloads. 100% of staff who were randomized into the study provided their caseloads and attended an interview. This resulted in a total sample of 736 service users (~24.5% of service users)

The Research and Innovation Department in NHS Greater Glasgow and Clyde (NHS GG&C) advised that this study did not need to go to an NHS ethics committee due to the use of routinely collected patient data. Therefore, the study was registered with and approved by the Alcohol and Drug Recovery Service Clinical Effectiveness Group. Service users consent at assessment that their routinely collected data can be used anonymously for research and audit purposes. As a result, permission was granted solely to access service users records and the records of their children were not accessed.

Staff were randomly selected in June 2015 and data were collected from electronic records from June 2015 to June 2017. None of the randomized staff members left their posts or changed teams or role in this time period. Routine electronic data included clinical case notes and the Scottish Morbidity Record 25 (SMR25). SMR25 were compulsory data returns completed by all Scottish Alcohol and Drug Recovery Services at assessment (Version A) and annually (Version B) until 2021. SMR 25 A and B were both used for data collection. Clinical case notes comprised of free-text notes written by staff detailing or summarising all appointments, and communication with and to other professionals or services. SMR25 data consisted of fixed responses or coded data such as gender, ethnicity, yes/no, type and frequency of substance use. SMR25 also has a free-text option to provide additional information or when there is an ‘other’ option. The electronic records also record information about relationships such as care manager, general practitioner and family members, which included a section for children.

Data were primarily extracted from SMR25 forms as this was the administrative form routinely used in Scottish Alcohol and Drug Recovery Services, all service users should have a SMR25 A in their electronic records following their initial assessment, even if they started treatment in a different health board in Scotland. SMR25 also records demographic information, information on drug and/or alcohol use, and information on children, including number of children, ages, and where they resided (home or local authority care). Data were then extracted from the remaining sections of the electronic records (clinical case notes and relationships section) for the full caseloads of each selected member of staff, then interviews were arranged with staff members.

Staff interviews were conducted between September 2015 and June 2017. During the interviews, staff had the ability to access the electronic records if needed. At each interview, all staff were asked for each service user on their caseload – the total number of offspring, number of children aged 16 and under, ages of each offspring, the residential location of each offspring during childhood, and whether there were any other children currently residing in the home with the service user.

Information provided from the staff interviews in relation to children aged 16 years and younger was compared with data extracted from electronic records to assess staff knowledge.

Proformas were created for data extraction from each data source (SMR25, case notes and staff interviews). As the data were primarily collected from SMR25 forms with a standardized template, there is no reason to suspect that data would differ between nurses and social care workers. All staff members were provided with training and guidelines about completing the SMR25 forms as part of their staff induction and training and provided with additional training about sensitively asking about offspring and working with parents with addiction issues. Initially the SMR25 forms were reviewed, then the clinical case notes. Once these were completed for the full caseload, interviews were arranged with staff members. Case notes and staff interviews allowed for the cross-checking of the SMR25 data and to collect any missing data.

Data Collection

Data were collected under the following headings: (1) Service user characteristics; (2) Child characteristics; (3) Mental health; and (4) Suicide.

(1) Service user characteristics

SMR25—Gender, age, ethnicity, substance use profile (treatment provided for drugs only; alcohol only; alcohol and drugs).

Case notes—Used for missing data.

(2) Child characteristics

SMR25—Number of children, number of children removed by Local Authority.

Case notes—Missing data, child age, where child resided during childhood, pattern of removal (one child or all children at one time; two groups or a group and a single child removed at different times; series of individual removals), other children living in the household, child mortality.

Staff interviews—Used for missing data and data regarding offspring aged 16 years and younger (number of children, child age, where child resided).

(3) Mental health

SMR25—Reviewed questions on current or history of mental health issues and prescribed medication for mental health issues.

Case notes—Reviewed for any mention of mental health diagnosis, contact with mental health services, requests for mental health assessment or a referral to mental health services, reported use of psychotropic medication, inpatient admissions to mental health units/wards.

Staff interviews—Asked if service user had current or history of mental health issues.

(4) Suicide

SMR25—Reviewed question on ever attempted suicide.

Case notes—Reviewed for any mention of suicide attempts.

Staff interviews—Asked if service user had ever attempted to take their own life.

Statistical Analysis

Data analysis using SPSS (version 28.0.0.0) was conducted to explore any differences between genders in demographic factors and in prevalence and patterns of child removal. Binary logistical regression was conducted to examine risk factors associated with child removal. Of the 736 service users selected for the study, parents who had no children removed (n = 287) were compared with parents who had experienced removal of children (n = 158). Factors examined were age, gender, substance use profile, mental health issues and suicide attempts. Ethnicity was excluded due to the lack of variability in this sample. The analysis was then repeated for each gender. Chi-squared analysis was used to further explore the relationship between suicidality and child removal. Mean and descriptive results were used to explore for any differences between staff knowledge and patient's electronic records about number of children aged 16 and younger.

Methodological considerations

The use of routinely collected patient healthcare data is increasingly being used as an alternative to generating prospective data from patients or clinicians (Franklin & Thorn, 2019; Hemkens et al., 2016; Mc Cord et al., 2018). Advantages of routinely collected data include reduced costs and resources, especially for large data sets; opportunities for novel study designs; and reduced research burden on patients and clinicians (Franklin & Thorn, 2019; Mc Cord et al., 2018; Sathyanarayanan, 2024). However, routinely collected data also has a number of limitations. As the data is routinely collected for clinical purposes it may not be suitable for research outcomes and introduce bias; there may be additional governance or approvals needed to access the data; the ability to extract and collect the data may be challenging depending on the system used; and multiple clinicians may input data but may not all use the same criteria so there may be issues with the quality and accuracy of the data leading (Franklin & Thorn, 2019; Hemkens et al., 2016; Mc Cord et al., 2018; Powell et al., 2021; Sathyanarayanan, 2024).

For the data used in chapters Four and Five, prospective data collection via service users risked high levels of drop out given the levels of disengagement and discharge from the service, especially given the aim for roughly 25% (~750) of service users. The randomisation process would have needed repeated on multiple occasions to achieve the desired sample size due to service users no longer being open to the service. In addition, drop out and non-completion of questionnaires and measures is common. Benbunan-Fich (2023) discussed the implications of payment for participation and stated that even in studies with fair payment systems dropout rates were between 20-30%. Given the sample size target, the likelihood of high dropout rates, the lack of a budget to compensate participants, potential concerns about participation burden in a population known to have additional stressors in addition to their alcohol and/or drug use and literacy issues, the use of the routinely collected data, which all service users agree can be used for research and audit purposes, was felt to be the best option for data collection.

However, this method of data collection comes with limitations and risk of bias. The quality and quantity of data available in the electronic records varied considerably depending on a number of factors including length of time in the service, differences in treatment for example a home detox from alcohol on one occasion versus several years on opiate substitution therapy (OST), and whether there were additional complexities or other services involved with the service user such as physical or mental health, criminal justice or social work. In addition, there was a variation in the quality and detail provided in the records between staff. Some staff members wrote extensive and detailed notes while others were brief or only used the fixed options in the SMR25 form without adding any additional information. Staff training was provided along with guidance about the SMR25 form and it could be assumed that there will be a degree of consistency in responses between staff members. There was great variation in the free written case notes, again with some being very detailed while others were brief. Some of this variation could be explained by caseload number and complexity. Staff with smaller caseloads had more time for admin and services users who were stable on OST and known to the service for many years did not need detailed notes unless there was a change in treatment or their presentation. The staff interviews were used as a way to balance out the variation in data available from the electronic records and to obtain any missing data.

The information recorded in the electronic records and the SMR25 forms are clinically relevant information. The information and the recording were planed and designed for clinical need and not for research. This is a potential limitation in what data is available for collection in studies using routinely collected data. This issue was considered at length in supervision and in the design stage of the study. The initial literature that was available indicated that although parental substance use was linked to risk of harm to children and linked to child welfare issues, there was limited information about the Scottish context or that looked at prevalence and patterns of child removal. Also, at this time there was clinical information and research suggesting a link between child removal and suicidal ideation and attempts (Memarnia et al., 2015; Neil et al., 2010) so this was an area we were keen to explore. This was possible as this data was routinely collected in the SMR25 forms and in clinical notes. We found that some data were more detailed than expected – for example we created extra codes for removal patterns and did not expect the mortality data but started to record this when it was recorded in notes or reported in staff interviews.

However, we were unable to collect other data that may have been useful – such as reasons for removal, if removal was permanent or temporary, and other factors which have been linked with child removal such as domestic abuse and incarceration as these were not routinely collected. While we were able to collect data from the electronic records, we were unable to extract it in a way where we could easily identify a timeline without exponentially increasing the workload. As a result, while we can identify parental substance use type, and the presence of mental health and suicide attempts, we cannot state whether there were before or after the removal of children. Similarly, the inability to access children's records or any of their data meant that we were unable to identify if children were counted more than once – for example if both parents were service users. During the staff interview, there were no reports of duplication with both mum and dad having the same care manager and that the information concerned the same child/ren. However, if both parents were open to the service and had different care managers, and both care managers were randomised into the study then it is possible that children may be counted twice in this study. This possibility was identified and discussed in supervision and, while possible, it was not possible to prevent without needed to access children's records which would be timely and possibly refused, and likely to only be a very small number of children. We decided to view this as an opportunity for some initial scoping as it would allow for some results and findings and the opportunity for recommendations for future studies, despite there being a potential risk of duplication of child/ren. As a result, we present the results as an overview of the service at one point in time – June 2015 to June 2017. There is no clinical knowledge or reasons to suspect that the service users at that point in time varied from other times and as data was collected from staff caseload one at a time over this period and any potential changes would have been incorporated into the data collection.

To reduce the likelihood of missing data, the SMR25 form was used as a template to design the study, data collection and proformas. The use of multiple sources of data

(SMR25 forms, clinical notes and staff interviews) aimed to reduce missing data by having alternative sources for data collection. When data was missing it was likely to be non-clinically relevant such as age and residential status during childhood of adult offspring of service users. For example – in paper Four we report that offspring age data was missing for 115 offspring, but this breaks down to 3 aged 16 and under, 105 of the offspring aged 17 and older, including the 7 offspring who had died. Similarly, residential status was unknown for one offspring aged 16 or under and 31 offspring aged 17 or older. While it is important to reduce missing data, this is not always possible and only represents 12.6% of offspring for age and 3.5% of offspring for residential status. Given the small amount of missing data, the strategies used to reduce missing data in this dataset, that most of the data would be reported using descriptive statistics and while we were interested in the offspring generally, our main focus was mothers and children aged 16 and under, we decided not to use any models to replace, impute or delete missing data (Mirzaei et al., 2022; Peeters et al., 2015) and to report when data was missing from electronic records and staff knowledge.

Chapter 6

Methodology

Method

Sampling and participants

Interviews were conducted with 12 mothers who were current service users or attended the Women's Recovery Group of an Alcohol and Drug Recovery Service in Scotland between February 2018 and August 2019.

Table 2 details demographic information for the 12 mothers. Due to the lack of diversity in the service ethnicity cannot be reported here as it may allow for identification for one or more of the mothers, but 10/12 mothers identified as White Scottish.

Table 2: Demographic Information

Demographic	N (%)
Age	
Range	28 – 49 years
Mean	38 years
Relationship status	
Single	5 (41.7%)
Living with a partner	4 (33.3%)
In relationship but not living together	1 (8.3%)
Separated	1 (8.3%)
Divorced	1 (8.3%)
Number of children	
Total	30
Removed from their care	23
Removal Status	
Child/ren permanently removed	7 (58.4%)
Trying to regain custody of child/ren	3 (25%)
Older children permanently removed and trying to regain custody of younger child	1 (8.3%)
Removal and return of child	1 (8.3%)
Were all children permanently or temporarily removed from their care	
Yes	8 (66.7%)
No	4 (33.3%)

Given the complexity with removals and to look in greater depth at patterns of removal, one (8.3%) mother had only one child which was removed and returned on two occasions, three (25%) mothers had one child removed but had another child or children that remained in their care, two (16.7%) had all of their children removed as a group on one occasion, one (8.3%) had their two eldest children removed on separate occasions and then had a period of stability and had other children that remained in their care, two (16.7%) had their eldest removed then a period of stability until losing a group of subsequent children, two (16.7%) had more than one child removed in a series of individual removals and one (8.3%) had their eldest removed on three occasions and their youngest removed twice.

Table 3 illustrates the children's age at removal and their location while removed from their mother for the 23 children that were removed. Child's age at removal ranged from birth to seven years old. 12 (52.2%) children were placed in kinship care, eight (34.8%) were fostered and three (13%) were adopted.

Table 3: Removal information for children

Child	Age at removal	Location	Age at removal 2	Location	Age at removal 3	Location
1	6	Kinship				
2	2	Adopted				
3	5	Fostered				
4	18 months	Fostered				
5	8 weeks	Kinship				
6	2	Kinship				
7	8 months	Kinship				
8	1	Kinship				
9	Birth	Adopted				
10	3 weeks	Fostered				
11	3	Fostered				
12	6 months	Kinship				
13	8 months	Kinship	4	Kinship		
14	5	Kinship				
15	1	Kinship				
16	1	Kinship				
17	8 weeks	Kinship				
18	9 months	Kinship				
19	9 months	Adopted				
20	7	Fostered				
21	6	Fostered				
22	15 months	Fostered	4	Fostered	7	Fostered
23	2	Fostered	5	Fostered		

Measures

Data were collected by conducting semi-structured individual interviews. The interview topic guide (See appendix 3) was developed following the guidance from Smith, Flowers and Larkin (2009). In addition, existing research and literature with mothers who have experienced removal of children or had contact with social services was reviewed to inform the question development (Broadhurst & Mason, 2017; Holland et al., 2014; Memarnia et al., 2015; Morriss, 2018). Questions were open ended with scope to explore the lived experience of removal of children and contact with services. Questions covered their experience of having their children removed, what services were provided and their experience of this support; what support they felt they needed or should have been provided and what services should know about having children removed. Questions were pilot tested with a group of volunteers who attended the Women's Recovery Group.

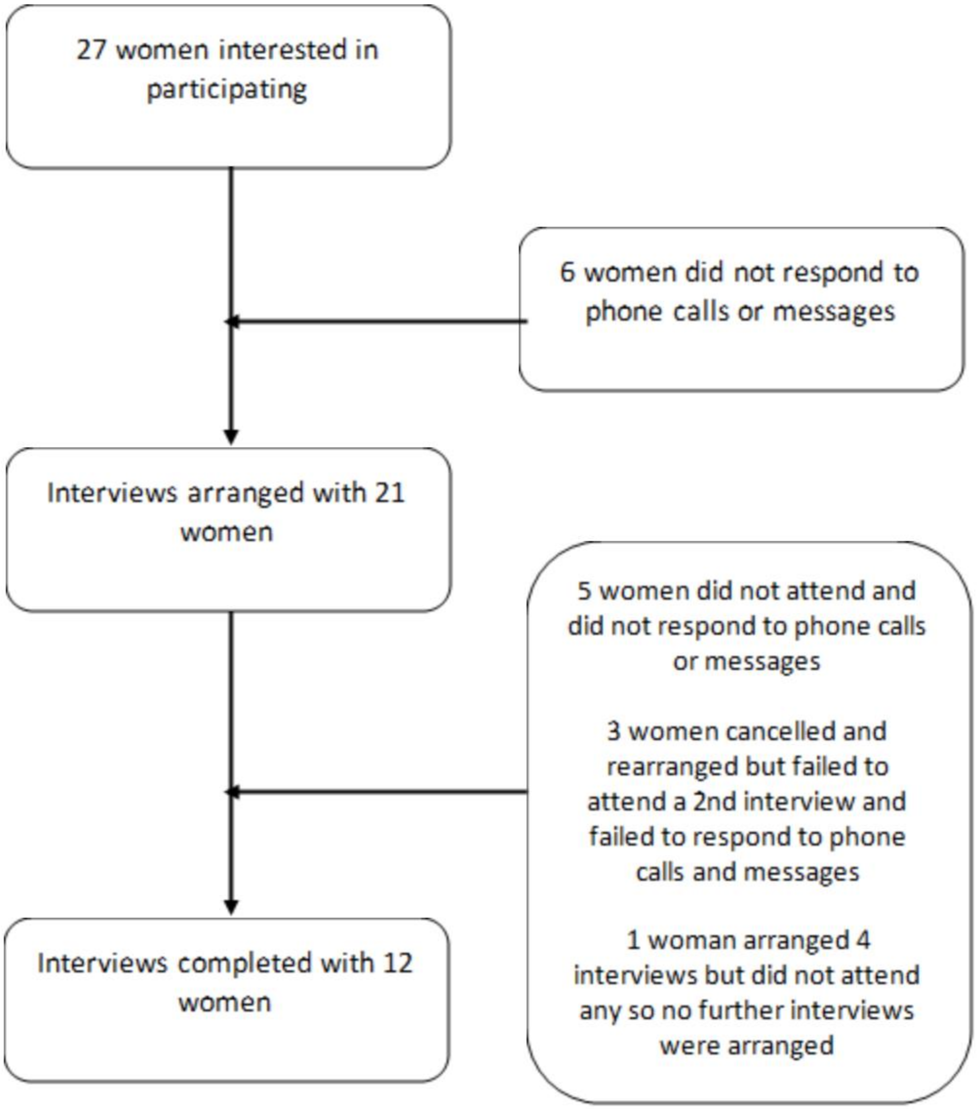
Procedure

Ethical approval was obtained from the West of Scotland REC 1 committee (Ref No: 17/WS/0255). Posters were placed in the waiting rooms of the Alcohol and Drug Recovery Service with information about the study and contact details for the researcher (LR). Emails were also sent to all staff working in the sector, including those supporting the volunteers to run the Women's Recovery Group, with information about the study, the eligibility criteria and contact details for the researcher to allow staff to discuss the study with women on their caseload. Potential participants could contact the researcher directly or ask their care manager to pass on their contact details to the researcher. As LR worked as a clinical psychologist in the service, any current or former patients were excluded and there were no established relationships between LR and any of the participants.

27 mothers expressed interest in participating. Contact with the researcher, drop out and participation numbers are detailed in Figure 1.

Six mothers did not answer any calls from the researcher and did not respond to a message asking them to contact the researcher if they were interested in participating in the interviews. The researcher spoke with 21 mothers; all agreed to participate and arranged a time and date for their interview which was at least one week after the telephone conversation. During that conversation LR disclosed her role in the service, her interest in research on gender-based issues and a desire to develop services in collaboration with their lived experience. All mothers were informed that they could change their mind and refuse to participate at any time, and this would not affect their treatment from the service or ability to attend the Women's Recovery group. Travel information was provided if women were unfamiliar with the venue for the interview (clinical room in one of the three Alcohol and Drug Recovery Services clinics); and discussions were held to see whether they wished to attend at the same time as their clinic appointment with their care manager to limit travel, whether they needed support from a partner or care manager to attend and whether bus tokens were needed to cover travel costs. The participant information sheet was sent out to each mother in the post.

Figure 1: Flow chart detailing participation and number of interviews



12 mothers participated and completed the interviews. All interviews were conducted by LR. One mother brought her youngest child with her as she lacked alternative childcare, but the other 11 mothers attended alone. Prior to the interviews starting the women were provided with an additional copy of the information sheet if they did not have their copy

and the researcher checked if they had any questions. All women were reminded that they could withdraw from the study with no consequences. Mothers were informed that due to the sensitive nature of the interviews they could request a break if needed, and one mother had a short break due to becoming distressed. Interviews ranged from 29 minutes to 134 minutes (mean=71 minutes) on a single occasion.

Once the interviews were completed, all mothers were provided with an information sheet with contact details for services if they became distressed following the interviews. All mothers were informed that either their care manager or the researcher would contact them within the next 5 days to check how they were following the interview. Mothers were also informed that, after a month, the researcher would contact their care manager to check if they needed to access any additional services or needed support following participating in the interview. No mothers needed additional support or input from services after their interview. All mothers who completed the interviews received a gift voucher for participating.

All interviews were audio-recorded and transcribed verbatim. The audio recordings and transcripts were stored on a secure drive with access to the files limited to the research team. All transcripts were pseudonymised and any information that could breach confidentiality (such as names of partners, children, staff members, services or locations in or out with Glasgow) were removed from the transcripts.

Data analysis

While all these mothers had experienced the removal of their children and had contact with social work, the main focus of this contact was on their children and their needs/wellbeing. As this study focussed on the mothers’ experiences of child removal and placed their experience at the foreground, consideration was given to which epistemological position and methodological approach would be most appropriate.

Given this focus and the aims of this study, a phenomenological epistemology was selected due to wanting to investigate the lived experience of child removal and contact with services (Patton, 2015). Interpretative Phenomenological Analysis (IPA) was used as the methodological approach as it has a phenomenological basis but also includes hermeneutics[1] and idiographic[2] epistemology (Smith et al., 2022). This allows the analysis to go beyond the lived experience of the phenomenon, to include the sense making and interpretation of this phenomenon using hermeneutics (Smith & Nizza, 2022). The double hermeneutic gives interpretative space for the participants to reflect and make their own interpretations of the phenomenon during the interview while the researcher conducts a similar interpretative and sense making process during the analysis (Smith et al., 2022). Finally, although all mothers experienced the removal of their child/ren, as can be seen above, there was heterogeneity in this group with mothers having all or some of their children removed, different placement types for children, and a wide time span since the removal (see tables 2 and 3). The idiographic aspect of IPA which allows for the identification of similarities and differences between participants gave space to be able to develop themes that were generalisable across the mothers but also reflecting areas of differences and why these differences may occur (Smith et al., 2022).

The anonymised transcripts were used for the analysis and proof checked before analysis. All transcripts were analysed by hand by LR and no data analysis software was used. LR met with HM, FT and RG on four occasions to review transcripts, coding and theme development and she kept a reflective diary through the study. All transcripts were analysed using the seven steps of analysis for IPA (Smith et al., 2022):

Step 1: Reading and re-reading
Step 2: Exploratory noting
Step 3: Constructing experiential statements
Step 4: Searching for connections across experiential statements
Step 5: Naming the Personal Experiential Themes (PETS) and consolidating and organising them in a table
Step 6: Continuing the individual analysis of other cases
Step 7: Working with PETS to develop Group Experiential Themes (GETS) across cases

Once connections were made across experiential statements, this resulted in each of the 12 mothers having between 3 and 5 PETs each, with between 2 and 5 subthemes per PET

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[1] The theory of interpretation
[2] The focus on the particular – understanding particular experiences of particular people in particular circumstances

(see appendix 5 for list of PETs and subthemes for each mother). Those PETs and subthemes were then developed into 4 GETs with 3 to 5 subthemes each (see appendix 6 for GET table with subthemes and links to each mothers PETs).

The Consolidated criteria for reporting qualitative research checklist was also completed (COREQ) (see appendix 8).

Researchers' characteristics and reflexivity

LR is a clinical psychologist who has worked in Alcohol and Drug Recovery Services and with mothers in Perinatal Mental Health and Maternity and Neonatal Services. She had conducted research previously on women's reproductive health and perinatal mental health issues. LR has clinical and research experience with this group of mothers but is not a mother and does not have lived experience of substance use issues. HM, FT and RG have conducted research with various stakeholders in the child welfare system including birth parents, foster carers and social workers and with individuals with mental health issues who may be considered hard to engage.

These multiple perspectives were considered to be a strength in the analytic and reflective processes. While our experiences may make us more likely to be supportive of the views and lived experience of birth mothers, we also had a wider perspective including the views of others within the child removal process and of service provision.

Methodological considerations

Choice of method

While there are many approaches that can be used in qualitative research, consideration has to be given to which is the most appropriate depending on epistemology, research questions, goals of the study and the data collection method (Braun & Clarke, 2013; Larkin & Gander-Zaucker, 2024; Patton, 2015). This study had a predominately phenomenological epistemological position and aimed to develop an understanding of the lived experience of mothers with an addiction who had children removed from their care. We wanted to hold the mother's voices central to the analysis and with a goal to potentially improve or develop services, needing to understand their context and how they made sense of their experiences. As a result, we ended up considering interpretative phenomenological analysis (IPA) (Smith et al., 2009, 2022) and reflective thematic analysis (RFA) (Braun & Clarke, 2022).

IPA has a defined epistemology – phenomenology, hermeneutics, and idiography (Smith et al., 2009, 2022), while RFA is more flexible and can be used from a variety of epistemological positions (Braun & Clarke, 2022). As a result, both can be used on the same data set and with the same epistemology and theoretical frameworks. Smith et al (2022) acknowledge that RFA can be used with an experiential or phenomenological focus and the results would have a degree of similarity or overlap with an IPA study. While, Spiers and Riley (2019) analysed one data set with both approaches, using thematic analysis to get the breadth of experience from all 47 interviews and then using IPA for depth with a subset of 10 of the richer transcripts.

As explained above and in chapter 6, LR hoped to obtain a rich and detailed data set which would allow her to understand the mothers lived experience of the removal of children from their care. She also wanted to understand how the mothers made sense of this phenomenon and the meaning they ascribed to it as this could help to inform service development – for example, if we understood the experience from the mothers perspectives then services could be targeted to their needs, we could discover what should be offered to these mothers and what was needed to make services seem appropriate and accessible. Therefore, IPA appeared a more suitable approach giving the depth of analysis, foregrounding of the mothers experiences, the focus on their sense and meaning making and the idiographic aspect to allow for similarities and differences between the mothers.

Sampling and recruitment challenges

Consideration was also given to recruitment and sampling. Due to working in the Alcohol and Drug Recovery Service, LR had links with the Women's Recovery Group after providing information sessions to the women on mental health topics and regularly delivering a women's psychoeducation trauma group within the Recovery Hub. As a result, the women who attended the group and the peer recovery group workers were all aware of this study and provided PPI involvement on several occasions as well as providing individual feedback. The women provided feedback on the design, methods and procedure, interview schedule, and follow up plan and advice for the study. Colleagues in the Alcohol and Drug Recovery Service also provided feedback on the study.

Issues regarding recruitment and sampling included

- Concerns about the sensitive nature of the study and potential to destabilise women.
- Concerns that women with active addictions would not be able to commit to and attend the interview or would attend while under the influence.
- Concerns about adding additional burden or strain to women who had multiple appointments or were undergoing assessment with social work, in addition to engaging with the Alcohol and Drug Recovery Service and potentially other services such as mental or physical health or criminal justice.
- Women were concerned that staff did not always know about their history and may not be able to identify who on their caseload were eligible to participate.
- Concerns that staff were very busy and may not have the time to either think about who might be eligible or the time to discuss the study during clinic appointment therefore excluding women who may wish to participate.
- Motivation to participate may be influenced by certain experiences for example mothers who had difficult experiences or were angry at social work may be more inclined to participate than mothers who engaged with the process and had children returned to their care.
- By only focussing on mothers who had children removed, mothers who had social work contact but retained custody of their children were excluded and they could have added an alternative perspective.

The study was then designed to mitigate or limit the effect of these concerns. Examples include discussions with the peer recovery workers at the recovery group as this was a group of women, several who had experienced the removal of their own children, who supported women who were currently going through this process or had previously, hopefully increasing access to the study for those women who did not disclose this history to their current care manager or whose care manager did not mention the study. Posters were placed in the waiting rooms of all three clinic bases in the sector, again to mitigate any issues with staff not mentioning the study to potential participants. One mother contacted LR directly after seeing the recruitment poster.

LR attended team meetings for all three teams and discussed the study regularly explaining that staff did not need to make assessments about suitability or stability to participate, staff just needed to review the inclusion and exclusion criteria for the study and could discuss with LR if unsure. One team (Families in Recovery Team) works directly with families with social work input, and it was expected that the majority of participants would come from their team. However, the other two teams worked with mothers who had been transferred from the Families in Recovery Team following the permanent removal of their children. To get as wide a sample as possible, the two generic teams were encouraged to discuss the study with any women on their caseload and enquire whether this would apply to them and would they like more information. Hopefully, this encouragement meant that women who may not have discussed previous child removals with their current worker could still find out about the study and participate if interested.

To reduce burden and strain/distress from participating, participants were able to pick a time and date for their interview. Some mothers chose to attend after attending their clinic appointment with their care manager to reduce burden and cost of travel and bus tokens were provided to cover travel costs. In most cases the care manager remained available in the building if needed during or after the interview, although no mothers felt they needed additional support. Two of the women who attended clinics at a different location were supported to attend by their care manager who drove them to and from the interview, one was driven by a friend and another was accompanied on the bus by her partner. In all cases, the mother attended the interview alone except for the one mother who lacked childcare and had her infant present. Participants were made aware that participation was voluntary, and they did not need to take part or could withdraw at any time, and this would not affect their treatment from the service or ability to attend the Women's Recovery Group. In addition, the mothers were able to refuse to answer any questions and take breaks if needed. One mother took a short break to go to the bathroom for tissues after crying mid interview but wished to continue. All mothers were provided with a debrief sheet with additional support numbers, all care managers were informed about the time and date of the interview to provide additional support if needed and follow up calls were made to the mothers within five days of their interview to check in. LR also contacted care managers roughly a month after the interview to check if any of the mothers needed additional support or if participating had destabilised them in any way. All care managers confirmed that none of the mothers had needed additional support or had needed any changes to their treatment plan or referrals for additional services.

In fact, the majority of care managers and the peer workers at the Women's Recovery Group reported that the mothers had found participating in the study to be a positive experience. Comments included that they felt heard for the first time; enjoyed the opportunity to focus on their own story and not a version by social work or centred on their child; reflections about how this was the first time they had been asked about their experiences and having mixed emotions about this as this highlighted how rare that opportunity was for them; and several mothers reflected on the impact of avoidance and that due to not thinking about their children to avoid sadness and negative emotions they also did not think about positive experiences with their children which they recalled in the interview and afterwards. As discussed in more detail in our paper about why mothers with addictions participate in research (Crawford et al., 2023), the mothers had multiple and complex reasons for wanting to participate. Some wanted to help generally, while others had been trying to access clinical psychology and/or therapy and had not been referred so wanted the opportunity to meet the team clinical psychologist and ask directly for therapy or to attend the women's trauma group, others felt this might be the only opportunity they had to shape and influence services and provide support for the mothers currently or in the future who would have their children removed. It may also be important to note that while all participants were provided with a shopping voucher for participating, many of the women stated they did not participate for a reward and only took the voucher after some persuading from LR.

Expanded analysis section

As stated above, the seven steps for IPA were followed (Smith et al., 2022). LR kept a reflective diary with sections for each participant to allow for reflections at each stage of the analysis process (interviews, individual analysis and group analysis). After each interview LR reflected on the interview and recorded and reflected on any emotional responses or thoughts about the interview. Interviews were transcribed by IO (Senior Business Support Assistant to HM and team). After each transcription was completed, LR completed proof checks, and each audio file was listened to while reading the transcript and any errors were corrected. In addition, small vocal responses like ‘emmm’ or ‘uhh’ and pauses were added to the transcripts at this point. Emotional content such as ‘sounds unhappy’, ‘sniffing and crying’ or ‘laughing in an angry manner’ were also added at this stage to add context and aid analysis. LR only used paper transcripts, coloured pens, post it notes and flipchart paper for the analysis and no data analysis software was used.

Once the transcripts were proof checked and correct, the data from each transcript was placed into a table with three sections as advised by Smith et al (2022), with experiential statements in the left column, data in the centre, and exploratory notes in the column on the right. Transcripts were read and re-read on several occasions to become familiar with the data. Exploratory notes were then written in the right column looking for objects of concern (Smith et al., 2022) for the participant but also noting anything of interest to or an emotional reaction in LR. Exploratory notes were also categorised into descriptive (describing experiences or things that are important to the participant), linguistic (use of language, phrasing, tone, metaphors, etc), and conceptual notes (questions or starting to move beyond descriptive to a deeper understanding of the data) (Smith & Nizza, 2022).

To move from exploratory noting to experiential statements, LR followed the guidance from Smith et al (2022) to use the multiple exploratory notes in each section of the text in the right hand column and to capture the meaning of these notes in a summary or short phrase in the left hand column. While acknowledging that there are no firm rules about numbers, there is a suggestion that each section has one or two experiential statements per section (although this is flexible and can be more depending on the richness of the text) and that these can either related to specific sentences or the section as a whole (Smith et al., 2022; Smith & Nizza, 2022). Given the length and richness of these interviews, placing the data into three columns for analysis resulted in transcripts that varied between 19 and 57 pages. As a result, each individual transcript had over a hundred to several hundred experiential statements. See appendix 4 for an example of coding with exploratory notes, descriptive, linguistic and conceptual coding and experiential statements.

Each individual experiential statement was written on individual post it notes and post it notes were categorised on flipchart paper, initially on similarity, then categorised into themes where individual categories were brought together depending on higher level analysis (similarities; convergence on a theme from different viewpoints or experience; in relation to the object of concern). Experiential statements that did not fit into higher order categories or were unrelated to the research questions or aims were dropped at this point and each of the remaining categories were named and then an overall category name was selected that fitted the theme as a whole and covered all the subthemes. The overall category names became the Personal Experiential Themes (PETs). The smaller categories within each PET became the subthemes. This process was repeated for each transcript and analysis needed to be completed before moving to the next transcript. PETs and subthemes for each participant can be reviewed in Appendix 5. Reflective notes for each analysis were added to the notes from the corresponding interview. Figure 2 is an image of this process with post it notes with experiential statements being categorised and highlights that categories differed in number of experiential statements.

Figure 2: Image of analysis process moving from experiential statements to PETs

The PETs and subthemes were then written onto post it notes and again categorised following the same process above. As advised by Smith et al (2022) previously excluded experiential statements were reviewed as they may not have fitted on an individual analysis and PETs but may link in with wider Group Experiential Statements (GETs). Categories were then named to reflect the wider group analysis resulting in GETs and subthemes. Please refer to Appendix 6 for a table of GETs and subthemes and which mother's PETs or experiential statements contributed to each GET and subtheme. Reflective notes were also recorded during the group analysis process.

As described in Chapter 6, LR met with HM, RG and FT on four occasions to review different transcripts, coding and themes. PETs and GETs were reviewed and discussed in supervision to allow space for reflection, justification and identification of bias or blind spots. As all three supervisors had reviewed several transcripts, they felt confident in their ability to understand the data at the individual transcript level and at a wider group level.

Given the natural variation in depth, richness and length of transcripts, mothers had between three to five PETs, with two to five subthemes per PET. The final group analysis resulted in four GETs, with three to five subthemes each.

Expanded reflexivity section

The motivations for this study, including those detailed in the overview chapter, may have an impact on my positionality and bias. These included working in an Alcohol and Drug Recovery Service, having relatives with lived or living experience of substance use and an interest in women's health care, particularly marginalised women. Before starting this research, I was aware that staff felt that mothers in the service were unsupported and there were no or limited services available to support them during or after the removal of their children. I had also worked with several mothers who had contact with social work or had had their children removed. While some mothers had positive relationships with their children's social worker, many did not and discussed some of the issues that became themes in Chapter 6. While bracketing and supervision were used to be aware of pre-existing beliefs and the impact they might have on the analysis, it is possible that this bias could have influenced the analysis. For example, greater weight or attention given to data regarding lack of support or challenging relationships with social workers, and less attention paid to data which challenged this narrative.

In addition, as a clinical psychologist who had been qualified for four years at the start of this PhD, it was challenging not to think as a 'clinical psychologist' and try to formulate the mothers, especially as almost all the mothers discussed multiple traumatic incidents and their own mental health. As discussed in the additional papers from this work, some of the mothers participated to gain access to the team psychologist and asked about referral pathways and the women's trauma group (Crawford et al., 2023). Maintaining boundaries between 'LR the researcher' and 'LR the clinical psychologist' was challenging, especially as the research was conducted within my workplace. Supervision was utilised – both PhD and clinical psychology – to reflect on this, to help with bracketing in both roles and to support the analysis.

One of the strategies used was the review of the PETs from the first transcript. LR completed the analysis and then shared the transcript with RG who also analysed it and reviewed LR's analysis and PETs. It was felt that the analysis may not fully meet the standards for IPA and had elements of a trauma-informed psychological formulation. As a result, LR read the analysis chapter in Smith et al (2022) again and repeated the analysis of the first transcript with a focus on following the guidance more closely and being more aware of bias and the need for bracketing. Following this, RG reviewed the second analysis and PETs. As this analysis and PETs reflected IPA rather than a psychological formulation and were similar to the analysis and PETs developed by RG, analysis was completed for the remaining 11 transcripts.

Furthermore, to try and mitigate against bias generally, transcripts were selected to be analysed in extended supervision sessions with at least two supervisors on four occasions. The process involved LR completing her analysis to the PETs and subtheme stage but not sharing this with her supervisors. Supervisors would then start their analysis by following the same steps detailed above and in Chapter 6 - the exploratory noting, moving to experiential statements and preliminary PETs stages, if there was time, given the level of detail and time needed for IPA analysis and the richness and length of these transcripts. Time was then spent discussing and comparing the different analysis of the same transcript. This allowed for multiple perspectives on the same transcripts and the opportunity to reflect on areas of similarity and difference between LR and supervisors' analysis, which is to be expected given the hermeneutic aspect of IPA, especially the double hermeneutic. Given the differing professional and personal experiences of the supervisory team, any bias or blind spots in LR's analysis had the potential to be identified in this process. While minor differences were to be expected, and did occur, no major differences were identified in this process. Minor issues included different terminology for the same experiential statement, PET and/or subtheme and small differences in focus or interpretation of text. It is important to note that high quality IPA studies are judged on the construction a compelling narrative, a vigorous experiential account, close reading of participants' words and paying attention to convergence and divergence rather than member checking or triangulation (Nizza et al., 2021) However, this was added in to this study to increase rigour and reduce bias.

References

Benbunan-Fich, R. (2023). To pay or not to pay? handling crowdsourced participants who drop out from a research study. Ethics and information technology, 25(3), 34. https://doi.org/10.1007/s10676-023-09708-8

Braun, V., & Clarke, V. (2013). Successful qualitative research: A practical guide for beginners. SAGE Publications.

Braun, V., & Clarke, V. (2022). Thematic analysis: a practical guide. SAGE Publications Ltd.

Broadhurst, K., & Mason, C. (2017). Birth Parents and the Collateral Consequences of Court-ordered Child Removal: Towards a Comprehensive Framework. International Journal of Law Policy and the Family, 31(1), 41-59. https://doi.org/10.1093/lawfam/ebw013

Crawford, K., Russell, L., Graham, S., & Turner, F. (2023). Helping themselves and helping others: how the passage of time influences why mothers with addictions take part in research. Frontiers in psychiatry, 14, 1204882-1204882. https://doi.org/10.3389/fpsyt.2023.1204882

Franklin, M., & Thorn, J. (2019). Self-reported and routinely collected electronic healthcare resource-use data for trial-based economic evaluations: the current state of play in England and considerations for the future. BMC medical research methodology, 19(1), 8-8. https://doi.org/10.1186/s12874-018-0649-9

Hemkens, L. G., Contopoulos-Ioannidis, D. G., & Ioannidis, J. P. A. (2016). Routinely collected data and comparative effectiveness evidence: promises and limitations. Canadian Medical Association journal (CMAJ), 188(8), E158-E164. https://doi.org/10.1503/cmaj.150653

Holland, S., Forrester, D., Williams, A., & Copello, A. (2014). Parenting and Substance Misuse: Understanding Accounts and Realities in Child Protection Contexts. The British journal of social work, 44(6), 1491-1507. https://doi.org/10.1093/bjsw/bcs197

Larkin, M., & Gander-Zaucker, S. (2024). Choosing your approach. In J. A. Smith (Ed.), Qualitative Psychology: A practical guide to research methods (4th ed., pp. 247-254). Sage Publications Ltd.

Mc Cord, K. A., Al-Shahi Salman, R., Treweek, S., Gardner, H., Strech, D., Whiteley, W.,…Hemkens, L. G. (2018). Routinely collected data for randomized trials: promises, barriers, and implications. Current controlled trials in cardiovascular medicine, 19(1), 29-29. https://doi.org/10.1186/s13063-017-2394-5

Memarnia, N., Nolte, L., Norris, C., & Harborne, A. (2015). 'It felt like it was night all the time': listening to the experiences of birth mothers whose children have been taken into care or adopted. Adoption & fostering, 39(4), 303-317. https://doi.org/10.1177/0308575915611516

Mirzaei, A., Carter, S. R., Patanwala, A. E., & Schneider, C. R. (2022). Missing data in surveys: Key concepts, approaches, and applications. Research in Social and Administrative Pharmacy, 18(2), 2308-2316. https://doi.org/https://doi.org/10.1016/j.sapharm.2021.03.009

Morriss, L. (2018). Haunted futures: The stigma of being a mother living apart from her child(ren) as a result of state-ordered court removal. The Sociological review (Keele), 66(4), 816-831. https://doi.org/10.1177/0038026118777448

Neil, E., Cossar, J., Lorgelly, P., & Young, J. (2010). Helping Birth Families: Services, costs and outcomes. British Association for Adoption & Fostering (BAAF).

Nizza, I. E., Farr, J., & Smith, J. A. (2021). Achieving excellence in interpretative phenomenological analysis (IPA): Four markers of high quality. Qualitative research in psychology, 18(3), 369-386. https://doi.org/10.1080/14780887.2020.1854404

Patton, M. Q. (2015). Qualitative Research & Evaluation Methods: Integrating Theory and Practice. SAGE Publishing.

Peeters, M., Zondervan-Zwijnenburg, M., Vink, G., & van de Schoot, R. (2015). How to handle missing data: A comparison of different approaches. European Journal of Developmental Psychology, 12(4), 377-394. https://doi.org/10.1080/17405629.2015.1049526

Powell, G. A., Bonnett, L. J., Smith, C. T., Hughes, D. A., Williamson, P. R., & Marson, A. G. (2021). Using routinely recorded data in a UK RCT: a comparison to standard prospective data collection methods. Trials, 22(1), 429. https://doi.org/10.1186/s13063-021-05294-6

Sathyanarayanan, A. (2024). The use of routinely collected healthcare records for outcome assessment in clinical trials: a UK perspective. Current medical research and opinion, 40(5), 887-892. https://doi.org/10.1080/03007995.2024.2333441

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory, Method and Research. Sage Publications Ltd.

Smith, J. A., Flowers, P., & Larkin, M. (2022). Interpretative phenomenological analysis: theory, method and research. SAGE Publications Ltd.

Smith, J. A., & Nizza, I. E. (2022). Essentials of interpretative phenomenological analysis. American Psychological Association.

Spiers, J., & Riley, R. (2019). Analysing one dataset with two qualitative methods: The distress of general practitioners, a thematic and interpretative phenomenological analysis. Qualitative Research in Psychology, 16(2), 276-290. https://doi.org/10.1080/14780887.2018.1543099

Chapter 3

Introduction

Prevalence of parental substance use

Parental substance use[3] has been associated with harm to children; although there is a lack of evidence regarding the mechanisms of these harms (Kuppens et al., 2020; Manning et al., 2009). Despite this acknowledgement of the potential for harm and risk, there are challenges with defining the number of parents and children affected by parental alcohol and/or substance use. This is partly due to issues around definition, as the terms substance use and misuse are used interchangeably, that substances are a heterogenous group with different effects and the lack of a clear relationship between substance use and harm (Tsantefski et al., 2015). There are also cultural differences in acceptability and stigma in relation to drug and alcohol use resulting in a lack of universal guidelines and definitions of misuse and harm (Simha et al., 2022). In addition, stigma and parent's fears of the consequences of reporting their addiction issues may lead to denial and underreporting (Forrester & Harwin, 2007; Templeton et al., 2006). Sampling issues may also have an impact as studies that focus on treatment services or parents involved with social work may have a higher prevalence than community based samples and mothers may be underrepresented as they may avoid presenting at services (Manning et al., 2009). The lack of clarification about definitions combined with potential under or over reporting means that the reported prevalence of parental substance use needs to be viewed cautiously and are reported as such or as estimates. However, this could have an impact on service provision and staffing allocation for services.

Despite these issues a number of studies have attempted to assess the scale of parental alcohol and substance use by addressing methodological issues in data collection and analysis. Manning and colleagues (2009) analysed the results of five UK national surveys which all reported on children living with substance using parents. Their analysis was compared with previous estimates that 250,000-350,000 children would experience parental drug misuse and 780,000-1.3 million children experience parental alcohol misuse. Their analysis indicated these were underestimates and 1 million children in the UK in the

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[3] Parental substance use includes the terms parental addiction, parental substance use and misuse and covers both alcohol and drugs

year 2000 lived with an adult who had used illicit drugs in the last year, with around half a million of those living with someone who had used in the last month and that number of children living in a household with only one adult, and that adult was using drugs doubled between 2000 and 2004/5. They also estimated that roughly 2.6 million children lived with an adult who drank at a hazardous level.

More recently, Galligan and Comiskey (2019) used a multimethod approach combining treatment service information with population survey data in Ireland. They estimate that within treatment services 3.7% of children were potentially impacted by parental drug use. However, at a population level they estimated that between 15-24% of children were potentially at risk due to parental drug use and 14-37% from parental alcohol use.

Similarly, Kraus and colleagues (2021) conducted an analysis in Germany combining results from an epidemiological survey with population statistics to estimate the number of children in German living with a parent with substance use disorder (SUD). They estimated that between 688,111-1,257,345 (5.1-9.2%) of children lived with at least one parent with alcohol issues and 87,817-158,401 (0.6-1.2%) children were living with a parent with illicit drug use.

Finally, Frederiksen and colleagues (2021) estimated parental SUD in Denmark using multiple sources including national survey data from young people (aged 15-25 years), their linked parental medical and treatment data from the national survey and adjustments for non-participation. They estimated 12.7% of young people experienced parental SUD from the national survey data. The linked medical and treatment register data was similar at 12.8% for participants, but 18.4% for non-participants; leading them to conclude an estimate of 15.2% parental SUD at a general population level after adjusting for the non-participation rate.

Despite novel approaches, use of multiple data sources and corrections for non-participation, the authors all stated their figures were estimates with the potential to be underestimating the number of children who experience parental substance use. The data does suggest that significant numbers of children and young people are living with a parent with drug and/or alcohol issues and are potentially at risk of harm from parental substance use. They also suggest that there are a group of children and young people who are missing from prevalence figures due to non-participation in research or parents not engaging with treatment services. Which also raises concerns about the number of parents who may not be receiving appropriate support for their substance use.

Impact of parental substance use on children

Parental substance use has the potential to have an impact on children through several mechanisms, including a developmental impact during pregnancy, and throughout child and adulthood, such as increased risks of experiencing adverse events. These experiences result in an increased risk of negative biopsychosocial outcomes for the child. Drug and alcohol use during pregnancy has been linked with foetal alcohol syndrome, neonatal withdrawal syndrome, sudden infant death syndrome (SIDS) and congenital abnormalities (Howe, 2005; McElhatton, 2004). However, there are challenges when making causal claims about the harms associated with prenatal exposure due to several factors including timing and duration of substance use, which substance was used, confounding effects of polysubstance use and the level and/or frequency of use (Konijnenberg, 2015). Parents who use substances are also more likely than their non substance-using peers to have heritable neurodevelopmental conditions such as ADHD, and this increased genetic risk is likely to be passed on to their offspring (Treur et al., 2021; Wimberley et al., 2020). While parents who use substance in the prenatal period may also go on to use postnatally, they may start using again in the postnatal period after stopping during pregnancy or start using once becoming a parent, creating a complex picture and different types of child exposure to substance use. The impact of parental substance use is not just limited to the effects of prenatal exposure.

Although links have been identified between prenatal alcohol exposure and children's subsequent alcohol use, postnatal factors have also been implicated as possible mechanisms for children's alcohol use such as parental modelling of alcohol use and parent's mental health issues and child factors including behavioural and mental health issues (Duko et al., 2022). Similarly, Mahedy and colleagues (2018) found children of moderate to high level alcohol users were more likely to consume alcohol but early alcohol initiation and peers were also associated with their alcohol use. Fathers' substance use had also been associated with children's use. Paternal alcohol use, including at sub-clinical levels, has been associated with increased risk of children developing substance-related disorders (Thor et al., 2022). Children who experience parental substance use are estimated to be at a four to tenfold increased risk of developing an addiction (Howe, 2005).

A recent meta-analysis using longitudinal studies examining child well-being found that parental substance use had a significant negative impact on child wellbeing over time, with a greater effect from drug use than alcohol or tobacco use (Kuppens et al., 2020). In addition, parental substance use has been associated with relationship difficulties with peers, attachment issues, lower educational attainment, and emotional and behavioural issues (Alati et al., 2013; Eiden et al., 2002; Forrester & Harwin, 2007; Guille & Aujla, 2019; Lander et al., 2013; Parolin & Simonelli, 2016; Tsantefski et al., 2015).

Parental substance use is also thought to affect parenting abilities in several domains including emotional availability and understanding, problem solving, judgement, reflective capacity and information processing speed and abilities; making parents less emotionally and cognitively available to their child (Howe, 2005). Parental substance use is also associated with the ability to regulate emotions (Tsantefski et al., 2015). Parents who struggle to regulate their own emotions are less able to model or support their child to emotionally regulate so parental substance use can affect parents’ ability to attune and respond appropriately to their child.

Parents who use substances are also more likely to have cooccurring mental health issues, to have experienced trauma in their childhood and/or as an adult, to have experienced parental substance use in their own parents, and to experience social issues such as homelessness or unstable housing, and contact with the criminal justice services (Agterberg et al., 2020; Anda et al., 2002; Covington, 2008; Grant et al., 2011; Hyatt & Lobmaier, 2020; Somers et al., 2015). Substance use in women has been associated with interpersonal trauma such as childhood abuse and domestic abuse and women are more likely than men to fund their substance use through sex work (Covington, 2008; Fox, 2020; Larrieu et al., 2008; Tuchman, 2010). All of these factors can have an impact on parenting and children can be exposed to risk or disrupted parenting.

Parental substance use and child welfare

Parental substance use has been associated with child maltreatment and involvement with care proceedings (Griffiths et al., 2020; Harwin & Barlow, 2022; Harwin et al., 2019); with some estimates as high as 50-80% of parents who have involvement with the child welfare systems having issues with substance use (Tsantefski et al., 2015).

There are several mechanisms through which parental substance use can lead to neglect and abuse. The presence of alcohol or substances in the home environment places children at risk of accidental overdose (Finkelstein et al., 2017). As substance use has an impact on cognitive functioning, response speed and information processing (Howe, 2005), parent's ability to assess and manage risk can be impaired. In addition, use during pregnancy, injecting illicit drug use, use within the last 12 months, stimulant use, greater levels of use, earlier onset of opiate use, and overdose and hospitalisations following substance use are associated with abuse, neglect and removal of children from birth parents (Canfield et al., 2017; Dube et al., 2001; Ghertner et al., 2018; Kepple, 2017; Prindle et al., 2018; Wall-Wieler et al., 2018).

Scotland is experiencing a drug related deaths crisis and the death rate is higher than other parts of the UK and Europe (Anderson et al., 2023; Sweeney, 2020), as a result children are not only at risk of harm from parental substance use but also at risk of losing parents to a drug related death. A review of Significant Case Reviews in Scotland between 2012 and 2015, following death or significant harm of a child found substance misuse in one or both parents was present in over half of the cases and in *all* cases that involved the death of an infant or pre-school aged child (Care Inspectorate, 2016). Parental substance use is a risk factor and is often used as a criterion for assessing whether children should remain in the custody of their birth parents or be removed from their care. A follow up study investigating outcomes of babies born in Glasgow to mothers with substance use issues found that 83% of babies went home. However, 87% were later removed from their parent/s care on at least one occasion before they were 10-12 years old and only 41% of children were in their birth parent/s care at the age of 10-12 (Mitchell & Mactier, 2021).

The most recent figures from the Scottish Government (2022) listed the concerns raised at child protection case conferences in Scotland in 2021/22. Multiple concerns can be raised for children at each conference. The most commonly raised concern was domestic abuse, followed closely by neglect and parental substance use. As this indicates, harm to children may not necessarily come directly from substance use and can be associated with the other risk factors linked with parental substance use, such as comorbid mental health, poverty, inadequate or unstable housing, and domestic violence (Canfield et al., 2021; Canfield et al., 2017; Fox, 2020; Griffiths et al., 2020; Ijadi-Maghsoodi et al., 2019). However, as these factors commonly occur, they present a cumulative risk to children (Harwin & Barlow, 2022; Larrieu et al., 2008; Patwardhan et al., 2017)

Impact of removal of children on parents

The safety and welfare of children is paramount, and where parental substance use is involved this may result in removal of children from birth parents' custody. However, removal can have a significant impact on parents. Previous research has primarily focussed on children and foster/adoptive parents rather than on the biological parents (Folman, 1998; Ní Chobhthaigh & Duffy, 2019; Turner et al., 2023). As a result, the emotional and psychological needs of this group of parents are not well understood. Previous research has demonstrated that a small group of women have recurrent removals of their children into care, and it has been suggested that this might be linked to a lack of parental support after a child is removed (Broadhurst et al., 2015; Broadhurst & Mason, 2020). Yet there is a lack of research describing the profile of mothers who are at greater risk of removal (Broadhurst et al., 2015; Broadhurst & Mason, 2013).

Initially research on birth parents focused on mothers who had consented to adoption, usually due to social stigma and pressure from their own families after becoming pregnant at a young age or not being married. There is evidence to suggest that the profile of women who relinquish babies, for example in private adoptions, has changed over time and currently mothers are older and tend to cite financial and economic factors as having a major role in their decision making (Sisson, 2022). Recent research has focused more on non-consenting parents involved in compulsory removals due to court or social work interventions. There are some concerns about whether those who voluntarily relinquish children and those with children who are removed without parental consent have the same needs and experiences and whether language and terms such as 'relinquishment' are appropriate in all cases (Broadhurst & Mason, 2017). However, this is a complex area, and many parents experience long term distress after the loss of their child, regardless of the circumstances (Aloi, 2009; Charlton et al., 1998). In addition, there have been concerns raised about parent's understanding of consent and voluntariness in the context of child removal (Broadhurst & Mason, 2017; Lewis, 2022). There is also an increased awareness of the harm resulting from historical state forced adoptions, especially in indigenous populations (Lambert, 2023; Landers et al., 2023)

Research focusing on birth parents tends to be qualitative and has focussed on the experience and impact of relinquishing a child. Common themes that emerge involve disenfranchised grief, distress and impact on current functioning, shame, blame (self and others) and impact on relationships (Aloi, 2009; Broadhurst & Mason, 2020; Charlton et al., 1998; Lewis, 2022; Memarnia et al., 2015; Schofield et al., 2011).

Disenfranchised grief

Doka (2002) describes disenfranchised grief as "the experience of grief that is not openly acknowledged, socially validated or publicly observed". Thornton and colleagues (1991) compared scenarios with disenfranchised grief (such as miscarriage) and recognised losses (such as the death of a loved one). They reported reduced recognition of the need for social support in the disenfranchised grief scenarios. The term disenfranchised grief has been applied to parents with children in the care system due to their grief response at the loss, the stigma of having a child removed and their own role in the removal (Schofield et al., 2011). The lack of acknowledgement of this loss results in a lack of support or identifiable referral pathways for service input and can also lead to birth parents developing beliefs about being undeserving of support (Aloi, 2009). Cooper (2002) suggested that processing grief from the removal of a child may be impacted by the lack of an acceptable ritual to grieve for this loss and highlighted issues around the lack of clarity about an acceptable time period to mourn this loss. She suggested that others may find it acceptable for a birth mother to be distressed for a short period of time following the loss but not for longer periods of time. Continuing to experience distress out with this 'acceptable' time period may lead to feelings of shame and guilt and have an impact on the ability to access support for this loss (Cooper, 2002). Memarnia and colleagues (2015) interviewed birth mothers whose children had been adopted or taken into care. They reported that the majority of mothers felt they had been left to deal with their grief alone after the removal of their child. They also stated that the birth mothers did not feel that their grief was considered “legitimate”. Similarly, Neil and colleagues (2010) interviews with birth families described the removal of a child in terms similar to a bereavement but emphasised the difference due to the lack of certainty and closure. Askren and Bloom’s (1999) review of grief following relinquishment found relinquishing mothers experienced more grief symptoms than women whose child died, and their grief reactions were more likely to become chronic and prolonged due to an inability to resolve their grief.

Mental health and child removal

Parents and birth families report experiencing distress and a deterioration in their mental health following the removal of children. Roughly two thirds of birth relatives reported symptoms or a diagnosis of depression which they felt was triggered or exacerbated by the removal (Neil et al., 2010). The same study also reported that 26% of birth relatives experienced suicidal thoughts following the removal, with roughly half of those birth relatives reporting an attempt to end their lives (Neil et al., 2010). Parents commonly report a deterioration in their mental health and high levels of distress following the removal of children (Broadhurst & Mason, 2020). Parents also report increased levels of self-harm, suicidal ideation and suicide attempts (Broadhurst & Mason, 2020; Memarnia et al., 2015) and relapse or increased use of substances (Aloi, 2009; Memarnia et al., 2015; Schofield et al., 2011). Parents experience a range of strong negative emotions including anger, agitation, anxiety, sadness and depression (Broadhurst & Mason, 2020; Charlton et al., 1998; Kenny et al., 2015; Memarnia et al., 2015).

Relationship difficulties are commonly reported pre and post removal. Parents reported difficulties in new relationships following removal including a lack of shared knowledge about and shared experiences with the “lost” child; while new partners struggled to understand this loss and lacked the knowledge to provide support (Charlton et al., 1998).

Non-consenting birth parents frequently describe the process of removal as traumatic (Broadhurst & Mason, 2017; Kenny et al., 2015). Charlton and colleagues (1998) experiences of working with non-consenting parents reported that parent’s perception of the system and process of removal is adversarial, with a focus on their weaknesses rather than their strengths. Many parents described feeling angry, humiliated and betrayed (Charlton et al., 1998; Memarnia et al., 2015; Schofield et al., 2011). Blame was also a common theme that regularly arose in interviews with birth parents. Parents often reported a lack of support which they feel may have prevented the need for removal and placed the blame with services (Charlton et al., 1998; Memarnia et al., 2015; Neil et al., 2010). Memarnia and colleagues (2015) describe parents having brief moments during their interviews where they acknowledged their mistakes and own role in the removal of their children. However, mothers were unable to tolerate this for long periods of time due to despair, guilt and shame.

Another common theme is the impact on self-esteem and identity. Parents report low self-esteem following removal or relinquishment, especially following non-consensual removal and having reports or discussions at meetings with a focus on mistakes and weakness (Charlton et al., 1998; Neil et al., 2010). Consenting and non-consenting relinquishing mothers have been described as ‘maternal outcasts’; mothers whose experiences fall outside of the normal expectations of motherhood (Broadhurst & Mason, 2013). Views of motherhood have shifted over time due to women’s changing roles in society, nevertheless, women still feel that motherhood continues to be idealised and normalised as the main role of womanhood and femininity (Broadhurst & Mason, 2013). Two main aspects of identity issues have been identified for parents who have had children removed – the loss of their identity as a ‘good parent’ due to stigma and shame and the challenge in maintaining an identity as a parent once your child has been removed from your care (Schofield et al., 2011). Schofield and colleagues (2011) interviewed parents of children growing up in foster care and found they expressed inconsistent views about themselves and their parenting abilities which led to cognitive dissonance (i.e. holding contradictory cognitions which leads to additional psychological distress and strategies to manage that distress). Parents reported hearing themselves being described as ‘cold’, ‘making no effort to change’ and ‘didn’t put the child’s needs first’ at child protection meetings or in court. However, these parents did not recognise these descriptions of themselves and often felt their parenting had been affected by their own experiences of childhood abuse, domestic violence or addiction. To deal with the dissonance produced these parents created a new narrative about loving their child and doing their best (Schofield et al., 2011). Similarly, Slembrouck and Hall (2003) described the term of ‘caring but not coping’; a narrative where parents were able to hold the view that they loved their child but could not manage on a practical level to meet their child’s needs which avoids the ‘spoiled identity’ of being a “bad parent” who had their child removed. Interviews with mothers whose children have been taken into care found a tendency for birth mothers to minimise the circumstances surrounding the removal to defend against this “bad mother” narrative (Memarnia et al., 2015).

While these is now an increasing body of evidence using qualitative research to explore mothers experience of child removal (Broadhurst & Mason, 2020; Charlton et al., 1998; Kenny et al., 2015; Memarnia et al., 2015) there is a need for quantitative or mixed method studies to explore the associations between removal and impact. In addition, these studies have explored the impact on the mothers and highlighted unmet need, there is a lack of evidence about service provision and what mothers feel works or does not work for them.

Multiple Removals

There is increasing recognition and concern regarding mothers who have experienced repeated pregnancies and removals of children (Broadhurst et al., 2015; Mason et al., 2020). Broadhurst and colleagues refer to these mothers as a “hidden population” due to the limited research and information available and the lack of dedicated services or discussion about their needs (Broadhurst et al., 2015; Broadhurst & Mason, 2013). Data from the Children and Families Court Advisory and Support Service (Cafcass) indicated that 24% of women went through repeated care proceedings between 2007 and 2014; and this increases to 31% for mothers aged under 20 (Broadhurst et al., 2015). The mean interval between episodes was seventeen months which limits the time available for interventions and work to be completed to increase the likelihood of retaining custody of future children (Broadhurst et al., 2015). In addition, their past trauma experiences combined with the trauma from the removal of their children can result in a lack of trust in services and these mothers being labelled as ‘non-engaging’; increasing the chances of future children being removed (Mason et al., 2020).

Although research in this area is limited, a feasibility study undertaken by the Hackney Borough Council Pause Project identified 49 women of reproductive age who had experienced removals of between two and eleven of their children. These 49 women had 205 children who had been placed in the care system. They reported that these women presented as complex with multiple social and health issues including drug and alcohol addiction (98%), domestic violence (71%), homelessness (51%), growing up in care (49%) and involvement with the criminal justice system (35%) (Pause, 2013).

Despite the lack of research on these mothers, it appears that although they might be small in number, they can have several children removed from their care. As many of these mothers also had experience of the care system as children this raises concerns about the intergenerational repeated patterns of child removal (Mason et al., 2020; Pause, 2013; Roy, 2021).

Interventions

Despite increasing recognition of the impact of removal on parents and children there is a lack of research to help us to understand and support this group of parents. In addition, while parents often report that they would like to engage with support following removal, research suggests there may be issues regarding which service should provide this as parents do not wish to engage with the same team that removed their child or feel wary of services they provide or commission (Charlton et al., 1998; Mason et al., 2020; Shockley McCarthy et al., 2022). However, mental health and addiction services may not see this work as within their remit and may lack the knowledge and skills to adequately support these parents (Neil et al., 2010) and acute distress following child removal may not meet service or referral criteria. A mapping exercise of post-adoption support provided in England and Wales found that all local authorities that responded either provided or commissioned post-adoption support to birth parents (Sellick, 2007). However, there were differences in the type and availability of support provided. The majority of services reported providing support for direct or indirect contact with their children (95%). The least commonly offered services were the provision of advocacy (62%) and therapy for birth relatives (57%) (Sellick, 2007).

While services are available for birth parents, and occasionally for other members of the birth family, there is limited research on these services and what is available can focus on a specific intervention, such as therapeutic support, rather than at a wider service level.

As a result, services have been commissioned but there is a lack of evidence about their ability to engage with birth parents or their outcomes (Cossar & Neil, 2010). Pause (Pause, 2013) initially started as a pilot project in Hackney, London and is now running in multiple locations within the UK. An independently commissioned study found the programme improved mother's wellbeing, their relationships with their children and reduced the number of children entering care in the local authorities who had commissioned the programme compared with an increase in comparator sites (Department for Education, 2020). The University of Hertfordshire evaluated the Adoptionplus Birth Relative Counselling Service and found that parents benefitted from the service. This service has been running since 2004 and accepts self-referrals and referrals from a number of UK Local Authorities (Nolte et al., 2019).

However, other services, despite initial results being positive, were unable to secure long term funding. For example, Before Adoption was a pilot project based in Manchester. It was funded for two years and failed to secure additional funding. It worked with parents in the period of time between the decision was made for adoption and before the child/ren were permanently placed and it offered counselling for birth parents, information and support to produce resources for their children (Charlton et al., 1998). Parents Without Children operated in Durham and due to a lack of funding closed after three years. It provided counselling and support services to birth parents who did not consent to the removal of their child. They provided either individual or joint counselling for birth parents, information about the adoption process and their rights and support to produce resources such as video and audio recordings, lifestory books and letters for their child (Charlton et al., 1998).

The mapping exercise (Sellick, 2007) and these services suggest that services are available for parents who have had their children removed from their care; which is in line with recommendations about providing support for birth parents (Broadhurst & Mason, 2013) However, the mapping exercise is now over 17 years old and no similar mapping has been completed recently to give an up to date picture of service provision and availability. While service are available for birth parents, there is a wide variation in service provision with the majority of services offering support and advice in relation to the adoption process and options for contact. Due to the lack of research and variability of services provided it is difficult to identify a model or approach to provide support for birth parents following removal of a child. In addition, the literature available was unable to identify any evidence-based psychological intervention for birth parents experiencing distress following the removal of their child or an established role for clinical psychologists working with this group of parents as the majority of this work is being undertaken by social workers and support workers.

Scottish policy context

While it is impossible to consider the needs of children or mothers without considering them in their wider family context, it is impossible to think about this thesis and body of work without considering the wider context in Scotland at the time of the research and relevant policies that were in place or developed during this time period. This period saw the introduction of a new drug and alcohol policy, a shift to recovery-oriented services, further viewing and moving to the position that addiction is a health issue, the introduction of minimum unit pricing on alcohol and plans to develop safe consumption rooms for drug use.

During this research, The Scottish Government published Rights, Respect and Recovery; a policy document covering alcohol and drugs. This policy updated previous alcohol and drug policies which looked at alcohol and drugs separately. Rights, Respect and Recovery acknowledged the harm within Scotland due to alcohol and drug use at an individual, family and society level and the increasing rates of drug related deaths in Scotland. Rights, Respect and Responsibilities aimed to take a “human rights” approach to alcohol and drug use with a focus on recovery rather than punishment (The Scottish Government, 2018). It presented a shift towards public health interventions such as the introduction of minimum unit pricing of alcohol in 2018 and a campaign to reduce stigma (https://www.gov.scot/news/tackling-the-stigma-of-addiction/). It had a chapter dedicated to the needs of children, young people and families. It also highlighted the importance of lived and living experience of substance use and affected family members and how those voices need to be combined with research to improve outcomes in Scotland (The Scottish Government, 2018).

In addition, the Scottish Government established the Scottish Drug Deaths Taskforce in 2019 with the aim of developing strategies to reduce drug related harm and deaths in Scotland. Tweed and colleagues (2022) highlighted that while drug deaths were more common in men, the number of drug deaths were increasing at a higher rate in women, with removal of children considered to be one of several factors involved in this increase. Recommendations from the Scottish Drug Deaths Taskforce included the development and introduction of the Medication Assisted Treatment (MAT) standards for Alcohol and Drug Recovery Services and support for wider public health initiatives like anti-stigma campaigns, Naloxone treatment network to reverse opioid overdoses and the development of supervised drug consumption facilities.

The MAT standards aimed to reduce postcode lottery treatment in Alcohol and Drug Recovery Services by standardising care, treatment and expectations across Scotland. There are 10 MAT standards and while some are directly related to medication (e.g. Standard 1: All people accessing services have the option to start MAT from the same day of presentation), others consider the wider needs of individuals with substance use such as Standard 6: The system that provides MAT is psychologically informed (Tier 1); routinely delivers evidence-based low intensity psychosocial interventions (tier 2); and supports individuals to grow social networks; Standard 8: All people have access to independent advocacy and support for housing, welfare and income needs; Standard 9: All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery; and Standard 10: All people receive trauma informed care.

In addition, this was a period of change and development for child welfare services in Scotland. Scotland had already developed and implemented Getting It Right For Every Child (GIFREC - https://www.gov.scot/policies/girfec/) a strategy to allow every child in Scotland to flourish and reach their full potential. Part of this strategy involved information sharing and that child welfare went beyond social work to every service working with children and adults. As a result, Alcohol and Drug Recovery Services were asking all services users about their children and any other children they had contact with and completing parental assessments.

The study also overlapped with the initial work on The Promise (https://thepromise.scot). The Promise was developed from the Independent Care Review in Scotland looking at the needs of care experienced children and young people. One of the outcomes was a commitment to keep young people in their families if they were safe – this could be with their parent/s or to consider kinship care as a first option for placement.

The ethos within Scotland at the time of this study no doubt shaped its design and development, a Scotland grappling with drug and alcohol addiction and a drug death crisis but that was also open to new ways of working, including reducing stigma, thinking about public health approaches and wanting the voices of those with lived or living experience to be central to service development, while also balancing the needs of their children and their safety and wellbeing.

Gaps in the literature and aims for this thesis

There are gaps in relation to prevalence of child removal; but there is also a lack of information about where these children go once they have been removed from their birth parents. Given the potential risks to child wellbeing and the association between parental substance use and child maltreatment, it would be beneficial to know if addiction services were keeping accurate records in relation to the child/ren of their clients. This will be addressed in paper 1 (Chapter 2).

Gender issues are clearly important, since far more women attending addiction services are reported to be mothers and have children removed from their care than men. Yet there are concerns that gender issues are overlooked in addiction services and there is a gap in the evidence base concerning child removal and gender. It would be beneficial to add to the small evidence base about prevalence of repeated removals of children. In addition, there is a need for a clearer understanding about which factors are associated with child removal in an addictions context. This will be addressed in paper 2 (Chapter 3).

Finally, the gaps in the literature indicate that research is required to develop a greater understanding of the needs of this group of mothers, particularly in relation to disenfranchised grief and the impact of child removal. In addition, there are gaps in our understanding about service provision and what is needed for these mothers; especially from the point of view of the mothers themselves. This will be address in paper 3 (Chapter 4).

Aim 1: Investigate prevalence of parenthood in an Alcohol and Drug Recovery Service, placement outcomes for children following removal from birth parents, and accuracy of staff reporting of child information in parents' clinical notes.

Aim 2: Obtain prevalence rates for child removal from parents in an Alcohol and Drug Recovery Service, investigate if there are gender differences in removal prevalence and patterns, and whether there are factors which were associated with the removal of children.

Aim 3: Use qualitative interviews to identify themes related to the lived experience of child removal and contact with services in mothers who are current service users of an Alcohol and Drug Recovery Service and the Women's Recovery Group.

Aim 4: Using the results from papers 1, 2 and 3 develop guidelines for services to support mothers who have had children removed from their care and identify future research directions.

References

Agterberg, S., Schubert, N., Overington, L., & Corace, K. (2020). Treatment barriers among individuals with co-occurring substance use and mental health problems: Examining gender differences. *Journal of substance abuse treatment*, *112*, 29-35. https://doi.org/10.1016/j.jsat.2020.01.005

Alati, R., Davey Smith, G., Lewis, S. J., Sayal, K., Draper, E. S., Golding, J., . . . Gray, R. (2013). Effect of prenatal alcohol exposure on childhood academic outcomes: contrasting maternal and paternal associations in the ALSPAC study. *PloS one*, *8*(10), e74844-e74844. https://doi.org/10.1371/journal.pone.0074844

Aloi, J. A. (2009). Nursing the disenfranchised: women who have relinquished an infant for adoption. *Journal of psychiatric and mental health nursing*, *16*(1), 27-31. https://doi.org/10.1111/j.1365-2850.2008.01324.x

Anda, R. F., Whitfield, C. L., Felitti, V. J., Chapman, D., Edwards, V. J., Dube, S. R., & Williamson, D. F. (2002). Adverse Childhood Experiences, Alcoholic Parents, and Later Risk of Alcoholism and Depression. *Psychiatric services (Washington, D.C.), 53*(8), 1001-1009. https://doi.org/10.1176/appi.ps.53.8.1001

Anderson, M., Atkinson, A. M., McAuley, A., Sumnall, H. R., Glancy, M. E., Bloomfield, H. A., & Trayner, K. M. A. (2023). Assessing the reach and engagement with the ' How To Save A Life ' mass media campaign on drug-related death prevention in Scotland. *Drugs : education, prevention & policy*, 1-10. https://doi.org/10.1080/09687637.2023.2262735

Askren, H. A., & Bloom, K. C. (1999). Postadoptive reactions of the relinquishing mother: a review. *Journal of obstetric, gynecologic, and neonatal nursing*, *28*(4), 395.

Broadhurst, K., Alrouh, B., Yeend, E., Harwin, J., Shaw, M., Pilling, M., . . . Kershaw, S. (2015). Connecting Events in Time to Identify a Hidden Population: Birth Mothers and Their Children in Recurrent Care Proceedings in England. *British Journal of Social Work*, *45*(8), 2241-2260. https://doi.org/10.1093/bjsw/bcv130

Broadhurst, K., & Mason, C. (2013). Maternal outcasts: raising the profile of women who are vulnerable to successive, compulsory removals of their children - a plea for preventative action. *The Journal of social welfare & family law*, *35*(3), 291-304. https://doi.org/10.1080/09649069.2013.805061

Broadhurst, K., & Mason, C. (2017). Birth Parents and the Collateral Consequences of Court-ordered Child Removal: Towards a Comprehensive Framework. *International Journal of Law Policy and the Family, 31*(1), 41-59. https://doi.org/10.1093/lawfam/ebw013

Broadhurst, K., & Mason, C. (2020). Child removal as the gateway to further adversity: Birth mother accounts of the immediate and enduring collateral consequences of child removal. *Qualitative Social Work*, *19*(1), 15-37, Article 1473325019893412. https://doi.org/10.1177/1473325019893412

Canfield, M., Norton, S., Downs, J., & Gilchrist, G. (2021). Parental status and characteristics of women in substance use treatment services: Analysis of electronic patient records. *Journal of substance abuse treatment*, *127*, 108365-108365. https://doi.org/10.1016/j.jsat.2021.108365

Canfield, M., Radcliffe, P., Marlow, S., Boreham, M., & Gilchrist, G. (2017). Maternal substance use and child protection: a rapid evidence assessment of factors associated with loss of child care. *Child abuse & neglect*, *70*, 11-27. https://doi.org/10.1016/j.chiabu.2017.05.005

Care Inspectorate. (2016). *Learning from significant case reviews in Scotland: a retrospective review of relevant reports completed in the period between 1 April 2012 and 31 March 2015*. Dundee

Charlton, L., Crank, M., Kansara, K., & Oliver, C. (1998). *Still Screaming: Birth parents compulsory separated from their children.*

Cooper, R. (2002). *Unrecognised losses in child adoption*. Research Press.

Cossar, J., & Neil, E. (2010). Supporting the Birth Relatives of Adopted Children: How Accessible Are Services? *The British journal of social work*, *40*(5), 1368-1386. https://doi.org/10.1093/bjsw/bcp061

Covington, S. S. (2008). Women and Addiction: A Trauma-Informed Approach. *Journal of psychoactive drugs*, *40*(sup5), 377-385. https://doi.org/10.1080/02791072.2008.10400665

Department for Education. (2020). *Evaluation of Pause*.

Doka, K. J. (2002). *Disenfranchised grief: new directions, challenges, and strategies for practice*. Research Press.

Dube, S. R., Anda, R. F., Felitti, V. J., Croft, J. B., Edwards, V. J., & Giles, W. H. (2001). Growing up with parental alcohol abuse: exposure to childhood abuse, neglect, and household dysfunction. *Child abuse & neglect*, *25*(12), 1627-1640. https://doi.org/10.1016/S0145-2134(01)00293-9

Duko, B., Pereira, G., Tait, R. J., Bedaso, A., Newnham, J., Betts, K., & Alati, R. (2022). Prenatal alcohol exposure and offspring subsequent alcohol use: A systematic review. *Drug and alcohol dependence*, *232*, 109324-109324. https://doi.org/10.1016/j.drugalcdep.2022.109324

Eiden, R. D., Edwards, E. P., & Leonard, K. E. (2002). Mother–infant and father–infant attachment among alcoholic families. *Development and psychopathology*, *14*(2), 253-278. https://doi.org/10.1017/S0954579402002043

Finkelstein, Y., Macdonald, E. M., Gonzalez, A., Sivilotti, M. L. A., Mamdani, M. M., Juurlink, D. N., & Canadian Drug Safety And Effectiveness Research, N. (2017). Overdose Risk in Young Children of Women Prescribed Opioids. *Pediatrics (Evanston)*, *139*(3). https://doi.org/10.1542/peds.2016-2887

Folman, R. D. (1998). "I Was Tooken": How Children Experience Removal from Their Parents Preliminary to Placement into Foster Care. *Adoption quarterly*, *2*(2), 7-35. https://doi.org/10.1300/J145v02n02_02

Forrester, D., & Harwin, J. (2007). Social work and parental substance misuse. In R. Phillips (Ed.), *Children exposed to parental substance misuse: Implications for family placements* (2nd ed., pp. 115-131). BAAF Adoption and Fostering.

Fox, S. (2020). […] you feel there's nowhere left to go: the barriers to support among women who experience substance use and domestic abuse in the UK. *Advances in dual diagnosis*, *13*(2), 57-71. https://doi.org/10.1108/ADD-09-2019-0010

Frederiksen, K. S., Hesse, M., Grittner, U., & Pedersen, M. U. (2021). Estimating perceived parental substance use disorder: Using register data to adjust for non-participation in survey research. *Addictive behaviors*, *119*, 106897-106897. https://doi.org/10.1016/j.addbeh.2021.106897

Galligan, K., & Comiskey, C. M. (2019). Hidden Harms and the Number of Children Whose Parents Misuse Substances: A Stepwise Methodological Framework for Estimating Prevalence. *Substance use & misuse*, *54*(9), 1429-1437. https://doi.org/10.1080/10826084.2019.1584224

Ghertner, R., Waters, A., Radel, L., & Crouse, G. (2018). The role of substance use in child welfare caseloads. *Children and youth services review*, *90*, 83-93. https://doi.org/10.1016/j.childyouth.2018.05.015

Grant, T., Huggins, J., Graham, J. C., Ernst, C., Whitney, N., & Wilson, D. (2011). Maternal substance abuse and disrupted parenting: Distinguishing mothers who keep their children from those who do not. *Children and youth services review*, *33*(11), 2176-2185. https://doi.org/10.1016/j.childyouth.2011.07.001

Griffiths, L. J., Johnson, R. D., Broadhurst, K., Bedston, S., Cusworth, L., Alrouh, B., . . . John, A. (2020). Maternal health, pregnancy and birth outcomes for women involved in care proceedings in Wales: a linked data study. *BMC pregnancy and childbirth*, *20*(1), 697-697. https://doi.org/10.1186/s12884-020-03370-4

Guille, C., & Aujla, R. (2019). Developmental Consequences of Prenatal Substance Use in Children and Adolescents. *Journal of child and adolescent psychopharmacology*, *29*(7), 479-486. https://doi.org/10.1089/cap.2018.0177

Harwin, J., & Barlow, C. (2022). The co-occurrence of substance misuse, domestic abuse, and child maltreatment: Can Family Drug and Alcohol Courts play a part? *Frontiers in psychiatry*, *13*, 989813-989813. https://doi.org/10.3389/fpsyt.2022.989813

Harwin, J., Broadhurst, K., Cooper, C., & Taplin, S. (2019). Tensions and contradictions in family court innovation with high risk parents: The place of family drug treatment courts in contemporary family justice. *International Journal of Drug Policy*, *68*, 101-108. https://doi.org/10.1016/j.drugpo.2018.04.019

Howe, D. (2005). *Child abuse and neglect: attachment, development, and intervention*. Palgrave Macmillan.

Hyatt, J. M., & Lobmaier, P. P. (2020). Medication assisted treatment (MAT) in criminal justice settings as a double-edged sword: balancing novel addiction treatments and voluntary participation. *Health & Justice*, *8*(1), 7-7. https://doi.org/10.1186/s40352-020-0106-9

Ijadi-Maghsoodi, R., Quan, M., Horton, J., Ryan, G. W., Kataoka, S., Lester, P., . . . Gelberg, L. (2019). Youth Growing Up in Families Experiencing Parental Substance Use Disorders and Homelessness: A High-Risk Population. *Journal of child and adolescent psychopharmacology*, *29*(10), 773-782. https://doi.org/10.1089/cap.2019.0011

Kenny, K. S., Barrington, C., & Green, S. L. (2015). “ I felt for a long time like everything beautiful in me had been taken out ”: Women's suffering, remembering, and survival following the loss of child custody. *The International journal of drug policy*, *26*(11), 1158-1166. https://doi.org/10.1016/j.drugpo.2015.05.024

Kepple, N. J. (2017). The Complex Nature of Parental Substance Use: Examining Past Year and Prior Use Behaviors as Correlates of Child Maltreatment Frequency. *Substance use & misuse*, *52*(6), 811-821. https://doi.org/10.1080/10826084.2016.1253747

Konijnenberg, C. (2015). Methodological Issues in Assessing the Impact of Prenatal Drug Exposure. *Substance Abuse: Research and Treatment*, *2015*(S2), 39-44. https://doi.org/10.4137/SART.S23544

Kraus, L., Uhl, A., Atzendorf, J., & Seitz, N.-N. (2021). Estimating the number of children in households with substance use disorders in Germany. *Child and adolescent psychiatry and mental health*, *15*(1), 1-9. https://doi.org/10.1186/s13034-021-00415-0

Kuppens, S., Moore, S. C., Gross, V., Lowthian, E., & Siddaway, A. P. (2020). The Enduring Effects of Parental Alcohol, Tobacco, and Drug Use on Child Well-being: A Multilevel Meta-

Analysis. *Development and psychopathology*, *32*(2), 765-778. https://doi.org/10.1017/S0954579419000749

Lambert, M. (2023). *A state apology for historic forced adoption in Britain: Briefing document*. Lancaster: Lancaster University

Lander, L., Howsare, J., & Byrne, M. (2013). The Impact of Substance Use Disorders on Families and Children: From Theory to Practice. *Social work in public health*, *28*(3-4), 194-205. https://doi.org/10.1080/19371918.2013.759005

Landers, A. L., Danes, S. M., Carrese, D. H., Mpras, E., Campbell, A. R., & White Hawk, S. (2023). I can still hear my baby crying: The ambiguous loss of American Indian/Alaska Native birthmothers. *Family process*, *62*(2), 702-721. https://doi.org/10.1111/famp.12815

Larrieu, J. A., Heller, S. S., Smyke, A. T., & Zeanah, C. H. (2008). Predictors of permanent loss of custody for mothers of infants and toddlers in foster care. *Infant mental health journal*, *29*(1), 48-60. https://doi.org/10.1002/imhj.20165

Lewis, S. (2022). 'I was putting her first': Birth parents' experiences of 'consent' to adoption from care in England. *Child & family social work*, *27*(3), 490-499. https://doi.org/10.1111/cfs.12901

Mahedy, L., MacArthur, G. J., Hammerton, G., Edwards, A. C., Kendler, K. S., Macleod, J., . . . Heron, J. (2018). The effect of parental drinking on alcohol use in young adults: the mediating role of parental monitoring and peer deviance. *Addiction (Abingdon, England)*, *113*(11), 2041-2050. https://doi.org/10.1111/add.14280

Manning, V., Best, D. W., Faulkner, N., & Titherington, E. (2009). New estimates of the number of children living with substance misusing parents: results from UK national household surveys. *BMC public health*, *9*(1), 377-377. https://doi.org/10.1186/1471-2458-9-377

Mason, C., Taggart, D., & Broadhurst, K. (2020). Parental Non-Engagement within Child Protection Services—How Can Understandings of Complex Trauma and Epistemic Trust Help? *Societies (Basel, Switzerland)*, *10*(93), 93. https://doi.org/10.3390/soc10040093

McElhatton, P. (2004). The effects of drug misuse in pregnancy In R. Phillips (Ed.), *Children exposed to parental substance misuse: Implications for family placement*. British Adoption & Fostering.

Memarnia, N., Nolte, L., Norris, C., & Harborne, A. (2015). 'It felt like it was night all the time': listening to the experiences of birth mothers whose children have been taken into care or adopted. *Adoption & fostering*, *39*(4), 303-317. https://doi.org/10.1177/0308575915611516

Mitchell, J., & Mactier, H. (2021). Accommodation outcomes for children of drug-misusing women. *Archives of disease in childhood, 106*(1), 80-82. https://doi.org/10.1136/archdischild-2018-316440

Neil, E., Cossar, J., Lorgelly, P., & Young, J. (2010). *Helping Birth Families: Services, costs and outcomes*. British Association for Adoption & Fostering (BAAF).

Nolte, L., Wright, H., Morgan, H., & Forbes, C. (2019). 'Like a Light in the Dark': A Hertfordshire University Evaluation of the Adoptionplus Birth Relative Counselling Service. In J. Alper (Ed.), *Supporting Birth Parents Whose Children Have Been Adopted*. Jessica Kingsley Publishers.

Ní Chobhthaigh, S., & Duffy, F. (2019). The effectiveness of psychological interventions with adoptive parents on adopted children and adolescents' outcomes: A systematic review. *Clinical child psychology and psychiatry*, *24*(1), 69-94. https://doi.org/10.1177/1359104518786339

Parolin, M., & Simonelli, A. (2016). Attachment Theory and Maternal Drug Addiction: The Contribution to Parenting Interventions. *Frontiers in psychiatry*, *7*, 152-152. https://doi.org/10.3389/fpsyt.2016.00152

Patwardhan, I., Hurley, K. D., Thompson, R. W., Mason, W. A., & Ringle, J. L. (2017). Child maltreatment as a function of cumulative family risk: Findings from the intensive family preservation program. *Child abuse & neglect*, *70*, 92-99. https://doi.org/10.1016/j.chiabu.2017.06.010

Pause. (2013). *Pause Creating a space for change: Hackney Feasibility Study*. London: Pause

Prindle, J. J., Hammond, I., & Putnam-Hornstein, E. (2018). Prenatal substance exposure diagnosed at birth and infant involvement with child protective services. *Child abuse & neglect*, *76*, 75-83. https://doi.org/10.1016/j.chiabu.2017.10.002

Roy, J. (2021). Children living with parental substance misuse: A cross-sectional profile of children and families referred to children's social care. *Child & family social work*, *26*(1), 122-131. https://doi.org/10.1111/cfs.12795

Schofield, G., Moldestad, B., & Höjer, I. (2011). Managing loss and threatened identity: experiences of parents of children growing up in foster care, the perspectives of their social workers and implications for practice. In *The British Journal of Social Work* (Vol. 41, pp. 74-92): Deutsches Zentralinstitut für soziale Fragen/DZI.

Sellick, C. (2007). An Examination of Adoption Support Services for Birth Relatives and for Post-Adoption Contact in England and Wales. *Adoption & fostering*, *31*(4), 17-26. https://doi.org/10.1177/030857590703100404

Shockley McCarthy, K., Price Wolf, J., & Dellor, E. (2022). Promoting permanency in families with parental substance misuse: lessons from a process evaluation of a multi-system program. *BMC public health*, *22*(1), 2261-2215. https://doi.org/10.1186/s12889-022-14528-4

Simha, A., Ahmed, S., Prasad, R., Dinesh, A. S., Kandasamy, A., & Rao, N. P. (2022). Effect of national cultural dimensions and consumption rates on stigma toward alcohol and substance use disorders. *International journal of social psychiatry*, *68*(7), 1411-1417. https://doi.org/10.1177/00207640211028611

Sisson, G. (2022). Who are the women who relinquish infants for adoption? Domestic adoption and contemporary birth motherhood in the United States. *Perspectives on sexual and reproductive health*, *54*(2), 46-53. https://doi.org/10.1363/psrh.12193

Slembrouck, S., & Hall, C. (2003). Caring but not coping: Fashioning a legitimate parent identity. In K. Juhila, T. Poso, S. White, C. Hall, & N. Parton (Eds.), *Constructing Clienthood in Social Work and Human Services : Interaction, Identities and Practices*. Jessica Kingsley Publishers.

Somers, J. M., Moniruzzaman, A., & Palepu, A. (2015). Changes in daily substance use among people experiencing homelessness and mental illness: 24-month outcomes following randomization to Housing First or usual care: Substance use and Housing First: results of a randomized trial. *Addiction (Abingdon, England)*, *110*(10), 1605-1614. https://doi.org/10.1111/add.13011

Sweeney, K. (2020). Drug-related deaths in Scotland: Looking beyond the numbers. *InnovAiT*, *13*(9), 561-563. https://doi.org/10.1177/1755738020924071

Templeton, L., Zohhadi, S., Galvani, S., & Velleman, R. (2006). "Looking Beyond Risk" Parental Substance Misuse: Scoping Study.

The Scottish Government. (2018). Rights, Respect and Recovery: Scotland’s strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths.

The Scottish Government. (2022). *Children's Social Work Statistics 2020/21* Report Scottish Government Children and Families Directorate.

Thor, S., Hemmingsson, T., Danielsson, A.-K., & Landberg, J. (2022). Fathers' alcohol consumption and risk of substance-related disorders in offspring. *Drug and alcohol dependence*, *233*, 109354-109354. https://doi.org/10.1016/j.drugalcdep.2022.109354

Thornton, G., Robertson, D. U., & Mlecko, M. L. (1991). Disenfranchised grief and evaluations of social support by college students. *Death studies*, *15*(4), 355-362. https://doi.org/10.1080/07481189108252440

Treur, J. L., Demontis, D., Smith, G. D., Sallis, H., Richardson, T. G., Wiers, R. W., . . . Munafò, M. R. (2021). Investigating causality between liability to ADHD and substance use, and liability to substance use and ADHD risk, using Mendelian randomization. *Addiction biology*, *26*(1), e12849-n/a. https://doi.org/10.1111/adb.12849

Tsantefski, M., Gruenert, S., & Campbell, L. (2015). *Working with substance-affected parents and their children*. Allen & Unwin.

Tuchman, E. (2010). Women and Addiction: The Importance of Gender Issues in Substance Abuse Research. *Journal of addictive diseases*, *29*(2), 127-138. https://doi.org/10.1080/10550881003684582

Turner, F., Kainth, G., MacDonald, S., O'Connor, R., Crawford, K., & Minnis, H. (2023). "I will commit to this child as much as I can for the time that they are with me:" A qualitative examination of how foster carer commitment relates to short-term foster care for young children following abuse and neglect. *Child abuse & neglect*, *135*, 105983-105983. https://doi.org/10.1016/j.chiabu.2022.105983

Tweed, E. J., Miller, R. G., Schofield, J., Barnsdale, L., & Matheson, C. (2022). Why are drug-related deaths among women increasing in Scotland? A mixed-methods analysis of possible explanations. *Drugs : education, prevention & policy*, *29*(1), 62-75. https://doi.org/10.1080/09687637.2020.1856786

Wall-Wieler, E., Roos, L. L., Brownell, M., Nickel, N. C., & Chateau, D. (2018). Predictors of having a first child taken into care at birth: A population-based retrospective cohort study. *Child abuse & neglect*, *76*, 1-9. https://doi.org/10.1016/j.chiabu.2017.09.033

Wimberley, T., Agerbo, E., Horsdal, H. T., Ottosen, C., Brikell, I., Als, T. D., . . . Dalsgaard, S. (2020). Genetic liability to ADHD and substance use disorders in individuals with ADHD. *Addiction (Abingdon, England)*, *115*(7), 1368-1377. https://doi.org/10.1111/add.14910

Chapter 2

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Where Are the Children?: Addiction Workers' Knowledge of Clients' Offspring and Related Risks

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Abstract

Parental substance use can harm and increase risk to children. Accurate reporting and monitoring by addiction staff is essential to support and protect families and children. The caseloads of 8 nurses and 12 social care workers (736 service users) were reviewed for offspring related information. 62.8% of service users were parents, 38.3% of those being parents of children aged 16 years and under. Data were available on 913 offspring, 475 (52%) aged 16 or under. 32% of the total offspring sample, and of the 16 and under sample, lived with a family member who was not the parent receiving treatment and had no social work involvement. Seven offspring (0.8%) were deceased—a two-fold increase in mortality rate compared to the general population, highlighting the increased risk of harm experienced by the offspring of this group of parents. In the records of 53 parents (11.5%; 68 children), there was a discrepancy between the electronic records and staff knowledge about children aged 16 and under. Of these 68 children, 56 (11.8%) were recorded on the electronic system but not reported by the care manager, and 12 (2.5%) were only reported by the care manager but were not recorded on the electronic system. Worryingly, there might also be children who are neither on electronic systems nor known to staff. Due to these discrepancies in recording and the increased risks to these children, we recommend that addiction staff routinely asks service users if they are parents and who provides care for their children.

Keywords Addiction · Offspring · Children · Risk · Mortality · Recording

Introduction

Parental addiction[4] is associated with the potential for serious harm to children throughout the lifespan. Alcohol and drug use during pregnancy has been associated with premature birth, foetal alcohol syndrome, neonatal abstinence syndrome, sudden infant death syndrome (SIDS), and congenital abnormalities (Howe, 2005; Tsantefski et al., 2015). Yet, there are methodological issues when making causal claims about the impact or severity of prenatal exposure as several factors can have an impact including the timing of the exposure, substance used, impact of polysubstance use, and level or frequency of use (Konijnenberg, 2015). In addition to pre-natal exposure, parents who used substances prenatally are likely to continue to use substances postnatally and some parents may start using substances after becoming parents. Duko and colleagues (2022) found a link between prenatal alcohol exposure and subsequent alcohol use in children but also found that the mechanisms for this link may include postnatal factors such as modelling of alcohol use, parental mental health and child behavioural, and mental health issues.

In childhood, parental addiction has been associated with children's lower educational attainment, relationship difficulties with peers, emotional and behavioural problems, and poorer child well-being (Alati et al., 2013; Forrester & Harwin, 2007; Guille & Aujla, 2019; Kuppens et al., 2020; Lander et al., 2013; Tsantefski et al., 2015). Children with a parent with addiction issues are estimated to be at a four to tenfold risk of developing an addiction (Howe, 2005). Substance use does not need to be significant to lead to harm; children from fathers with sub-clinical levels of alcohol use were at increased risk of developing substance-related disorders (Thor et al., 2022).

Parental addiction has also been linked with child maltreatment with estimates that between 50 and 80% of parents involved with child welfare systems have addiction issues (Tsantefski et al., 2015). Drug use during pregnancy, higher levels of use, stimulant use, injecting drug use, earlier onset of heroin use, recent use (use in last 12 months), and substance related overdose or hospitalization have all been associated with child removal, abuse, or neglect (Canfield et al., 2017; Dube et al., 2001; Ghertner et al., 2018; Kepple,

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[4] 1 Parental addiction includes the terms parental substance use and misuse and covers both alcohol and drugs

2017; Prindle et al., 2018; Wall- Wieler et al., 2018). The use of alcohol and/or substances can impact parenting abilities in several ways. Depending on the substance used, information processing speed, problem solving-abilities, coordination, and reflective capacities can all be affected (Howe, 2005). The ability to regulate emotions can also be impaired (Tsantefski et al., 2015). This then affects parents' ability to assess and manage risk, be able to sensitively attune and respond to their child, and can make parents more likely to be irritable, angry, or distressed around their children and, in turn, unable to model or help their children to regulate their emotions. Children of parents with an addiction are also at risk of accidental overdose (Finkelstein et al., 2017). In addition, parental substance use can be a criteria for risk and removal in child welfare systems. For example, the most common concern raised at child protection case conferences in Scotland in 2020/21 was domestic abuse closely followed by parental addiction, neglect, parental mental health problems, and emotional abuse; multiple concerns can be raised at each conference (The Scottish Government, 2022). As such, harm may not be a direct result of substance use and can be related to multiple risk factors also associated with parental substance use including parental mental health issues (Canfield et al., 2017; Taplin & Mattick, 2013; Wall-Wieler et al., 2018), domestic violence (Manning et al., 2009; Velleman & Templeton, 2007), and poverty and inadequate housing (Canfield et al., 2017; Fang et al., 2018; Griffiths et al., 2020; Ijadi-Maghsoodi et al., 2019). However, these factors often overlap resulting in cumulative risk to children (Larrieu et al., 2008; Patwardhan et al., 2017).

Despite the serious implications of parental addiction, underreporting is common making it challenging to obtain prevalence rates (Manning et al., 2009). When rates of prevalence of parental addiction or the number of children affected by parental addiction have been reported nationally, at a locality level or within certain populations, each rate is reported as an estimate and usually provides a warning for potential underreporting. This can be due to multiple causes including the lack of official reporting procedures for parental addiction, using data only from parents in treatment, the difficulties of defining parental addiction and with defining when that has an effect on children, parents' underreporting due to stigma and fears of highlighting their addiction, and cultural differences in acceptability of alcohol and substance use (Galligan & Comiskey, 2019; Johnson, 2014; Manning et al., 2009; POST, 2018). Despite these issues, there is widespread agreement that parental addiction is overrepresented in certain populations including parents involved with child protection services and parents of children and young people who themselves have addiction issues (Arria et al., 2012; Harwin et al., 2018; Howe, 2005).

We recently found that mothers accessing an Alcohol and Drug Recovery Service in Scotland were six times more likely to have had children removed by the Local Authority than fathers (Russell et al., 2022). However, questions about their children were left unanswered despite the levels of risk known to exist for children with a parent with addiction issues.

Purpose of the Study

This study is aimed at examining child related information stored in their parents' routinely collected electronic addictions service data and case notes. We aimed to identify the prevalence of parenthood, the number of offspring, whether children lived at home or were in local authority care, and relationships with other children residing in the family home. We then aimed to establish mortality rates in the off- spring of this population. Finally, we wished to establish whether addiction service care managers were aware of the existence of their client's children aged 16 years and younger.

Materials and Methods

Procedure

This study focused on the information available in parent's Alcohol and Drug Recovery Service electronic records and on the knowledge held by care managers. It took place in one locality team within the Service in Glasgow, Scotland. Service users had moderate to severe alcohol and/or substance misuse issues and additional complexity or risk (such as criminal justice involvement or mental or physical health issues). There were roughly 3000 active service users at the time of this study, with some variation due to client disengagement and new referrals.

We aimed to gather information on ~ 25% of service users attending the service. As the focus was on staff knowledge, staff rather than service users were randomly selected, and the target population was defined through the caseloads of the selected members of staff. The service consisted of 25 nurses and 40 social care workers. An initial randomization generated a sample of 6 nurses and 10 social care workers but failed to generate a sample of ~ 25% of service users so the randomization process was repeated with the remaining staff and a further 2 nurses and 2 social care workers were included. 100% of staff who were invited to take part participated and provided details on their full caseloads. As this study used routinely collected data and all service users had consented to the anonymous use of their data for audit and research purposes, the Research and Innovation Department advised that ethical committee approval was not needed, and the study was reviewed and approved by the Alcohol and Drug Recovery Service Clinical Effectiveness Group. Permission was granted solely to access parent's records, and children's records were not accessed.

Random selection of staff took place in June 2015 with data collected between June 2015 and June 2017 (for full details of the randomization process see Russell et al., 2022). Routine electronic data accessed included clinical case notes and the Scottish Morbidity Record 25 (SMR25). SMR 25 were compulsory data returns completed by Scottish Alcohol and Drug Recovery Services until 2021. Version A was completed at first assessment and version B annually thereafter. Both versions were used for data collection. Data from clinical case notes comprised of free-text notes detailing the content of all appointments and communication with other professionals and services. SMR 25 data consisted of fixed response options/coded data such as ethnicity, gender, yes/no, type, and frequency of substance use. Free-text can also be added to SMR 25 to provide additional information for certain questions or when answering "other." Electronic case notes also have a section to record personal and professional relationships, which included a section for children.

Data were primarily extracted from SMR25 forms as this is the only administrative form routinely collected in Scottish Alcohol and Drug Recovery Services, and all service users should at the minimum have a SMR 25A in their electronic records, even if they started treatment in a different health board in Scotland. In addition, SMR 25 records demographic information, information on drug and/or alcohol use, and information on children, including number of children, ages, and where they resided (home or local authority care). Data were then extracted from electronic records (clinical case notes and relationships section) for the full caseloads of each selected member of staff, and, finally, interviews were arranged with staff members. During the interviews, staff were able to access the electronic records if needed. For each service user, staff were asked for total number of offspring, number of children aged 16 and under, ages of each offspring, the residential location of each offspring during childhood, and whether there were any other children currently residing in the home with the service user. Information provided from the interviews on children aged 16 years and younger was compared with data extracted from electronic records to assess staff knowledge. Proformas were created for data extraction from each data source. As the data were primarily collected from SMR25 forms with a standardized template, there is no reason to suspect that data would differ between nurses and social care workers. All staff members were provided with training and guidelines about completing the SMR25 forms and provided with additional training about sensitively asking about offspring and working with parents with addiction issues.

Data Extraction

Data were extracted under the following headings: (1) service user characteristics and (2) child characteristics.

For service user characteristics, we extracted data on gender, age, ethnicity, sub- stance use profile (treatment provided for drugs only, alcohol only, and alcohol and drugs); number of children, and other children in the household.

For child characteristics, we extracted data on age, where children resided during childhood, social work involvement, and child mortality.
SPSS (version 28.0.0.0) was used to explore any differences between staff knowledge and parent's electronic data using mean and descriptive results.

Results

8 nurses and 12 social care workers (30.8% of staff in the service) provided their full caseload information and attended interviews. Data were collected for 736 service users, giving a sample of ~24.5%. Table 4 illustrates their demographic information. 66% of service users were male and 97% were White Scottish. Over half of the sample (56.8%) were receiving treatment for substance use issues only, over a fifth (23.2%) were receiving treatment for alcohol use only, and the remaining service users (20%) were receiving treatment for both.

158 (21.5%) of total sample of service users (and 34.2% of those 462 service users who were parents) had had children removed from their care by the local authority. 111 mothers had had children removed (15.1% of the total sample, 24% of the parents only group, and 56.6% of all the mothers in this sample). 47 fathers had children removed (6.4% of the total sample, 10.2% of parents, and 17.7% of fathers).

Table 4: Parent demographic information

Demographic factors	N(%)
Client age Mean (years) Range (years)	 42.8 15-78
Parent Number (%) in Total Sample Mothers (% in Parent Group) Fathers (% in Parent Group) With children aged 16 and under % in Total Sample % in Parents Sample	 462 (62.8) 196 (78.4) 266 (54.7) 282 (38.3) (61)
Number of children Mean Range	 1.2 1-8

Prevalence of Parenthood and Children Aged 16 and Under

From the 736 service users, data from electronic records and staff knowledge were available for 913 offsprings; 7 of whom were deceased. 462 (62.8%) service users were parents to children; including adult children. This differed between genders as 196 (78.4%) of female services users were mothers compared with 266 (54.7%) of male service users who were fathers. Almost 40% of active service users were a parent to a child or children aged 16 years or under. These parents had a total of 475 children, 52% of the total offspring sample. Mean age for the offspring was 14.7 years (range 0–43 years). Data was missing about exact age for 115 offspring (12.6%); 3 who were 16 years or under; 105 who were aged 17 or older, and the 7 offspring who were deceased.

Residential Status of Offspring and Local Authority Involvement

For the total offspring sample, the majority of 294 (32.2%) lived with another family member (such as their other parent or the wider family) with no social work involvement either currently or during their childhood. This was closely followed by 293 (32.1%) who were in local authority care and 287 (31.4%) who lived at home with their parent (the service user). Data about residential status was unknown for 32 (3.5%) offspring. The majority of children who were in local authority care were in kinship care (116; 17.6% of total offspring sample and 54.9% of the offspring in local authority care). Kinship care occurs when the local authority deems that children cannot remain with their birth parent/s and are living with other family members or friends. For full details on residential status, see Table 5.

Table 5: Children's residential status according to staff

Residential Status	Aged 16 and under (N=475) N(%)	Aged 17 and over (N=431) N(%)	Total sample (N=913) N(%)
Home	123 (25.9)	164 (38.1)	287 (31.4)
Family (no social work involvement)	152 (32)	142 (32.9)	294 (32.2)
LAC (unspecified)	17 (3.6)	15 (3.5)	32 (3.5)
Kinship	114 (24)	47 (10.9)	161 (17.6)
Fostered	32 (6.7)	17 (3.9)	49 (5.4)
Adopted	30 (6.3)	5 (1.2)	35 (3.8)
Residential Children's Unit	6 (1.3)	10 (2.3)	16 (1.8)
Deceased	-	-	7 (0.8)
Not known	1 (0.2)	31 (7.2)	32 (3.5)

For children aged 16 and under, 389 (81.9%) were living with their family, either at home with the parent who was a service user (123; 25.9%), with other family members with no social work involvement (152; 32%), or in kinship care (114; 24%). For those children living with family members other than the parents, it is possible that these children have continuing contact with the parent who is receiving treatment.

Staff members knew and recorded the locations of almost all children aged 16 years and under (data was unavailable or not known for only 1 child; 0.2%). However, they were unaware of residential status during childhood of 31 (7.2%) offspring aged 17 years or older.

Other Children in the Home

Records or staff interviews indicated that 12 (1.6%) service users currently had a child living in their home that was not their biological child. This group comprised of 18 children, including 11 step-children, 4 siblings, 2 grandchildren, and a cousin.

Offspring Mortality Rate

Seven children (0.8%) had died, compared to a mortality rate for individuals aged under 75 years in Scotland of 0.4% (National Records of Scotland, 2021). Information was not available about their location or exact ages prior to death. Data on cause of death was missing for four individuals and available for three individuals; one was due to cot death and two died as adults from drug overdoses.

Service Awareness of Client's Children

For 53 (11.5%) parents, there was a discrepancy between the information reported about children by care managers in face-to-face interviews and the information recorded about children in the electronic system. For 42 (9.1%) parents, the electronic system had records of children that the care manager did not report, and for 11 (2.4%) parents, the care manager reported that there were children in the family that were not recorded in the electronic system. Since a parent may have more than one child, records were further analysed to check for the number of children for each discrepancy. 56 children (11.8% of children aged 16 and under) were recorded on the electronic system but not reported by the care manager, and 12 children (2.5% of children aged 16 and under) were reported by the care manager but not recorded on the electronic system.

Discussion

Our findings indicate that the majority of service users in the Alcohol and Drug Recovery Service were parents (62.8%), and over three quarters of female service users were mothers (78.4%). A significant proportion of parents who are receiving treatment have children that are 16 years of younger (61%). These findings indicate that significant numbers of children in this sector of Glasgow may be impacted by parental addiction. This supports the estimates by The Scottish Government, (2013) that 40–60,000 children may be affected by parental problematic drug use and 36–51,000 children were living with parents with problematic alcohol use highlighting the scale of this issue in Scotland.

The mortality rate of offspring in this study was 0.8%, a twofold increased mortality rate in the offspring of current service users compared to the mortality rate in Scotland as a whole — although this is likely an underestimate as all of these offspring are well under 75 years of age, which is the upper age limit for the Scottish mortality rate figures. It was out with the scope of this paper to investigate whether these offspring were living with their parent with addiction issues at the time of death and the ages and causes of death. Future research could explore this area further but may also want to look at rates of miscarriage and stillbirth in this population due to the known risks to offspring in this population.

Given the risks to offspring, it was positive to note that when staff were aware of children aged 16 and under, they are asking and recording information about children and their residential status. Staff were able to report details on the residential status of every child aged 16 and under except one (99.8%). Once children were aged 17 or over, staff reported information about children and residential status for 400 offspring (92.8%). This is still a high rate of recording, but staff mentioned in their interviews that they were less concerned about collecting and recording data regarding offspring once they were adults. There are potential risks associated with this view as our results about mortality rates indicate there are continued risks to the offspring of these parents in adulthood. Additionally, children that do not live with their parent with addiction issues or are in local authority care may continue to have contact or establish contact with their birth parents once they become adults.

Roughly, a third of children who were placed into local authority care in Scotland were returned to their parents (Biehal et al., 2019), and a cycle of reunification and returning to the local authority care is common for looked after children (Carlson et al., 2020), so it is important that staff regularly ask service users about their children. While staff may be less concerned about adult children, it is also important that contact is reviewed regularly as service users may provide care for grandchildren or other family members. Our data also show that service users may also live with other children—such as stepchildren and siblings. This also highlights the importance of staff being aware and up to date about where service users live and with whom.

Our results also highlight a worrying issue that children were not always accurately recorded on the electronic system when staff were aware of their existence and that staff were unaware of the existence of children despite this information being recorded and accessible to staff. There was a discrepancy in the records of over 10% of parents in the service, resulting in inaccurate information about 68 children. In the majority of cases, the electronic system had more children recorded than staff reported. There may be several reasons for this discrepancy — some staff decided to report from memory and did not check the electronic system during their interviews so they may have recorded this information on the system but were unable to recall in their interview given the size of their caseloads; the relationship section of the electronic records can be updated and linked to their children's records by other professionals such as social workers so they may not be aware of updates or other information being added if not checking the system regularly; and parents in addictions, especially mothers, regularly report concerns about disclosing information about being a parent due to fear about social work involvement and potentially having their children removed from their care (Agterberg et al., 2020; Frazer et al., 2019) so may avoid disclosing this information to care managers. As underreporting of the prevalence of parental addiction and the number of children affected is commonly reported (Manning et al., 2009), these results highlight the importance of communication between social work, health, and education as this is essential in identifying and recording the number of children who are at risk from parental addiction (Galligan & Comiskey, 2019).

In addition to the impact on children, contact with social work and the removal of children has an impact on birth parents. Birth parents describe removal as traumatic and report a deterioration in their mental health and relapse or increase in their alcohol and/or substance use following removal (Broadhurst & Mason, 2020; Kenny et al., 2015; Memarnia et al., 2015). Early identification of high-risk families could be beneficial for children and their parents with the potential to reduce further risk and harm. This highlights the importance of good relationships between addiction staff and service users and the value of regularly asking about and accurately recording information about service users and their children.

A strength of this study is the 100% participation rate of addiction staff and the large sample size, indicating these results are representative of the locality team sampled and the service generally. However, these results may not be representative of other areas with greater ethnic diversity. Another limitation is the lack of approval to access children's records in addition to their parents, which may have provided further information to support or challenge these results.

Conclusion

This study highlights that a significant number of service users in the Alcohol and Drug Recovery Service are parents, with high prevalence rates for mothers and parents with children aged 16 and under. Even when children were not living with a service user parent, they potentially continued to have access as the majority of children either lived with family with no social work involvement or were in kinship care.

We also identified a two-fold increase in mortality rate for the offspring of these parents and missing information about children. There was a discrepancy in recording of presence of children in over 10% of parent's records and missing data on 68 children. Extrapolating to the whole city, this could be over 800 children in Glasgow with inaccurate information and potentially at increased risk of harm. What is even more worrying is the fact that there might be children that were not recorded on the system or known to staff, leading us to wonder: where are the children?

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Data Availability

The data that support the findings of this study are available from the corresponding author upon request.

Declarations

Conflict of Interest: The authors declare no competing interests.

References

Agterberg, S., Schubert, N., Overington, L., & Corace, K. (2020). Treatment barriers among individuals with co-occurring substance use and mental health problems: Examining gender differences. Jour- nal of Substance Abuse Treatment, 112, 29–35. https://doi.org/10.1016/j.jsat.2020.01.005

Alati, R., Davey Smith, G., Lewis, S. J., Sayal, K., Draper, E. S., Golding, J., . . . Gray, R. (2013). Effect of prenatal alcohol exposure on childhood academic outcomes: contrasting maternal and paternal associations in the ALSPAC study. PloS one, 8(10), e74844-e74844. https://doi.org/10.1371/journ al.pone.0074844

Arria, A. M. P. D., Mericle, A. A. P. D. M. S. W., Meyers, K. P. D., & Winters, K. C. P. D. (2012). Parental substance use impairment, parenting and substance use disorder risk. Journal of Substance Abuse Treatment, 43(1), 114–122. https://doi.org/10.1016/j.jsat.2011.10.001

Biehal, N., Cusworth, L., Hooper, J., Whincup, H., & Shapira, M. (2019). Permanently progressing? Building secure futures for children in Scotland. Pathways to permanence for children who become looked after in Scotland. Stirling: University of Stirling

Broadhurst, K., & Mason, C. (2020). Child removal as the gateway to further adversity: Birth mother accounts of the immediate and enduring collateral consequences of child removal. Qualitative Social Work, 19(1), 15–37. https://doi.org/10.1177/1473325019893412. Article 1473325019893412.

Canfield, M., Radcliffe, P., Marlow, S., Boreham, M., & Gilchrist, G. (2017). Maternal substance use and child protection: A rapid evidence assessment of factors associated with loss of child care. Child Abuse & Neglect, 70, 11–27. https://doi.org/10.1016/j.chiabu.2017.05.005

Carlson, L., Hutton, S., Priest, H., & Melia, Y. (2020). Reunification of looked-after children with their birth parents in the United Kingdom: A literature review and thematic synthesis. Child & Family Social Work, 25(1), 192–205. https://doi.org/10.1111/cfs.12663

Dube, S. R., Anda, R. F., Felitti, V. J., Croft, J. B., Edwards, V. J., & Giles, W. H. (2001). Growing up with parental alcohol abuse: Exposure to childhood abuse, neglect, and household dysfunction. Child Abuse & Neglect, 25(12), 1627–1640. https://doi.org/10.1016/S0145-2134(01)00293-9

Duko, B., Pereira, G., Tait, R. J., Bedaso, A., Newnham, J., Betts, K., & Alati, R. (2022). Prenatal alcohol exposure and offspring subsequent alcohol use: A systematic review.

Drug and Alcohol Depend- ence, 232, 109324–109324. https://doi.org/10.1016/j.drugalcdep.2022.109324

Fang, S.-Y., Huang, N., Tsay, J.-H., Chang, S.-H., & Chen, C.-Y. (2018). Excess mortality in children born to opioid-addicted parents: A national register study in Taiwan. Drug and Alcohol Depend- ence, 183, 118–126. https://doi.org/10.1016/j.drugalcdep.2017.10.015

Finkelstein, Y., Macdonald, E. M., Gonzalez, A., et al. (2017). Overdose risk in young children of women prescribed opioids. Pediatrics, 139(3), e20162887.

Forrester, D., & Harwin, J. (2007). Social work and parental substance misuse. In R. Phillips (Ed.), Chil- dren exposed to parental substance misuse: Implications for family placements (2nd ed., pp. 115– 131). BAAF Adoption and Fostering.

Frazer, Z., McConnell, K., & Jansson, L. M. (2019). Treatment for substance use disorders in pregnant women: Motivators and barriers. Drug and Alcohol Dependence, 205, 107652–107652. https://doi. org/10.1016/j.drugalcdep.2019.107652

Galligan, K., & Comiskey, C. M. (2019). Hidden harms and the number of children whose parents misuse substances: A stepwise methodological framework for estimating prevalence. Substance Use & Misuse, 54(9), 1429–1437. https://doi.org/10.1080/10826084.2019.1584224

Ghertner, R., Waters, A., Radel, L., & Crouse, G. (2018). The role of substance use in child welfare case- loads. Children and Youth Services Review, 90, 83–93. https://doi.org/10.1016/j.childyouth.2018.05. 015

Griffiths, L. J., Johnson, R. D., Broadhurst, K., Bedston, S., Cusworth, L., Alrouh, B., . . . John, A. (2020). Maternal health, pregnancy and birth outcomes for women involved in care proceedings in Wales: A linked data study. BMC pregnancy and childbirth, 20(1), 697–697. https://doi.org/10. 1186/s12884-020-03370-4

Guille, C., & Aujla, R. (2019). Developmental consequences of prenatal substance use in children and adolescents. Journal of Child and Adolescent Psychopharmacology, 29(7), 479–486. https://doi.org/ 10.1089/cap.2018.0177

Harwin, J., Alrouh, B., Broadhurst, K., McQuarrie, T., Golding, L., & Ryan, M. (2018). Child and parent outcomes in the London family drug and alcohol court five years on: Building on international evidence. International Journal of Law, Policy, and the Family, 32(2), 140–169. https://doi.org/10. 1093/lawfam/eby006

Howe, D. (2005). Child abuse and neglect: Attachment, development, and intervention. Palgrave Macmillan.

Ijadi-Maghsoodi, R., Quan, M., Horton, J., Ryan, G. W., Kataoka, S., Lester, P., . . . Gelberg, L. (2019). Youth growing up in families experiencing parental substance use disorders and homelessness: A high-risk population. Journal of child and adolescent psychopharmacology, 29(10), 773–782. https://doi.org/10.1089/cap.2019.0011

Johnson, T. P. (2014). Sources of error in substance use prevalence surveys. International Scholarly Research Notices, 2014, 923290–923221. https://doi.org/10.1155/2014/923290

Kenny, K. S., Barrington, C., & Green, S. L. (2015). " I felt for a long time like everything beautiful in me had been taken out ": Women's suffering, remembering, and survival following the loss of child custody. The International Journal of Drug Policy, 26(11), 1158–1166. https://doi.org/10.1016/j. drugpo.2015.05.024

Kepple, N. J. (2017). The complex nature of parental substance use: Examining past year and prior use behaviors as correlates of child maltreatment frequency. Substance Use & Misuse, 52(6), 811–821. https://doi.org/10.1080/10826084.2016.1253747

Konijnenberg, C. (2015). Methodological issues in assessing the impact of prenatal drug exposure. Sub- stance Abuse: Research and Treatment, 2015(S2), 39–44. https://doi.org/10.4137/SART.S23544

Kuppens, S., Moore, S. C., Gross, V., Lowthian, E., & Siddaway, A. P. (2020). The enduring effects of parental alcohol, tobacco, and drug use on child well-being: A multilevel meta-analysis. Develop- ment and Psychopathology, 32(2), 765–778. https://doi.org/10.1017/S0954579419000749

Lander, L., Howsare, J., & Byrne, M. (2013). The impact of substance use disorders on families and children: From theory to practice. Social Work in Public Health, 28(3–4), 194–205. https://doi.org/10. 1080/19371918.2013.759005

Larrieu, J. A., Heller, S. S., Smyke, A. T., & Zeanah, C. H. (2008). Predictors of permanent loss of custody for mothers of infants and toddlers in foster care. Infant Mental Health Journal, 29(1), 48–60. https://doi.org/10.1002/imhj.20165

Manning, V., Best, D. W., Faulkner, N., & Titherington, E. (2009). New estimates of the number of chil- dren living with substance misusing parents: Results from UK national household surveys. BMC Public Health, 9(1), 377–377. https://doi.org/10.1186/1471-2458-9-377

Memarnia, N., Nolte, L., Norris, C., & Harborne, A. (2015). 'It felt like it was night all the time': Listening to the experiences of birth mothers whose children have been taken into

care or adopted. Adoption & Fostering, 39(4), 303–317.
https://doi.org/10.1177/0308575915611516

National Records of Scotland. (2021). Age-standardised death rates calculated using the European standard population. The Scottish Government. Retrieved from https://www.nrscotland.gov.uk/stati stics-and-data/statistics/statistics-by-theme/vital-events/deaths/age-standardised-death-rates-calculated-using-the-esp

Patwardhan, I., Hurley, K. D., Thompson, R. W., Mason, W. A., & Ringle, J. L. (2017). Child maltreatment as a function of cumulative family risk: Findings from the intensive family preservation pro- gram. Child Abuse & Neglect, 70, 92–99. https://doi.org/10.1016/j.chiabu.2017.06.010

POST. (2018). Parental alcohol misuse and children. POSTNOTE.

Prindle, J. J., Hammond, I., & Putnam-Hornstein, E. (2018). Prenatal substance exposure diagnosed at birth and infant involvement with child protective services. Child Abuse & Neglect, 76, 75–83. https://doi.org/10.1016/j.chiabu.2017.10.002

Russell, L., Gajwani, R., Turner, F., & Minnis, H. (2022). Gender, Addiction, and Removal of Children Into Care. Front Psychiatry, 13, 887660. https://doi.org/10.3389/fpsyt.2022.887660

Taplin, S., & Mattick, R. P. (2013). Mothers in methadone treatment and their involvement with the child protection system: A replication and extension study. Child Abuse & Neglect, 37(8), 500–510. https://doi.org/10.1016/j.chiabu.2013.01.003

The Scottish Government. (2013). Getting our priorities right. Scottish Government.

The Scottish Government. (2022). Children’s social work statistics, Scotland 2020–21. The Scottish Government.

Thor, S., Hemmingsson, T., Danielsson, A.-K., & Landberg, J. (2022). Fathers’ alcohol consumption and risk of substance-related disorders in offspring. Drug and Alcohol Dependence, 233, 109354– 109354. https://doi.org/10.1016/j.drugalcdep.2022.109354

Tsantefski, M., Gruenert, S., & Campbell, L. (2015). Working with substance-affected parents and their children. Allen & Unwin.

Velleman, R., & Templeton, L. (2007). Understanding and modifying the impact of parents’ substance misuse on children. Advances in Psychiatric Treatment: The Royal College of Psychiatrists’ Journal of Continuing Professional Development, 13(2), 79–89. https://doi.org/10.1192/apt.bp.106. 002386

Wall-Wieler, E., Roos, L. L., Brownell, M., Nickel, N. C., & Chateau, D. (2018). Predictors of having a first child taken into care at birth: A population-based retrospective cohort study. Child Abuse & Neglect, 76, 1–9. https://doi.org/10.1016/j.chiabu.2017.09.033

Reflections on paper 1

What's new?

Paper 1 built on previous literature by examining the profile of parents, especially parents of children 16 years and under, in a large service likely to be typical of many addiction services in wealthy countries. Almost 63% of service users were parents and almost 40% had a child aged 16 or younger. In this service, therefore, it indicates that the majority of service users are parents and may have caring responsibilities.

Paper 1 also showed, for the first time, a doubling of the mortality rate in offspring of parents receiving treatment for substance use. Due to the service criteria, it is likely that their substance use is having a negative impact on themselves and their children, which might be a factor in the high mortality rates in the offspring.

Paper 1 also found strong indications of gender differences in prevalence of parenthood and in removal of children, with removal of children more common in mothers than fathers who are attending an Alcohol and Drug Recovery Service.

While previous research had indicated that child removal was common, this study allowed us to identify where children were placed when they were removed from parents receiving treatment for alcohol and/or drug issues.

Children split into three roughly equal groups – living with the birth parent who was a service user, living with family informally with no social work involvement and in local authority care, with over half being in kinship care. These results indicate that the majority of children may have ongoing contact with their parent with substance misuse issues.

Other children may also be in the house with the service user, and they may have contact with children through family and relationships.

Despite the known risks to children from parental substance use and the high number of parents within the service, record keeping was not always accurate or up to date and workers did not continue to ask about contact with children once children were adults or following removal, despite the possibility of ongoing contact or return of custody. Adult children may go on to have their own children and service users may also have contact with grandchildren.

What are the implications?

Paper 1 highlighted the importance of addiction staff asking and accurately recording information about children and contact with children in parent's records. It also highlighted the need to obtain a clearer picture of these high-risk families to see if it is possible to identify and provide additional support for parents and children.

Next steps

Paper 2 will shift the focus onto parents who are accessing treatment for substance use issues. Firstly, investigating gender differences in removal of children and patterns of removal. It will also explore whether any parental risk factors are associated with the removal of children, finally it will investigate any links between suicide and child removal.

Chapter 5

BRIEF RESEARCH REPORT
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Gender, Addiction, and Removal of Children Into Care

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ABSTRACT

Introduction: Parental addiction can result in harm to children and removal of children by the Local Authority. Less is known about the impact of removal of children on their parents and whether gender has a role in this process.

Methods: Data on 736 service users were obtained from the caseloads of 8 nurses and 12 social care workers from an Alcohol and Drug Recovery Service in Scotland. Gender differences in prevalence/patterns of child removal, associations between child removal and parental factors and the relationship between removal and suicidality were examined.

Results: Mothers were more likely to have had one or more children removed compared to fathers (56.6 vs. 17.7%; $p < 0.001$) and were more likely to have a series of individual child removals (22.5 vs. 4.3%; $p = 0.014$). In addition to female gender, younger age, drug use, mental health and suicide attempts were also associated with child removal. Mothers who had children removed and women who were not mothers were more likely to have made an attempt to end their lives than women who had children but had not had them removed.

Conclusion: Gender differences were apparent in prevalence and patterns of child removal. Mothers were six times more likely to have children removed compared to fathers. Child removal occurred alongside other risk factors suggesting that families need holistic support for their multiple areas of need. Services should be aware of the link between child removal and suicide and provide additional support to mothers during and after removal.

Keywords: addiction, mothers, child removal, suicide, gender

INTRODUCTION

Parental addiction[5] has been associated with harm to children (1–3). In a Scottish context, drug or alcohol addiction, by one or both parents, was present in over half of the Significant Case Reviews (carried out when a child has died or been significantly harmed) between 2012 and 2015 and present in all cases where there was a death of an infant or pre-school child (4). Similar findings regarding risk and mortality have been reported in other countries (5-7). A follow up study in Glasgow, Scotland, of babies born to mothers with addiction issues found that 83% of children were discharged from the maternity unit to parental care, but 87% of these children were later taken into care at least once before the age of 10–12 years. Only 41% were in the care of their birth parent/s at 10–12 years of age (8).

Harm to children may be a direct result of exposure to substances prenatally, while other harms may be related to the multiple risk factors also associated with parental addiction including parental mental health issues (3, 9–11); domestic abuse (3, 9, 11, 12); poverty (3, 10, 13) and inadequate housing (11). These factors overlap in many situations to present a cumulative risk to parents' ability to adequately care for children (11, 14–16). Parents with addiction issues are therefore more likely to have their children removed from their care by social work services due to risk of harm or harm already caused (17, 18).

Not all child removals[6] are to permanent placements. Almost a third of children taken into care in Scotland were returned to the care of their birth parents, with the average time to reunification being just over 9 months (19). Parental wellbeing is linked to child wellbeing (18), for example, parental stress and responsiveness have been associated with child cognitive development and prosocial behavior (20) and a recent systematic review found a preliminary link between parental mental health and wellbeing and intergenerational transmission of attachment but was unable to identify the mechanisms for this relationship (21).

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[5] Parental addiction includes the terms parental substance abuse and misuse and covers both alcohol and drugs.

[6] Child removal refers to children removed from their parents and placed in alternative care by the Local Authority and does not include informal agreements.

However, removal of children also has the potential for harm, which may undermine the chances of reunification or increase the risk that children will be removed from their parents' care in the future. Parents and birth families report experiencing distress and a deterioration in their mental health following the removal of children. One study found roughly two thirds of birth parents and families reported symptoms or a diagnosis of depression which they felt was triggered or exacerbated by the removal, 26% experienced suicidal thoughts following the removal and roughly half of those reported an attempt to end their lives (22). In addition to reporting increased rates of suicide attempts and self-harm (23, 24), relapse or an increase in drug and alcohol use is common following removal (22, 23, 25, 26). Parents also reported experiencing strong negative emotions including anger, agitation, anxiety and sadness (23, 27–29).

In addition, a grief response is also experienced following the removal of children (26, 30–32). Disenfranchised grief is defined as "the experience of grief that is not openly acknowledged, socially validated or publicly observed" (33) and has been applied to mothers with children in the care system due to their grief response at the loss, the stigma of having a child removed and their own role in the removal (26). The lack of acknowledgment of this loss results in a lack of support or identifiable referral pathways for service input and can also lead to mothers developing beliefs about being undeserving of support (25). Birth mothers have reported feeling that their grief was not considered "legitimate" (23). While mothers who relinquished children experienced more grief symptoms than women whose child died and their grief reactions were more likely to become chronic and prolonged due to an inability to resolve their grief (34).

Low self-esteem is reported consistently following removal of children (22, 27). Mothers who have children removed have been described as "maternal outcasts"; mothers whose experiences fall outside of the normal expectations of motherhood (35). Mothers who have had children removed struggle with two main aspects of their identity—firstly, dealing with the stigma and shame attached to the removal of their child and their threatened identity as a "good parent" and secondly, difficulty maintaining an identity as a mother without a child in their care (26). Mothers with an addiction are also dealing with the additional stigma attached to having an addiction while being pregnant or as a mother (17, 36, 37).

Mothers who have had children removed describe the process and experience of removal as traumatic (23, 29). They describe the process as adversarial; with a focus on their weaknesses and little recognition of any strengths or positives in their parenting or relationship with their children (27). Parents reported feeling angry, humiliated and betrayed during the removal process (23, 26, 27).

Mothers with addiction issues are more likely than fathers to be primary carers (38) therefore they are more likely to experience removal of children and may be at greater risk of these subsequent issues following removal. In addition, service users in addiction and recovery services are predominately male (39) so services may not be focused on or aware of gender-specific issues that are more likely to have an impact on women, such as parenting issues or the impact of child removal into care (17, 39, 40). Exploring the impact of gender on child removal and associated factors could lead to increased understanding, improved mental health and reduced suicidality in women attending addiction services, new service developments and improvements in service delivery, especially for those women who are mothers.

We aimed to examine whether there were gender differences in the prevalence and patterns of child removal (i.e., individually or sibling groups) from parents, to examine the associations between child removal and parental factors (gender, age, substance use profile, mental health issues, and suicide attempts) and the relationship between removal and suicidality in parents attending an Alcohol and Drug Recovery Service in Scotland.

MATERIALS AND METHODS

Procedure

This study was conducted within one sector of an Alcohol and Drug Recovery Service in Glasgow, Scotland with roughly 3,000 active service users. To access the service individuals need to have moderate to severe addiction issues and complexity or risk (such as physical or mental health issues, childcare, criminal justice involvement).

Data were gathered on ~25% of randomly selected service users as detailed in Table 6. Due to the high levels of disengagement from the service, staff were randomized rather than service users and 100% of staff provided a copy of their caseload. The Research and Innovation Department advised that this study did not need to go to ethics committee due to the use of routinely collected patient data. Therefore, the study was registered with and approved by the Alcohol and Drug Recovery Service Clinical Effectiveness Group. Service users consent at assessment that their routinely collected data can be used anonymously for research and audit purposes.

Table 6: Sampling and data collection process

Stage	Procedure
1	Staff members were excluded if they were currently off work for an extended period of time (such as maternity or long term sick leave), did not have a caseload (such as team leads or students) or were co-workers (such as health care workers, medics and the blood borne virus nurse).
2	Remaining staff were split into two groups of 25 nurses and 40 social care workers.
3	Surnames were entered into two SPSS worksheets.
4	SPSS generated a random sample of 6 nurses and 10 social care workers (~25%).
5	Each member of staff was approached by the researcher and provided with information about the study.
6	All (100%) members of staff provided the researcher with a copy of their full caseloads.
7	Each service user's unique ID number was recorded in an Excel database to prevent duplication.
8	Service users were only included if the member of staff was their care manager rather than a co-worker for a brief piece of work (such as a physical or mental health assessment).
9	Electronic records data were collected before speaking to the worker in all cases.
10	Data from each member of staff's caseload was fully gathered before starting with the next member of staff.
11	Due to varying caseloads (due to role or part time working) and exclusions of service users (as a result of duplication or co-working) the original sampling process failed to generate a sample of ~25% of service users. Staff previously included in the study were removed from the original list of surnames in SPSS and stages 1 to 11 were repeated to generate an additional 2 nurses and 2 social care workers and a sample of ~24.5%.

Staff were randomly selected in June 2015 and data were collected from electronic records from June 2015 to June 2017. Electronic records included the Scottish Morbidity Record 25 (SMR25), which are compulsory data returns completed at assessment (Version A) and annually (Version B) in Scottish Alcohol and Drug Recovery Services, and clinical case notes. Staff interviews were conducted between September 2015 and June 2017. A proforma was created for each format (SMR25, case notes and interviews) for data collection and categorization. Initially the SMR25 forms were reviewed, then the clinical case notes. Once these were completed for the full caseload, interviews were arranged with staff members. Case notes and staff interviews allowed for the cross-checking of the SMR25 data and collecting any missing data.

Data Collection

Data were collected under the following headings: (1) Service user characteristics; (2) Child characteristics; (3) Mental health; and (4) Suicide.

(5) Service user characteristics

SMR25—Gender, age, ethnicity, substance use profile (treatment provided for drugs only; alcohol only; alcohol and drugs).
Case notes—Used for missing data.

(6) Child characteristics

SMR25—Number of children, number of children removed by Local Authority.
Case notes—Missing data and pattern of removal (one child or all children at one time; two groups or a group and a single child removed at different times; series of individual removals).
Staff interviews—Used for missing data.

(7) Mental health

SMR25—Reviewed questions on current or history of mental health issues and prescribed medication for mental health issues.
Case notes—Reviewed for any mention of mental health diagnosis, contact with mental health services, requests for mental health assessment or a referral to mental health services, reported use of psychotropic medication, inpatient admissions to mental health units/wards.
Staff interviews—Asked if service user had current or history of mental health issues.

(8) Suicide

SMR25—Reviewed question on ever attempted suicide. Case notes—Reviewed for any mention of suicide attempts.

Staff interviews—Asked if service user had ever attempted to take their own life.

Statistical Analysis

Data analysis using SPSS (version 28.0.0.0) was conducted to explore any differences between genders in demographic factors and in prevalence and patterns of child removal. Binary logistical regression was conducted to examine risk factors associated with child removal. Of the 736 service users selected for the study, parents who had no children removed (*n* = 287) were compared with parents who had experienced removal of children (*n* = 158). Factors examined were age, gender, substance use profile, mental health issues and suicide attempts. Ethnicity was excluded due to the lack of variability in this sample. The analysis was then repeated for each gender. Chi-squared analysis was used to further explore the relationship between suicidality and child removal.

RESULTS

Descriptive

The interviews and caseload reviews of the 8 nurses and 12 social care workers produced data on 736 (~24.5%) of service users. Table 7 illustrates the demographic information for the total sample plus each gender. The sample was 66% male and 97% White Scottish. Substance use profiles were similar across genders, but women were significantly younger and more likely to have a current or history of mental health issues and suicide attempts.

Prevalence and Patterns of Child Removal

Data were analyzed to investigate the prevalence of removal of children. Patterns of removal (one episode of a single child or a sibling group; two removals of sibling groups or a sibling group and an individual child at a separate time; or repeated individual removals) were also analyzed and are reported in Table 8.

Table 7: Demographic information

Demographic factors	Females (N=250) N(%)	Males (N=486) N(%)	Total Sample (N=736) N(%)
Age*			
Mean (years)	40.3	44.1	42.8
Range (years)	15-78	21-78	15-78
Substance Use Profile			
Drugs only	144 (57.6)	274 (56.4)	418 (56.8)
Drugs and alcohol	66 (26.4)	105 (21.6)	171 (23.2)
Alcohol only	40 (16)	107 (22)	147 (20)
Current or history of mental health issues*			
Yes	176 (70.4)	236 (48.6)	412 (56)
History of suicide attempts*			
Yes	116 (46.4)	100 (20.6)	216 (29.3)

* indicates significant difference between genders (age p<.001; mental health p<.001; suicide p<.001)

There was a significant difference in prevalence between genders with removal being more likely from mothers than fathers. Mothers had greater number of children removed than fathers. There was also a significant difference in removal patterns with mothers being more likely to experience repeated individual removals.

Table 8: Prevalence and patterns of child removal

Removal	Mothers (N=196) N(%)	Fathers (N=266) N(%)	All parents (N=462) N(%)
Children removed*			
Median	2	1	1
Range	0-6	1-4	1-4
One episode of removal (child or sibling group)	73 (65.8)	35 (74.5)	108 (68.4)
Two episodes of removals involving groups	4 (3.6)	4 (8.5)	8 (5.1)
Series of removals of individual children*	25 (22.5)	2 (4.3)	27 (17.1)
Prevalence*	111 (56.6)	47 (17.7)	158 (34.2)

* indicates significant difference between genders (children removed p<.001; pattern p=.014; prevalence p<.001)

Child Removal and Relationships With Age, Gender, Substance Use, Mental Health, and Suicide Attempts

Table 9 illustrates the odds ratios for the associations between each factor and child removal.

Table 9: Factors associated with the removal of children

Factors	B	S.E.	Wald	df	p	OR	95% C.I.
Age	-0.06	0.01	20.76	1	<0.001	0.95	0.92 – 0.97
Gender	1.78	0.22	66.58	1	<0.001	5.91	3.85 – 9.05
Substance use	0.78	0.28	7.68	1	0.006	2.19	1.26 – 3.8
Mental health issues	0.51	0.21	6.11	1	0.013	1.66	1.11 – 2.49
Suicide attempts	1.06	0.21	25.13	1	<0.001	2.89	1.91 – 4.38

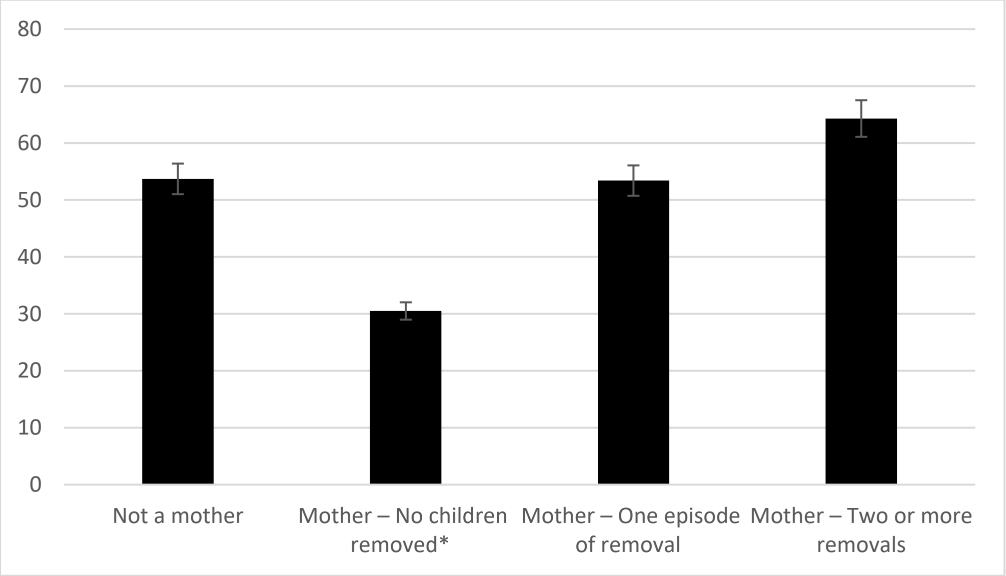
* Each association takes the other factors into account

Parental age was significantly negatively associated with removal and with each increasing year parents were less likely to have their child or children removed. Mothers were nearly six times more likely than fathers to experience removal. Parents with drug or drug and alcohol addictions were more than twice as likely to experience removal than those with only alcohol addictions. Parents with mental health issues were nearly 70% more likely to have children removed and parents who had attempted suicide were nearly three times more likely to have children removed.

To examine the impact of gender on removal, the analysis was repeated separately for each gender. For women, younger age, drug/drug and alcohol use, mental health issues and suicide attempts continued to be significantly associated with child removal. No factors were significantly associated with child removal in fathers.

To further explore the relationship between suicidality and child removal, chi-squared analysis compared rates of suicidality across removal groups (not a mother, mother no removals, mother one episode of removal, mother more than one episode of removal). Due to the small number of group removals; data were recategorised to one episode of removal or more than one episode of removal. Figure 3 highlights the increase in prevalence of suicide attempts as the number of child removals increases. Mothers who had not experienced removal were significantly less likely to have attempted suicide than women who were not mothers, and mothers who had experienced removal.

Figure 3: Prevalence of suicide attempts (%) across different removal groups in mothers



* indicates significant difference between groups (p=.003)

DISCUSSION

There were stark gender differences found in our study when it came to prevalence and patterns of child removal. Women make up 34% of the service but 78% of these women are mothers while 55% of men were fathers. Women were more likely to be parents than men and more than half of female service users who were mothers had one of more of their children removed compared with less than a fifth of fathers. Mothers were almost six times more likely to experience removal than fathers. Some of which may be explained by the high rates (~92%) of female-headed single parent families in Scotland (41). It is also important to note that while the majority of removals across both genders involved a single episode of removal, some of these parents are still of reproductive age with the potential to have further children and experience further removals.

Previous research has shown that women are more likely to have their children removed than fathers, even when fathers are perpetrators of similar levels of abuse or neglect (42). Women using addiction and recovery services report experiencing barriers accessing services and having additional needs related to their family and carer responsibilities, relationships, and mental health issues (39, 43). When caring for children, women are more likely to experience isolation due to higher rates of domestic and interpersonal abuse which results in less support with parenting (44, 45). There are recommendations that gender specific issues should be acknowledged in addiction and recovery services including the need for single gender support groups, interventions related to trauma, relationships and parenting and the provision of childcare (17, 43, 46). Our findings add further support to the recommendations for the provision of childcare and parenting interventions with the high rates of women in this service having children and concerns about parenting and risk due to the prevalence of child removal. Foster care provided by Glasgow City Council Social Work costs roughly £500 per child/week and is more expensive when provided by external providers (8). Therefore, providing parenting interventions has the potential not only to reduce costs but also to reduce risk and save lives of women and their children.

The lack of awareness and acknowledgment of gender specific issues on the part of staff may result in mothers receiving treatment for their addiction without consideration of how the experience of being a mother, their feelings about the impact of their addiction on their children and the impact of removal of children may be linked to their recovery, or lack of. Indeed, we found a significant relationship between removal of children and suicidality. If services fail to acknowledge or ask about child removal, then they are constantly failing women with addiction issues by using an individualized rather than a family focused approach which risks excluding the most vulnerable women and their families and perpetuates further harm. Therefore, we recommend that services ask all female service users about children and child removal and do not just focus on current children in their care. While current child information is essential for child protection and welfare, the links found between child removal and suicide mean any information related to child removal needs to be included as part of the mother's risk assessment and treatment plan. This may also highlight if additional support is needed during and after removal or at significant dates such as date/s of removal and children's birthdays. Support may involve attendance at meetings with the Local Authority, referrals for mental health treatment, supporting women to make and accompanying them to appointments and encouragement to engage with peer recovery support groups. In addition, staff should also monitor for change in frequency or pattern of drug/alcohol use, mood, increase in suicidality or self-harm and withdrawal from usual routines or support systems as this might indicate increased risk.

As this is a cross-sectional study, we cannot infer the direction of causality: women with more severe mental health issues and greater suicidality might be more likely to have their children removed, but it is also possible that suicide attempts followed removal of children. Future longitudinal studies will be required to evidence this, but the link underscores the vital need to understand the relationship between parent factors and child factors if we are to better support recovery from addiction and the wellbeing of children.

This study identified a group of parents who had multiple children individually removed from their care; who were more likely to be mothers than fathers. Previous research has also indicated that mothers are more likely to experience repeated individual removals (35, 47). Our study identified the group at the highest risk of having their children removed as younger women who had drug and mental health issues and who had attempted to take their own lives: this supports previous findings linking younger maternal age to risk of repeated removals (47) and younger age, mental health issues and substance use with involvement in care proceedings (14).

Stigma may have a role in explaining why drug use, as opposed to alcohol use, was a risk factor for removal. Alcohol use is more socially acceptable (48) and risk to children from alcohol might therefore attract less stigma than drug use despite the fact that prenatal alcohol use is associated with more harm than prenatal drug use (49). Women report experiencing, or perceiving they experience, greater stigma than men due to their addiction issues especially when mothers or pregnant (17, 39, 50, 51). The fear of increased stigma and concerns about the removal of children can act as a barrier to pregnant women or mothers accessing addiction and recovery services (51) which delays treatment, placing these women and their children at increased risk of harm. These findings on removal risk factors support previous research indicating that parental addiction commonly occurs within a constellation of other risk factors (14, 16) that are cumulative (15, 16). This complexity suggests that interventions aimed at reducing harm to children by focusing solely on parental addiction may not improve outcomes and may actually worsen outcomes. Instead, we suggest a public health approach is needed focusing on early intervention with high-risk families, taking a holistic view to target the multiple areas of support needed by these families and the cyclical effects that may occur when addiction affects child outcomes, which further affects parental mental health and the success of addiction and recovery services in improving adult outcomes. The divide between social work, adult mental health and children's health services makes implementation science challenging and we need to bridge the gap between these services through partnership working. We suspect this would be viewed as challenging by services but there are examples of good partnership working which acknowledge the complexity, challenges and benefits that this style of working brings (52).

Due to engagement issues the sample was obtained by randomly sampling staff rather than service users. Hundred percent of staff provided a copy of their caseload. A strength of this study is the sample size and its representativeness of the wider service. It also includes service users at all stages of treatment from assessment onwards rather than just those who completed treatment. These findings are likely to be generalizable to other addiction and recovery services but may not be fully generalizable to other geographical areas, especially those with greater ethnic diversity. In addition, this sample may not be representative of parents with addiction issues who are not engaged with services; such as parents who do not meet the criteria for the service due to milder levels of addiction issues, including those who are engaging with community organizations such as 12 step groups or third sector organizations, and parents who are actively trying to avoid engaging with services. Another limitation is the use of self-report information and routinely collected data about child removal and mental health issues as this may be underreported or minimized; although some of this data was corroborated by health and social work records.

Because only one researcher was given permission to access the data, no reliability checking by a second rater was possible. Additionally, data was only accessible from parent's records and not their children's. As a result, it was not possible to assess if parents were primary carers before removal occurred. Therefore, our data on parents who have experienced removal may include a subgroup of parents who were not primary carers prior to removal. Also, it was not always possible to access information on when children were removed. While we were able to collect data on quantity and frequency of alcohol and/or drug use at the time of data collection, this may not be an accurate reflection of their addiction at the time of removal. Therefore, we categorized service users depending on whether they were receiving treatment for drug use only, alcohol use only or drug and alcohol use. We collected data on suicide attempts and suicidal behavior may be underrepresented if service users did not disclose attempts to end their life to their care manager. Similarly, the data does not capture other risk markers such as self-harm and recurrent suicidal ideation.

CONCLUSION

We have shown that mothers with addiction issues are six times more likely to have their children removed than fathers and these mothers are significantly more likely to have made attempts to end their lives. We have evidenced the complexity of the relationship between parental factors and the removal of children from parental care, implicating the mental health and suicidality of parents in addiction and recovery services. This makes it clear that these findings have implications for both health and social care services and highlight the importance and value of partnership working. This is an urgent issue with has an impact on mortality, wider society, and children’s life chances.

While it is clear that addiction of parents can have a serious effect on children and result in the removal of children, the removal of children is having a serious effect on parents, which may in turn further exacerbate their addiction and further affect children who may return to their care and/or any future children they might have. This cyclical process is in dire need of further investigation, particularly qualitative work with parents in addiction and recovery services to better understand how unmet needs and child removal are affecting both parents and children.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

Ethical approval was not provided for this study on human participants because data was collected from routinely collected data. NHS GG&C R&I department confirmed that NHS Ethics was not needed and recommended review by NHS Clinical Effectiveness Committee who provided approval. The participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

LR conducted the acquisition, analysis, and interpretation of data for the work. LR, RG, FT, and HM made substantial contributions to the conception or design of the work, drafting the work or revising it critically for important intellectual content, provided approval for publication of the content, and agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. All authors contributed to the article and approved the submitted version.

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REFERENCES

1. Harwin J, Alrouh B, Broadhurst K, McQuarrie T, Golding L, Ryan M. Child and parent outcomes in the London family drug and alcohol court five years on: building on international evidence. *Int J Law Policy Family*. (2018) 32:140–69. doi: 10.1093/lawfam/eby006

2. Grant T, Huggins J, Graham JC, Ernst C, Whitney N, Wilson D. Maternal substance abuse and disrupted parenting: distinguishing mothers who keep their children from those who do not. *Child Youth Serv Rev*. (2011) 33:2176–85. doi: 10.1016/j.childyouth.2011.07.001
3. Taplin S, Mattick RP. The nature and extent of child protection involvement among heroin-using mothers in treatment: high rates of reports, removals at birth and children in care. *Drug Alcohol Rev*. (2015) 34:31–7. doi: 10.1111/dar.12165
4. Care Inspectorate. Learning from significant case reviews in Scotland: a retrospective review of relevant reports completed in the period between 1 April 2012 and 31 March 2015. In: *Communications*, editor Dundee. (2016).
5. Wolfe EL, Davis T, Guydish J, Delucchi KL. Mortality risk associated with perinatal drug and alcohol use in California. *J Perinatol*. (2005) 25:93–100. doi: 10.1038/sj.jp.7211214
6. Finkelstein Y, Macdonald EM, Gonzalez A, Sivilotti MLA, Mamdani MM, Juurlink DN, et al. Overdose risk in young children of women prescribed opioids. *Pediatrics (Evanston)*. (2017) 139:e20162887. doi: 10.1542/peds.2016-2887
7. Fang S-Y, Huang N, Tsay J-H, Chang S-H, Chen C-Y. Excess mortality in children born to opioid-addicted parents: a national register study in Taiwan. *Drug Alcohol Depend*. (2018) 183:118–26. doi: 10.1016/j.drugalcdep.2017.10.015
8. Mitchell J, Mactier H. Accommodation outcomes for children of drug-misusing women. *Arch Dis Child*. (2021) 106:80–2. doi: 10.1136/archdischild-2018-316440
9. Anda RF, Whitfield CL, Felitti VJ, Chapman D, Edwards VJ, Dube SR, et al. Adverse childhood experiences, alcoholic parents, and later risk of alcoholism and depression. *Psychiatric Serv*. (2002) 53:1001–9. doi: 10.1176/appi.ps.53.8.1001
10. Canfield M, Radcliffe P, Marlow S, Boreham M, Gilchrist G. Maternal substance use and child protection: a rapid evidence assessment of factors associated with loss of child care. *Child Abuse Negl*. (2017) 70:11–27. doi: 10.1016/j.chiabu.2017.05.005

11. Canfield M, Norton S, Downs J, Gilchrist G. Parental status and characteristics of women in substance use treatment services: analysis of electronic patient records. *J Subst Abuse Treat*. (2021) 127:108365. doi: 10.1016/j.jsat.2021.108365

12. Manning V, Best DW, Faulkner N, Titherington E. New estimates of the number of children living with substance misusing parents: results from UK national household surveys. *BMC Public Health*. (2009) 9:377. doi: 10.1186/1471-2458-9-377

13. Velleman R, Templeton L. Understanding and modifying the impact of parents' substance misuse on children. *Adv Psychiatr Treatm*. (2007) 13:79–89. doi: 10.1192/apt.bp.106.002386

14. Griffiths LJ, Johnson RD, Broadhurst K, Bedston S, Cusworth L, Alrouh B, et al. Maternal health, pregnancy and birth outcomes for women involved in care proceedings in Wales: a linked data study. *BMC Preg Childbirth*. (2020) 20:697. doi: 10.1186/s12884-020-03370-4

15. Larrieu JA, Heller SS, Smyke AT, Zeanah CH. Predictors of permanent loss of custody for mothers of infants and toddlers in foster care. *Infant Ment Health J*. (2008) 29:48–60. doi: 10.1002/imhj.20165

16. Patwardhan I, Hurley KD, Thompson RW, Mason WA, Ringle JL. Child maltreatment as a function of cumulative family risk: findings from the intensive family preservation program. *Child Abuse Negl*. (2017) 70:92–9. doi: 10.1016/j.chiabu.2017.06.010

17. Simpson M, McNulty J. Different needs: women's drug use and treatment in the UK. *Int J Drug Policy*. (2007) 19:169–75. doi: 10.1016/j.drugpo.2007. 11.021

18. Howe D. *Child Abuse and Neglect: Attachment, Development, and Intervention*. Basingstoke, Hampshire; New York, NY: Palgrave Macmillan (2005).

19. Biehal N, Cusworth L, Hooper J, Whincup H, Shapira M. *Permanently Progressing? Building Secure Futures for Children in Scotland Pathways to Permanence for Children Who Become Looked After in Scotland Stirling*. Stirling: University of Stirling (2019).

20. Ward KP, Lee SJ. Mothers' and fathers' parenting stress, responsiveness, and child wellbeing among low-income families. *Child Youth Serv Rev*. (2020) 116:105218. doi: 10.1016/j.childyouth.2020.105218

21. Risi A, Pickard JA, Bird AL. The implications of parent mental health and wellbeing for parent-child attachment: a systematic review. *PLoS ONE*. (2021) 16:e0260891-e. doi: 10.1371/journal.pone.0260891

22. Neil E, Cossar J, Lorgelly P, Young J. *Helping Birth Families: Services, Costs and Outcomes*. London: British Association for Adoption & Fostering (BAAF) (2010).
23. Memarnia N, Nolte L, Norris C, Harborne A. ‘It felt like it was night all the time’: listening to the experiences of birth mothers whose children have been taken into care or adopted. *Adopt Fost*. (2015) 39:303–17. doi: 10.1177/0308575915611516
24. Broadhurst K, Mason C. Child removal as the gateway to further adversity: birth mother accounts of the immediate and enduring collateral consequences of child removal. *Qualit Soc Work*. (2020) 19:15–37. doi: 10.1177/1473325019893412
25. Aloi JA. Nursing the disenfranchised: women who have relinquished an infant for adoption. *J Psychiatr Ment Health Nurs*. (2009) 16:27–31. doi: 10.1111/j.1365-2850.2008.01324.x
26. Schofield G, Moldestad B, Höjer I. Managing loss and threatened identity: experiences of parents of children growing up in foster care, the perspectives of their social workers and implications for practice. *Br J Soc Work*. (2011) 41:74–92. doi: 10.1093/bjsw/bcq073
27. Charlton L, Crank M, Kansara K, Oliver C. *Still Screaming: Birth Parents Compulsory Separated from Their Children*. Manchester: After Adoption (1998).
28. Jackson J. Developing a post-adoption groupwork service for non-consenting birth mothers. *Adopti Fostering*. (2000) 24:32–9. doi: 10.1177/030857590002400406
29. Kenny KS, Barrington C, Green SL. “I felt for a long time like everything beautiful in me had been taken out”: women’s suffering, remembering, and survival following the loss of child custody. *Int J Drug Policy*. (2015) 26:1158–66. doi: 10.1016/j.drugpo.2015.05.024
30. Broadhurst K, Mason C. Birth parents and the collateral consequences of court-ordered child removal: towards a comprehensive framework. *Int J Law Policy Fam*. (2017) 31:41–59. doi: 10.1093/lawfam/ebw013
31. Nixon KL, Radtke HL, Tutty LM. “Every day it takes a piece of you away”: experiences of grief and loss among abused mothers involved with child protective services. *J Public Child Welf*. (2013) 7:172–93. doi: 10.1080/15548732.2012.715268
32. Cooper R. *Unrecognised Losses in Child Adoption*. Doka K, editor. Champaign, IL: Research Press. (2002).
33. Doka KJ. *Disenfranchised Grief: New Directions, Challenges, and Strategies for Practice*. Champaign, IL: Research Press (2002).

34. Askren HA, Bloom KC. Postadoptive reactions of the relinquishing mother: a review. *J Obstetr Gynecol Neonatal Nurs*. (1999) 28:395. doi: 10.1111/j.1552-6909.1999.tb02008.x

35. Broadhurst K, Mason C. Maternal outcasts: raising the profile of women who are vulnerable to successive, compulsory removals of their children - a plea for preventative action. *J Soc Welf Fam Law*. (2013) 35:291–304. doi: 10.1080/09649069.2013.805061

36. Eggertson L. Stigma a major barrier to treatment for pregnant women with addictions. *Can Med Assoc J*. (2013) 185:1562. doi: 10.1503/cmaj.109-4653

37. Gunn AJ, Canada KE. Intra-group stigma: examining peer relationships among women in recovery for addictions. *Drugs Educ Preven Policy*. (2015) 22:281–92. doi: 10.3109/09687637.2015.1021241

38. Neo SHF, Norton S, Kavallari D, Canfield M. Integrated Treatment programmes for mothers with substance use problems: a systematic review and meta-analysis of interventions to prevent out-of-home child placements. *J Child Fam Stud*. (2021) 30:2877–89. doi: 10.1007/s10826-021- 02099-8

39. Andersson C, Wincup E, Best D, Irving J. Gender and recovery pathways in the UK. *Drugs Educ Prevent Policy*. (2021) 28:454–64. doi: 10.1080/09687637.2020.1852180

40. Tuchman E. Women and addiction: the importance of gender issues in substance abuse research. *J Addict Dis*. (2010) 29:127–38. doi: 10.1080/10550881003684582

41. Public Health Scotland. *6.Child Poverty in Scotland: Priority Groups - Lone Parent Families*. Scotland2020. Available online at: http://healthscotland.scot/media/3133/child-poverty-in-scotland_priority-groups_lone-parent-families_ briefing.pdf

42. Crawford B, Bradley MS. Parent gender and child removal in physical abuse and neglect cases. *Child Youth Serv Rev*. (2016) 65:224–30. doi: 10.1016/j.childyouth.2016.04.013

43. Agterberg S, Schubert N, Overington L, Corace K. Treatment barriers among individuals with co-occurring substance use and mental health problems: examining gender differences. *J Subst Abuse Treat*. (2020) 112:29–35. doi: 10.1016/j.jsat.2020.01.005

44. Tsantefski M, Gruenert S, Campbell L. *Working with Substance-affected Parents and Their Children*. Crows Nest: Allen & Unwin (2015).

45. Isobe J, Healey L, Humphreys C. A critical interpretive synthesis of the intersection of domestic violence with parental issues of mental health and substance misuse. *Health Soc Care Community*. (2020) 28:1394–407. doi: 10.1111/hsc.12978

46. Nelson-Zlupko L, Dore MM, Kauffman E, Kaltenbach K. Women in recovery: their perceptions of treatment effectiveness. *J Subst Abuse Treat*. (1996) 13:51–9. doi: 10.1016/0740-5472(95)02061-6

47. Broadhurst K, Alrouh B, Yeend E, Harwin J, Shaw M, Pilling M, et al. Connecting events in time to identify a hidden population: birth mothers and their children in recurrent care proceedings in England. *Br J Soc Work*. (2015) 45:2241–60. doi: 10.1093/bjsw/bcv130

48. Room R. Stigma, social inequality and alcohol and drug use. *Drug Alcohol Rev*. (2005) 24:143–55. doi: 10.1080/09595230500102434

49. Guille C, Aujla R. Developmental consequences of prenatal substance use in children and adolescents. *J Child Adolesc Psychopharmacol*. (2019) 29:479–86. doi: 10.1089/cap.2018.0177

50. Corrigan PW, Shah BB, Lara JL, Mitchell KT, Simmes D, Jones KL. Addressing the public health concerns of fetal alcohol spectrum disorder: impact of stigma and health literacy. *Drug Alcohol Depend*. (2018) 185:266–70. doi: 10.1016/j.drugalcdep.2017.12.027

51. Schamp J, Simonis S, Roets G, Van Havere T, Gremeaux L, Vanderplasschen W. Women's views on barriers and facilitators for seeking alcohol and drug treatment in Belgium. *Nordisk Alkohol Nark*. (2021) 38:175–89. doi: 10.1177/1455072520964612

52. Turner-Halliday F, Welch V, Bryce G, Forde M, Cotmore R, Wilson P, et al. Partnership approaches to the evaluation of complex policy initiatives: qualitative research as key to building effective relationships: partnership approaches. *Int J Soc Welf*. (2018) 27:381–7. doi: 10.1111/ijsw. 12326

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Reflections on paper 2

What’s new?

Paper 2 moved the focus from children to parents, particularly mothers. While paper 1 indicated that more mothers than fathers in an Alcohol and Drug Recovery Service experience removal of children, paper 2 found this difference was statistically significant. Mothers in the service were also more likely to experience multiple individual removals. An issue that is getting increasing recognition and needs further research (Broadhurst et al., 2015; Broadhurst & Mason, 2013).

Mothers receiving treatment were found to be six times more likely to have children removed than fathers.

Factors associated with the removal of children from parents in the service were – female gender, younger age, drug use, and the presence of mental health issues and suicide attempts.

What are the implications?

This paper indicated that parental substance use was rarely a factor on its own and tended to sit as part of a constellation of issues for high-risk families. Mothers within Alcohol and Drug Recovery Services should be identified and offered additional support with parenting and their mental health, especially following the removal of children as this is linked with suicidal ideation and attempts.

Next steps

Paper 2 justified the focus on mothers and their experiences of child removal. However, there is a need to look beyond the numbers and get their mothers views on their experiences of child removal and services. This would allow a greater understanding of this group of mothers but also provide information for service provision and development. Paper 4 (McFarline et al., 2023)(see appendix 10) found that staff who work with mothers who have children removed found the role complex with a need to balance the tension between working with parents while also supplying child welfare services with information and reports; and the challenges and how they coped with the emotional demands of the work. In addition, Paper 5 (Crawford et al., 2023) (see appendix 11) found that mothers who were involved with child welfare systems wanted to be involved in research to help themselves (for example to access services or to facilitate the return of children) but they also wanted to have a voice and advocate for other mothers.

Paper 3 is a qualitative paper with mothers accessing an Alcohol and Drug Recovery Service or the Women's Recovery Group who have had children removed with the aim of giving them a voice about their lived experience and placing them as an expert in terms of what this group of women need from services.

Broadhurst, K., Alrouh, B., Yeend, E., Harwin, J., Shaw, M., Pilling, M., . . . Kershaw, S. (2015). Connecting Events in Time to Identify a Hidden Population: Birth Mothers and Their Children in Recurrent Care Proceedings in England. *British Journal of Social Work*, *45*(8), 2241-2260. https://doi.org/10.1093/bjsw/bcv130

Broadhurst, K., & Mason, C. (2013). Maternal outcasts: raising the profile of women who are vulnerable to successive, compulsory removals of their children - a plea for preventative action. *The Journal of social welfare & family law*, *35*(3), 291-304. https://doi.org/10.1080/09649069.2013.805061

Crawford, K., Russell, L., Graham, S., & Turner, F. (2023). Helping themselves and helping others: how the passage of time influences why mothers with addictions take part in research. *Frontiers in psychiatry*, *14*, 1204882-1204882. https://doi.org/10.3389/fpsyt.2023.1204882

McFarline, S., White, N., & Russell, L. (2023). The Experience of Alcohol and Drug Recovery Service Staff Working with Mothers Who Have Had Their Children Removed. *Health & social care in the community*, *2023*, 1-8. https://doi.org/10.1155/2023/2983040

Chapter 6

“everything is fear based”: Mothers with experience of addiction, child removal and support services

Abstract

Parental substance use can expose children to harm and risks to their wellbeing, and removal from parents’ care is sometimes necessary. This can result in feelings of grief and poor mental health in parents, and concerns about a lack of support to prevent child removal or to have their children returned. Previous research has mainly focused on children or foster and adoptive parents’ experiences rather than birth parents. This study, therefore, aimed to develop an understanding of the experience of child removal and contact with services from the perspectives of mothers with an addiction. Twelve mothers accessing Alcohol and Drug Recovery Services in Scotland and who had children removed from their care were interviewed about their lived experiences. Using Interpretative Phenomenological Analysis (IPA), four themes were identified – ‘safe/unsafe’, ‘changing identity’, ‘loss’, and ‘no way to win’ with important implications for service development. Services that can develop a sense of safety in their clients through continuity in workers, clarity and consistency about boundaries and communication with other services and supporting mothers to feel respected and validated as a person and as a mother, regardless of whether their child/ren are removed, are more likely to engage their clients and achieve better outcomes.

Key words: child removal, mothers, addiction, safety, loss, identity.

1. Introduction

1.1 Parental substance use[7] and child wellbeing

It is widely acknowledged that parental substance use can have an impact on children. Prenatal exposure to substances has been linked to foetal alcohol syndrome, neonatal withdrawal syndrome, sudden infant death syndrome and congenital abnormalities (Howe, 2005; McElhatton, 2004). However, it is uncertain whether there is direct causality

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[7] Parental substance use includes the terms parental substance use and misuse and covers both alcohol and drugs

between parental substance use and specific harms and, even with prenatal exposure, the risk factors can vary depending on gestational stage and use, the particular substance used, the impact of polysubstance use and the amount and frequency of use (Konijnenberg, 2015). In addition, prenatal exposure can continue into use in the postnatal period; and/or for potentially long periods of time throughout childhood. Parental alcohol use at a sub-clinical level has also been found to increase the risk of development of substance-related disorders in children (Thor et al., 2022), raising concern that any level of use may have a potential impact on children.

1.2 Parental substance use and child welfare

Parental substance use can have an impact on child welfare and is a common reason for social work involvement with families (Griffiths et al., 2020; Harwin & Barlow, 2022). It is estimated that between 50 to 80% of parents who are involved in child welfare systems have substance use issues (Tsantefski et al., 2015).

Several factors can increase the risk to children. For example, parental substance use increases the likelihood of accidental overdose in children by the presence of substances in the home (Finkelstein et al., 2017). In addition, parental substance use can have an impact on parents ability to care for their children and their ability to assess and respond to risk due to the impact substances have on information processing speed and skills, problem solving abilities, judgement, reflective capacity and emotional availability (Howe, 2005).

Parental substance use has also been associated with family conflict and violence; and the increased risk of domestic abuse (Harwin & Barlow, 2022; Howe, 2005). Domestic abuse was the most common concern raised at child protection case conferences in Scotland in 2021/22; however, it is common for multiple concerns to be raised and neglect and parental substance use are cited almost as frequently (The Scottish Government, 2022). This highlights that parental substance use may not be a sole factor in risk to children but may be part of a constellation of risk factors that children are exposed to.

1.3 Impact of Child removal on birth parents and families

The child welfare system focuses on the needs and wellbeing of the child and research has mainly focused on children and foster/adoptive parents experiences. Birth families are also impacted by the processes involved in the child welfare system and often feel their needs are overlooked. The lack of research means we do not fully understand the impact of removal on birth parents or their needs during and after the removal process. This knowledge is essential in order to design services to support birth parents and families – crucial since not all removals are permanent. In Scotland roughly a third of children were returned to the care of their birth parent/s and the average time frame for returns was nine months (Biehal et al., 2019), while Adoption UK (2023) reported in their Annual Barometer Report that 90% of adopted parents had a contact agreement with the birth mother and roughly 20% of parents reported informal indirect contact between their teenaged child/ren and a member of their birth family, some of which was unplanned.

Birth parents and family members commonly report that the removal of children has a negative impact on their mood and mental health. Feelings of sadness, anxiety, anger, agitation, depression and distress have all been reported by birth parents following removal of their children (Broadhurst & Mason, 2020; Charlton et al., 1998; Kenny et al., 2015; Memarnia et al., 2015). Neil and colleagues (2010) found that roughly two-thirds of birth family members felt their depression was triggered or exacerbated by the removal of children; with 26% experiencing suicidal ideation and about half of those making an attempt to end their lives following removal. Parents reported increases in suicidal thoughts, suicide attempts and self-harm (Broadhurst & Mason, 2020; Memarnia et al., 2015). Similarly, subsequent relapse or increased use of drugs and/or alcohol is common (Aloi, 2009; Memarnia et al., 2015; Schofield et al., 2011).

1.4 Removal of children and grief

Ambiguous loss has been defined as a unclear loss without resolution (Knight & Gitterman, 2019), while disenfranchised grief describes experiences of grief that are not socially validated or acknowledged (Doka, 2002). While both terms are similar, Knight and Gitterman (2019) propose that ambiguous loss occurs first and the lack of resolution and recognition of the loss then leads to the loss becoming disenfranchised. When loss is not recognised then support is rarely offered and there may not be appropriate services for this loss (Aloi, 2009).

Schofield and colleagues (2011) have described the grief response parents have following the removal of their children as disenfranchised grief, due to the stigma attached to removal of children and that attached to the parents own role in this loss. In addition to stigma, the lack of recognition of this as grief or a significant loss worthy of support results in a lack of service provision and understanding of the needs of this group of grieving parents, which in turn can lead to parents feeling undeserving of support (Aloi, 2009). The lack of recognition then results in the lack of formal rituals or procedures for parents to work through to process their grief (Cooper, 2002). In interviews with birth mothers following removal of their children, Memarnia and colleagues (2015) found that mothers felt they had been left to process their grief alone with no support provided and this made them feel that their response was not 'legitimate'. Mothers who had children removed were found to experience more grief symptoms than those who child had died, were more likely to have a chronic and prolonged response and were unable to resolve their grief (Askren & Bloom, 1999).

1.5 Parents experience of services

Parents with substance use commonly have additional issues such as mental health issues, homelessness or unstable housing and criminal justice involvement (Agterberg et al., 2020; Anda et al., 2002; Covington, 2008; Grant et al., 2011; Hyatt & Lobmaier, 2020; Somers et al., 2015). There are also gender specific issues and women are more likely to have experienced trauma, especially gender based violence and trauma, in childhood and/or as an adult and more likely to be involved in sex work as a way to fund their addiction (Canfield et al., 2021; Covington, 2008; Fox, 2020; Harwin & Barlow, 2022; Larrieu et al., 2008; Tuchman, 2010).

As a result, parents with substance use issues were likely to present with complex needs that may require input from multiple services before they and their children became involved with child welfare systems. Once this is combined with disenfranchised grief and their needs not being met in relation to the loss of their children, then it is not surprising that many parents report that services do not meet their needs (Memarnia et al., 2015; Siverns & Morgan, 2021).

Parents involved with the child welfare system report finding it traumatic (Broadhurst & Mason, 2017; Kenny et al., 2015; Lewis, 2022). Many describe the process as adversarial; focused on their deficits as a parent while neglecting any focus on the positives in their parenting and/or relationship with their child/ren (Charlton et al., 1998; Holland et al., 2014; Memarnia et al., 2015). When combined with their previous trauma experiences this may lead to problems trusting services and parents being labelled as non-engaging; further risking removal or stopping the return of their children (Mason et al., 2020). Parents often feel blamed for the loss of their child/ren despite their belief that being provided with the appropriate support at the right time may have prevented removal (Charlton et al., 1998; Memarnia et al., 2015; Neil et al., 2010).

Despite the high level of need for this group of parents, there is a lack of consensus and evidence base to guide practice or service development. A scoping exercise of post-adoption support in England and Wales for birth parents found a wide variety in the support and service offered, with most only offering support in relation to direct or indirect contact (e.g. support with letter box contact) and therapeutic support was the least offered service (Sellick, 2007). There is also confusion about who should offer this support as distress following removal may be seen as an acute reaction and not meet the criteria for mental health services. Services may also feel they lack the knowledge and skills to work with birth parents (Neil et al., 2010), while birth parents may not want to work with services that have links to the teams that have removed their child/ren (Charlton et al., 1998; Mason et al., 2020; Shockley McCarthy et al., 2022). Occasionally, services have been designed and commissioned for birth parents but there is a lack of evidence about their outcomes and issues with securing long-term funding are common (Cossar & Neil, 2010).

1.6 Mothers and Child Removal

Currently Scotland is experiencing a drug related deaths crisis; with a death rate higher than any other part of the UK and Europe (Anderson et al., 2023; Sweeney, 2020). While more men than women die from drug related death, the rate of deaths in women is increasing faster than in men; and removal of children has been suggested as one of several causes for this difference in gender patterns (Tweed et al., 2022). Our previous research identified that over 78% of women in a Scottish Alcohol and Drug Recovery

Service were mothers while almost 55% of male service users were fathers (Russell et al., 2023). These mothers were six times more likely to experience removal of children than the fathers in the service (Russell et al., 2022). Therefore, we chose to focus on mothers alone given the higher numbers of mothers in the service, the increasing rate of drug deaths in women, and the suggested links between this increase and children removal.

1.7 Aims for the study

This study aimed to obtain mothers views on their experience/s of removal of their child/ren and the services and support they received in relation to this. It was hoped that their lived experience could add to the limited evidence base about this group of women and aid with the development of guidance and an evidence base for support and service development.

2. Method

2.1 Sampling and participants

Interviews were conducted with 12 mothers who were current service users or attended the Women's Recovery Group of an Alcohol and Drug Recovery Service in Scotland between February 2018 and August 2019. Since that time, 3 of the mothers have died.

Table 10 details demographic information for the 12 mothers. Due to the lack of diversity in the service ethnicity cannot be reported here as it may allow for identification for one or more of the mothers, but 10/12 mothers were White Scottish.

Given the complexity with removals and to look in greater depth at patterns of removal, one (8.3%) mother had only one child which was removed and returned on two occasions, three (25%) mothers had one child removed but had another child or children that remained in their care, two (16.7%) had all of their children removed as a group on one occasion, one (8.3%) had their two eldest children removed on separate occasions and then had a period of stability and had other children that remained in their care, two (16.7%) had their eldest removed then a period of stability until losing a group of subsequent children, two (16.7%) had more than one child removed in a series of individual removals and one (8.3%) had their eldest removed on three occasions and their youngest removed twice.

Table 10: Demographic Information

Demographic	N (%)
Age	
Range	28 – 49 years
Mean	38 years
Relationship status	
Single	5 (41.7%)
Living with a partner	4 (33.3%)
In relationship but not living together	1 (8.3%)
Separated	1 (8.3%)
Divorced	1 (8.3%)
Number of children	
Total	30
Removed from their care	23
Removal Status	
Child/ren permanently removed	7 (58.4%)
Trying to regain custody of child/ren	3 (25%)
Older children permanently removed and trying to regain custody of younger child	1 (8.3%)
Removal and return of child	1 (8.3%)
Were all children permanently or temporarily removed from their care	
Yes	8 (66.7%)
No	4 (33.3%)

Table 11 illustrates the children's age at removal and their location while removed from their mother for the 23 children that were removed. Child's age at removal ranged from birth to seven years old. 12 (52.2%) children were placed in kinship care, eight (34.8%) were fostered and three (13%) were adopted.

2.2 Measures

Data were collected by conducting semi-structured individual interviews. The interview topic guide (See appendix 3) was developed following the guidance from Smith, Flowers and Larkin (2022). In addition, existing research and literature with mothers who have experienced removal of children or had contact with social services was reviewed to inform the question development (Broadhurst & Mason, 2017, 2020; Holland et al., 2014; Lewis, 2022; Mason et al., 2020; Memarnia et al., 2015; Morriss, 2018). Questions were open ended with scope to explore the lived experience of removal of children and contact with services. Questions covered their experience of having their children removed, what services were provided and their experience of this support; what support they felt they

Table 11: Removal information for children

Child	Age at removal	Location	Age at removal 2	Location	Age at removal 3	Location
1	6	Kinship				
2	2	Adopted				
3	5	Fostered				
4	18 months	Fostered				
5	8 weeks	Kinship				
6	2	Kinship				
7	8 months	Kinship				
8	1	Kinship				
9	Birth	Adopted				
10	3 weeks	Fostered				
11	3	Fostered				
12	6 months	Kinship				
13	8 months	Kinship	4	Kinship		
14	5	Kinship				
15	1	Kinship				
16	1	Kinship				
17	8 weeks	Kinship				
18	9 months	Kinship				
19	9 months	Adopted				
20	7	Fostered				
21	6	Fostered				
22	15 months	Fostered	4	Fostered	7	Fostered
23	2	Fostered	5	Fostered		

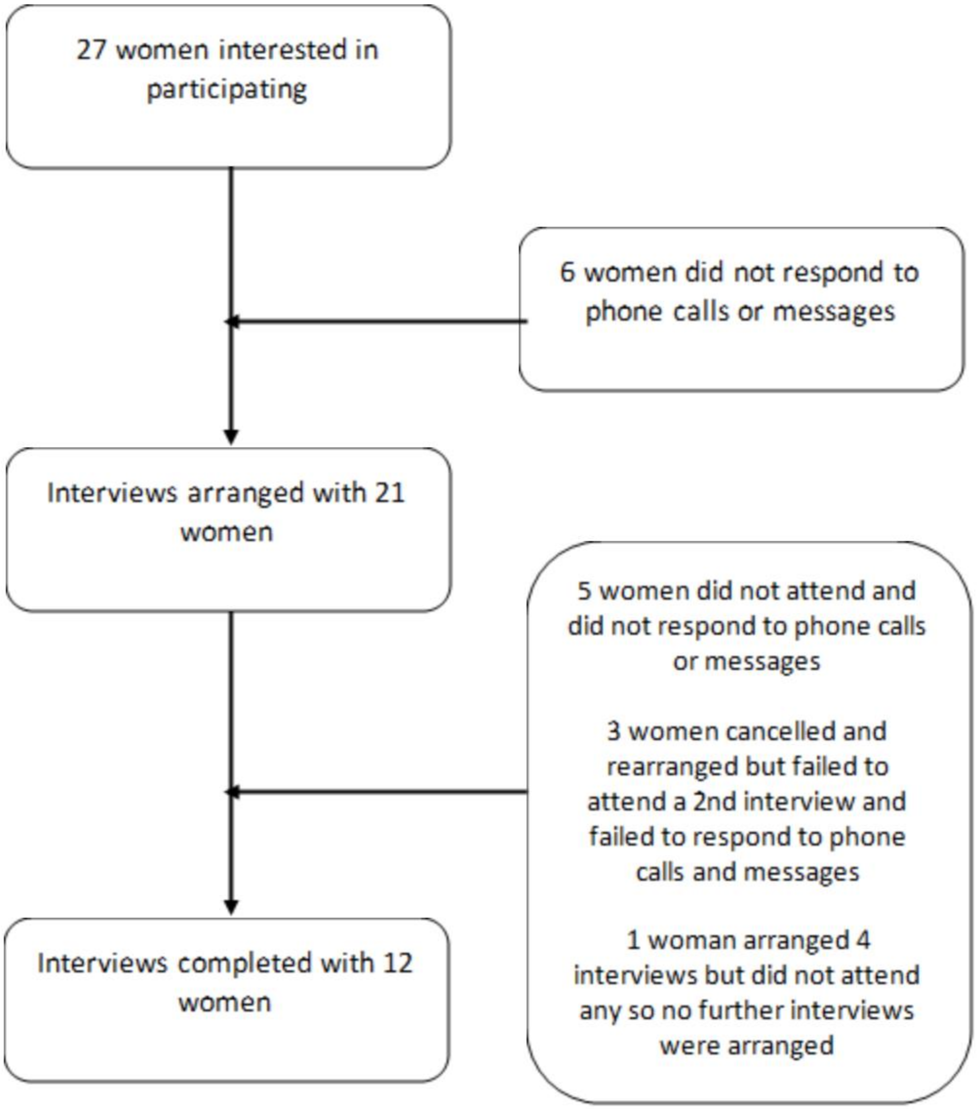
needed or should have been provided and what services should have known about having children removed. Questions were pilot tested with a group of volunteers who attended the Women's Recovery Group.

2.3 Procedure

Ethical approval was obtained from the West of Scotland REC 1 committee (Ref No: 17/WS/0255). Posters were placed in the waiting rooms of the Alcohol and Drug Recovery Service with information about the study and contact details for the researcher (LR). Emails were also sent to all staff working in the sector, including those supporting the volunteers to run the Women's Recovery Group, with information about the study, the eligibility criteria and contact details for the researcher to allow staff to discuss the study with women on their caseload. Potential participants could contact the researcher directly or ask their care manager to pass on their contact details to the researcher. As LR worked as a clinical psychologist in the service, any current or former patients were excluded and there were no established relationships between LR and any of the participants.

27 mothers expressed interest in participating. Contact with the researcher, drop out and participation numbers are detailed in Figure 4.

Figure 4: Flow chart detailing participation and number of interviews



Six mothers did not answer any calls from the researcher and did not respond to a message asking them to contact the researcher if they were interested in participating in the interviews. The researcher spoke with 21 mothers; all agreed to participate and arranged a time and date for their interview which was at least one week after the telephone conversation. During that conversation LR disclosed her role in the service, her interest in research on gender-based issues and a desire to develop services in collaboration with their lived experience. All mothers were informed that they could change their mind and refuse to participate at any time and this would not affect their treatment from the service or ability to attend the Women's Recovery group. Travel information was provided if women were unfamiliar with the venue for the interview (clinical room in the Alcohol and Drug Recovery Service); and discussions were held to see whether they wished to attend at the same time as their clinic appointment with their care manager to limit travel, whether they needed support from a partner or care manager to attend and whether bus tokens were needed to cover travel costs. The participant information sheet was sent out to each mother in the post.

12 mothers participated and completed the interviews. All interviews were conducted by LR. One mother brought her youngest child with her as she lacked alternative childcare, but the other 11 mothers attended alone. Prior to the interviews starting the women were provided with an additional copy of the information sheet if they did not have their copy and the researcher checked if they had any questions. All women were reminded that they could withdraw from the study with no consequences. Mothers were informed that due to the sensitive nature of the interviews they could request a break if needed. Interviews ranged from 29 minutes to 134 minutes (mean=71 minutes) on a single occasion.

Once the interviews were completed, all mothers were provided with an information sheet with contact details for services if they became distressed following the interviews. All mothers were informed that either their care manager or the researcher would contact them within the next 5 days to check how they were following the interview. Mothers were also informed that, after a month, the researcher would contact their care manager to check if they needed to access any additional services or needed support following participating in the interview. No mothers needed additional support or input from services after their interview. All mothers who completed the interviews received a gift voucher for participating.

All interviews were audio-recorded and transcribed verbatim. The audio recordings and transcripts were stored on a secure drive with access to the files limited to the research team. All transcripts were pseudonymised and any information that could breach confidentiality (such as names of partners, children, staff members, services or locations in or out with Glasgow) were removed from the transcripts.

2.4 Data analysis

While all these mothers had experienced the removal of their children and had contact with social work, the main focus of this contact was on their children and their needs/wellbeing. As this study focussed on the mothers' experiences of child removal and placed their experience at the foreground, consideration was given to which epistemological position and methodological approach would be most appropriate.

Given this focus and the aims of this study, a phenomenological epistemology was selected due to wanting to investigate the lived experience of child removal and contact with services (Patton, 2015). Interpretative Phenomenological Analysis (IPA) was used as the methodological approach as it has a phenomenological basis but also includes hermeneutics[8] and idiographic[9] epistemology (Smith et al., 2022). This allows the analysis to go beyond the lived experience of the phenomenon but to include the sense making and interpretation of this phenomenon using hermeneutics (Smith & Nizza, 2022). The double hermeneutic gives interpretative space for the participants to reflect and make their own interpretations of the phenomenon during the interview while the researcher conducts a similar interpretative and sense making process during the analysis (Smith et al., 2022). Finally, although all mothers experienced the removal of their child/ren, as can be seen above, there was heterogeneity in this group with mothers having all or some of their children removed, different placement types for children, and a wide time span since the removal (see tables 6 and 7). The idiographic aspect of IPA which allows for the

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[8] The theory of interpretation

[9] The focus on the particular – understanding particular experiences of particular people in particular circumstances

identification of similarities and differences between participants gave space to be able to develop themes that were generalisable across the mothers but also reflecting areas of differences and why these differences may occur (Smith et al., 2022).

The anonymised transcripts were used for the analysis and proof checked before analysis. All transcripts were analysed by hand by LR and no data analysis software was used. LR met with HM, FT and RG on four occasions to review transcripts, coding and theme development and she kept a reflective diary through the study. All transcripts were analysed using the seven steps of analysis for IPA (Smith et al., 2022):

Step 1: Reading and re-reading
Step 2: Exploratory noting
Step 3: Constructing experiential statements
Step 4: Searching for connections across experiential statements
Step 5: Naming the Personal Experiential Themes (PETS) and consolidating and organising them in a table
Step 6: Continuing the individual analysis of other cases
Step 7: Working with PETS to develop Group Experiential Themes (GETS) across cases

Once connections were made across experiential statements, this resulted in each of the 12 mothers having between 3 and 5 PETs each, with between 2 and 5 subthemes per PET (see appendix 5 for list of PETs and subthemes for each mother). Those PETs and subthemes were then developed into 4 GETs with 3 to 5 subthemes each (see appendix 6 for GET table with subthemes and links to each mothers PETs).

The Consolidated criteria for reporting qualitative research checklist was also completed (COREQ) (see appendix 8).

2.5 Researchers' characteristics and reflexivity

LR is a clinical psychologist who has worked in Alcohol and Drug Recovery Services and with mothers in Perinatal Mental Health and Maternity and Neonatal Services. She had conducted research previously on women's reproductive health and perinatal mental health issues. LR has clinical and research experience with this group of mothers but is not a mother and does not have lived experience of substance use issues. HM, FT and RG have conducted research with various stakeholders in the child welfare system including birth parents, foster carers and social workers and with individuals with mental health issues who may be considered hard to engage.

These multiple perspectives were considered to be a strength in the analytic and reflective processes. While our experiences may make us more likely to be supportive of the views and lived experience of birth mothers we also had a wider perspective including the views of others within the child removal process and of service provision.

3. Results

Four group experiential themes (GETs) were identified in relation to mother's lived experience of child/ren removal and contact with services: (1) safe/unsafe, (2) changing identity, (3) Loss, and (4) No way to win. Table 12 lists the GETs and the subthemes. See appendix 12 for an expanded results section submitted as supplementary material.

Table 12: Group Experiential Themes and Subthemes

GET (Number of participants that contributed to GET)	Subthemes (Number of participants that contributed to subtheme)
Safe/Unsafe (12)	◊ Lack of safety across their lives (8) ◊ Services don't feel safe (10) ◊ Safe(r) service provision and connections (6)
Changing identity (12)	◊ Not just a bad mum but a bad person (11) ◊ Eradication of the self by child removal processes (7) ◊ Upward and downward comparisons (7) ◊ Reclaiming their identity (7)
Loss (11)	◊ Impact of the loss of child/ren (9) ◊ Removal is like a bereavement (4) ◊ Link between coping strategies and loss (4)
No way to win (12)	◊ Intergenerational contact with services (8) ◊ Lack of appropriate support (9) ◊ Confusion and context (9) ◊ Unachievable standards (4) ◊ Being at war over the child/ren (8)

3.1 Safe/unsafe

In their interviews, all mothers discussed aspects of safety, but mainly about feeling unsafe. Three subthemes were identified: (1) lack of safety across their lives; (2) services don't feel safe; and (3) safe(r) service provision and connections.

3.1.1 Lack of safety across their lives

The mothers discussed being unsafe due to domestic abuse and a lack of partner/family support, and a lack of safety via their substance use. All of the mothers except one reported experiencing trauma, usually multiple traumatic incidents, in childhood and as an adult and the resulting lack of safety that they feel. The mothers disclosed varying experiences of abuse and neglect as children. In addition, several also experienced domestic abuse in their adult relationships and had experienced incidents such as rape and assault like Charlene who revealed "*I can't get rid of that fear factor since I was stabbed*".

Their interpretation of their trauma experiences appeared to add context to the removal of their children beyond their own addiction, and the difficulties they had parenting in unsafe situations. The impact of the mothers not being safe meant it was difficult for them to create or maintain safety for their children. For example, Rachel's experience of domestic abuse and the role it played in the removal of her child:

"I shouldn't have put up with the things I did and now I have lost my daughter through it and it is killing me" (Rachel)

The only mother who did not report experiencing childhood trauma or abuse within relationships was Toni. Toni can see that this upbringing and support was beneficial when she became involved with social work and her children were removed:

"I only got through that because I got a good childhood, so I got taught skills, I also had a partner who was supportive" (Toni)

3.1.2 Services don't feel safe

Given their trauma experiences, and addiction and mental health issues, many of the mothers acknowledged that they needed additional support from services:

"And then I told them that I was really, really depressed, but I had been going to the doctors before that…so they knew about the depression" (Julie)

Despite asking for help, mothers often found that their needs were not met or referrals for appropriate support were not made:

"*I was wanting to go to the Women's Aid [domestic abuse organisation], you know things like that… but it never got done" (Rachel)*

Most mothers discussed fears around confidentiality and information sharing between services:

"I just felt they were there to be nosy [support service arranged by social work] more than anything else. So I stopped letting them in and that was another thing that went against me" (Julie)

"I would love to be able to just come and go like 'Look I am feeling like shit and need somebody to talk to', but I just really struggle with that. I mean maybe just now my barriers have come down a wee bit, but I still feel that I can't open up like with [addiction worker]. I maybe get there, but still right at this moment it is still all raw that I feel that I can't because of all that [child removal]." (Lynne)

As a result of this fear about information sharing and further child removal, the mothers revealed a desire for what had so far been impossible within their experiences with services – safety via a service or worker who would be completely confidential and not share information with social work:

"there is an element of not wanting to speak to your addiction worker for fear of things you talk about being passed back to social work and then being used against you. So it's

needing a service provider that… you just needing a someone who you can comfortably and confidently talk to without your information being passed back and used against you." (Toni)

As services cannot keep information confidential where children are involved, the mothers end up in a dilemma of needing support but feeling unsafe and concerned about child removal if they are open about their issues.

3.1.3 Safe(r) service provision and connections

Despite all the mothers discussing their lack of safety in their personal lives and within their contact with services, some of the mothers had positive and safe or safer experiences, sometimes with a service or with a particular worker or group of workers:

"She is my rock. I look at her more than I do my own family" (Samantha)

When mothers discussed their positive experiences, they reflected on the importance of safety within relationships and the value they placed on connections. Mothers appeared to value "normality" and connection, at times, over specific types of support:

"She was amazing. She used to take me out for coffee, she would come and pick me up and take me out all the rest of it. Oh she was great, and she would take me along to groups" (Charlene)

However, whilst clearly valuing and appreciating this safety, it could feel unfamiliar and the temporary nature of relationships with workers could make these safe relationships and connections feel unsafe. Here Jess discusses the impact of thinking that her workers will leave now she is in recovery:

"I am a size 6 because I thought my workers were leaving me because I'm not in addiction anymore, so why should they stay with me? Because I was told on the build-up that's what happens and I just thought they were leaving, without even asking them I just thought and I just faded away to this horrible size, but they're not" (Jess)

The impact of Jess's previous relationships meant she assumed that people would leave her and once she realised that this would include her workers, she stopped eating. Despite reassurances from her workers, they have acknowledged that at some point they will need to stop working with her, either as she is in recovery and no longer needs their input, or due to role or service pressures limiting how long they can work with people. This leaves these mothers with another dilemma, engage with services and workers and there is a chance of developing a safe connection and relationship, but these relationships may feel unsafe due to the unfamiliarity of feeling safe and by their temporary nature.

3.2 Changing Identity

All of the mothers discussed how they felt their identity changed due to the child removal processes and the removal of their child/ren. Four subthemes were identified: (1) Not just a bad mum but a bad person, (2) eradication of the self by child removal processes, (3) upward and downward comparisons, and (4) reclaiming their identity.

3.2.1 Not just a bad mum but a bad person

Almost all the mothers reflected on the challenge of trying to maintain their identity as a 'good' mum and felt this was not possible within the child removal process. While the mothers acknowledged their role in the removal of their children, they felt that the information gathered and conveyed by services (e.g. in reports, official documents and in meetings) only reflected negative aspects of their parenting. They felt a strong sense of disappointment that any positives, in their ability to care for and love their children, were missing.

"There's none of the good side of it that's in the reports." (Shona)

"I felt everything I'd done wasn't ever good enough to that social worker, I felt that I was always this bad mammy, you know that's the way I felt." (Rachel)

For some of the mothers the process went beyond just challenging their identity as a mother to also challenging their wider identity, leaving them feeling 'bad' and worthless in a more general sense.

“Basically, you are a piece of garbage, you don’t deserve to be a mother, that’s the way I felt” (Vivian)

3.2.2 Eradication of the self by child removal processes

Some of the mothers noticed that, despite the process being invasive and all aspects of their lives being questioned and examined, they felt overlooked, unseen and less than human in a process that they perceived as reducing them to nothing. This left some of the mothers with no identity or sense of self following the removal of their child/ren.

The assessment process was thorough; to the level that some mothers felt it was invasive with nothing being off limits:

“You’re kind of ‘under the light’. They [social work] are always watching you” (Jess)

“They [social worker] would go through your cupboards, through your fridge, through the freezer, they tell you how neat your house was” (Shona)

Yet despite that intensity, mothers often felt that they lacked a voice and did not feel seen or heard during the process.

While some mothers also described how the process left them not only feeling unseen but made them feel less than human with several using animal metaphors, including “*used as a Guinea Pig*” (Lisa), “like putting *a tiger in a cage and poking at it*” (Samantha) and “*sticking a rabbit in a hutch and watching it*” (Shona). Several mothers requested that services see them as ‘human’.

“I remember that one social worker down here. That man that came to my home. He looked at me as if it was nothing” (Vivian)

Mothers perceived that, through the process of removal, they became dehumanised, invisible, or ceased to exist.

3.2.3 Upward and downward comparisons

Throughout their interviews, the mothers compared themselves to their children, their partners or ex-partners and other parents. The mothers made sense of their experiences through these comparisons.

The mothers understood that there was a difference between their experience and that of their children, but the comparison only served to underscore the disparity between the experiences of mother and child.

"I actually had to put my wee boy in the car and watch him drive off and that was him adopted emm and I was left to go and get the bus home." (Lisa)

The comparisons were not only linked to the removal process. Shona spoke positively about her children's foster family, who she saw as providing stability and extended family support for her children in comparison to the instability and limited contact she has with her family:

"They were happy where they were living, and they were starting to get into that routine of where they've got like aunties, uncles and that" (Shona)

Mothers also regularly compared themselves to their children's fathers. Some felt that fathers were held to lower standards than mothers. Such as Vivian's perception that her drinking was viewed differently from her then husband's.

Vivian: "Then he would finish work at 3:30pm and then he would be up in the pub drinking away, and is that alright because he is a man? But at least I've admitted, at least I know I am to blame."
Int: "Do you feel you were judged differently with you being female."
Vivian: "Oh yes, very, very. Without a doubt."

Most of the parents tried to make sense of why their child was removed by comparing themselves to other parents, usually who had custody of their children. Many expressed concern and anger when they talked about a friend or acquaintance who use substances and still have care of their children:

"I know a lassie who has got a child, she uses Heroin, she uses alcohol, she uses emm that street Valium, and she lets Tom, Dick and Harry all in and out of her house with this wee lassie, going to nursery and she walks out and she talks like that [slurring her words] all the times and she wears sunglasses to hide her eyes." (Charlene)

"I was like that wow how come cunts like that get to keep their weans and I can't." (Annie)

3.2.4 Reclaiming their identity

Although they described the threats and challenges to their identities, several of the mothers also discussed how they had either challenged or changed these views.

Annie decided to give her child up for adoption through an adoption agency and was able to pick the adoptive parents. Here she talks about the moment she told the adoptive parents in a meeting:

"I've made my decision. I says emm 'I pick yous'. And see the joy it brought to that couple. I could, I could see it. It was unbelievable and even though it was hard for me, I had to think of [son]. I couldn't have gave him the life that they've gave him." (Annie)

Annie was able to acknowledge the sadness of having to give her son up for adoption but was also able to balance this with the knowledge that she made the adoptive parents happy and felt that she was doing the best for her son. Annie was able to reclaim an identity as a 'good' mum and 'good' person by considering the needs of her son and seeing the joy she brought.

3.3 Loss

All mothers discussed some aspect of loss, which was interpreted to be a main theme (GET) made up of three subthemes: (1) the impact of the loss of their child/ren; (2)

accounts of removal feeling like a bereavement, and (3) the link between their coping strategies and loss.

3.3.1 Impact of the loss of child/ren

All mothers described the impact of removal, on themselves and their children. When asked about the removal of their children, the devastation of the removal was generally the first area they discussed:

“Traumatic” (Vivian)

“It’s the worst thing in the world” (Annie)

“I wouldn’t wish it on my worst enemy” (Sonja)

Several mothers also described the visceral and physical impact of removal that resulted from the feelings of devastation:

“because how it then impacts on your life is difficulties with eating, the difficulties with sleeping, difficulties with just concentrating” (Toni)

In addition, the removal process exacerbated pre-existing mental health issues:

“I suffer from panic attacks anyway, well before any of this, and obviously that’s made it worse” (Vivian)

Several mothers reported that they felt suicidal or made attempts to end their lives after their child/ren were removed:

“I was in a homeless unit after an attempted overdose, no tried to throw myself in the river. My life had just got to a stage where I wanted my wee boy back and life had just become so unbearable that I just didn’t want to be here anymore” (Lisa)

While most of the mothers could acknowledge the reasons why their children were removed, they reflected on the impact of the removal on their child/ren. Here Shona felt that attending meetings exposed her children to information that was potentially confusing or distressing for them and possibly not age appropriate:

"they bring them in and I think it's a dead adult world…they'll talk to the weans and then they'll go right into this big in-depth conversation and sometimes I think it is too much for weans" (Shona)

Attendance at meetings or children having contact with professionals were not the only aspects of the removal process that the mothers felt had an impact on their child/ren:

"But my wee boy has started to take things out his granddad. I think he thinks that his granddad is keeping us away from him. Emm he is biting him and slapping him." (Julie)

3.3.2 Removal is like a bereavement

Several mothers discussed the loss of their children using metaphors or comparisons with bereavement:

"you know what it feels like? It is like a grieving process, you are grieving for something that's still there and you see them, you are walking by your own weans [children] and you can't say 'hello', you are not allowed to say 'hello', you are not allowed to touch them, you are not allowed to speak" (Charlene)

Some of the mothers directly compared their loss experiences with bereavement experiences:

"it has been like a bereavement because I didn't understand why the pain was so bad, I just know that I had gave birth to this child and then he was no longer there and I could no longer talk to him, I could no longer see him…I didn't understand why I felt so bad and I could only associate with the feelings when I lost my grandad" (Lisa)

Rachel had lost a child to cot death and was also able to compare both experiences:

"I thought losing my son, that was hard, but having my daughter removed from my care and I can't kiss or cuddle her. It's hard, it's the hardest thing I've ever been through." (Rachel)

3.3.3 Link between coping strategies and loss

Mothers reflected on the aftermath of their child being removed from their care and identified coping strategies that they used that were often maladaptive:

"I wanted to numb myself, but yet it is a vicious cycle because that's the reason why [daughter] got taken in the first place." (Lynne)

Not all mothers made sense of their drug or alcohol use as a way to cope with removal. Sonja reflected that although she was distressed following removal, without caring responsibilities she and her partner were able to use substances more often than when caring for their child:

"Yeah things got quite bad, because there was nothing stopping us then" (Sonja)

3.4 No way to win

The mothers all conveyed a sense that the system was set up so they could not 'win'. This theme contained five subthemes: (1) their intergenerational contact with services, (2) a lack of appropriate services for mothers, (3) confusion and context in the child removal process, (4) unachievable standards for mothers, and (5) being at war over the child/ren.

3.4.1 Intergenerational contact with services

Several of the mothers discussed their own childhood experiences with social work and the care system. They felt this influenced their views on social workers. Samantha discussed how her mother made her and her siblings lie to social workers and at school about the abuse they were experiencing and the fact she was claiming benefits as a single parent while living with her partner. When she became a mother and social work were involved with her and her children, she felt that honesty was not working:

"I was trying to be honest with them at the start, like telling them I didn't have this - and then, when [Social Work Manager] threatened me, that's when things changed for me personally. Then I saw that I had to be hiding things" (Samantha)

Some of the mothers felt that their own abuse and trauma experiences were used again them when they became mothers:

"they were going back to when I was 7, and I was, what, 23, 24, and I'm going seriously that was years and years ago, days I can't even remember and it was about my mum, there was things getting dragged up about her and to me it didn't make any sense cause I was going 'right well I get the point of looking at me as a child', but then starting to dig things up that I didn't even know about and then flinging them in reports to make it look a lot worse than what it is. I would have got the point if it was happening there and then and everything, but I grew up, I didn't even know about certain circumstances." (Shona)

Due to their own experiences, several mothers had wanted to break intergenerational patterns and give their children a better life:

"I hated myself for it, especially because of I think growing up in that situation myself as a child and I wanted never ever to be putting my own children through that, you know and yet this wee one was going through the same things" (Lisa)

3.4.2 Lack of appropriate support

This was a group of mothers with addiction issues; however, many also had co-occurring mental and/or physical health issues. Several women also needed support in relation to domestic abuse or due to the impact of current or previous trauma. Many of the mothers felt that services did not meet their needs, and this also had an impact on their ability to meet their children's needs:

"if I got more help round about my mental health, I don't believe they would ever have been removed." (Julie)

While the mothers generally were positive about their support from addiction services, several mothers mentioned that there was a focus on medication and prescriptions, and their other needs could be missed:

“the clinic is busy, its full, so sometimes the appointment would be just in, get your script [prescription] and out the door again. So there was, you know, minimal supports offered and available” (Toni)

However, some mothers acknowledged that additional support was available but not always utilised:

“I would just come in and talk shite just to get my script [prescription] and then go” (Sonja)

Some of the mothers even acknowledged this and felt that staff who were persistent and kept offering services after they refused were essential:

“[Addiction worker] is like a dog with a bone” (Sonja)

Not all mothers had the experience of services not meeting their needs, Samantha discussed a “*brilliant*” service with links with addictions, criminal justice and mental health services which meant that Samantha was able to get her needs met in one place:

“They get you, your trauma; they get you linked in with mental health, everything, your addictions, emm the courts, everything, it is just a one-stop-shop" (Samantha)

Several mothers also mentioned the benefits of peer-based services:

“when I went into the recovery stuff, it was other people who had been through exactly the same things and changed their life around, they didn’t judge me, they just put their arms round me, gave me a hug and told that everything would be alright, you know ‘just keep coming back and doing what you are doing’, and every time I went back I just felt like I was at home” (Lisa)

“I was able to talk and chat about how I was feelings with all the stuff with the kids being away because she had been in that situation herself, and now got through it and is working in the field and was doing bloody well and still is” (Toni)

3.4.3 Confusion and context

All mothers discussed confusion and context in some form. Going through their transcripts it was clear that many used their interview as a way to try to make sense of the removal of their children but were unable to do so:

“I look after my kids, they’re fed, they’re bathed, they’re loved, but they got took away from me, I just can’t. I just don’t get it” (Julie)

Mothers also highlighted a lack of understanding of rules and processes, and issues with ‘jargon’:

“it’s all these big complicated words, having that lawyer there she dumbs everything down for me. And it does, it makes you feel better ‘cause you know what you are going into then, you know what you’re sitting talking about, you're not just sitting there hearing all these people talking round about you and feeling exclude excluded from the conversation” (Shona)

The mothers also felt that services and workers were confused and lacked context about them and their lives:

“you don’t just get up and go I’m going to become an addict, there’s a lot of shit in there that you have suppressed all the years” (Charlene)

Mothers also felt that important details and context was missing in reports. For example, Annie discussed the decision by social work to stop her contact visits. She described her anger at this decision and the description of her actions:

“I went ‘do you know what you didn’t take into consideration that day the fact that when I got raped last year, I locked myself in my room for eight fucking weeks’, I says emm ‘and then through the trial that lasted two weeks I couldn’t fucking make it’, and I went ‘and you are just putting all that down as if I don’t give a fuck’, and I said ‘there were reasons’” (Annie)

3.4.4 Unachievable standards

In addition to confusion about the process and language used, mothers felt there was a vagueness about what was needed to either stop their children from being removed or to have them returned to their care. Most of the mothers described feeling there was no plan or description about what was needed, only that what they were doing was wrong.

“I was bawling my eyes out every time I left ma wee boys an I put this wall right in front of me so that when I did leave them I wouldn’t be greeting [crying], I could just let them go into the car, and then I’d bawl [cry] when I got home, but then I’d get told this, told that I had this façade in front ‘ah, you look like a robot, you look cold, you look’. And it wasn’t it was more to protect myself and to protect my boys and I think people take that as well she has no feeling” (Shona)

“I felt like even though I was giving clean urines it still was never good enough, what I was doing, you know, I was never doing anything that suited her [social worker]” (Rachel)

3.4.5 Being at war over the child/ren

Most of the mothers made sense of the removal of their children as a battle or war between themselves and social work. Shona, Lisa and Lynne described themselves and their family feeling “*bombarded*” by social work while Toni described the periods of not knowing what was happening with her children as *“no-man’s land”*.

“I just felt as though I was always constantly fighting a battle with everybody” (Lisa)

“I felt as if it was more like a war, it was like a battle between who could do the right thing first.” (Shona)

Some mothers felt that this could become all-consuming to the point where they lost sight of what they were battling for:

“then I thought ‘wait a minute, you are losing sight of why you are here, Toni, you are here for your son’…it had become this huge battle between me and social work.” (Toni)

Mothers also made sense of their responses from social work as punishment for fighting with them; indicating that they believed social workers felt this was a personal battle:

“It got so personal, that’s how I felt, they didn’t like it that we were fighting against them, I seen, I noticed that they don’t like it when you fight against them.” (Lynne)

Metaphors were frequently used; often evoking violent imagery. For example, Jess when discussing her interactions with her children’s social worker:

“I put a lot, a lot of trust into that woman [social worker] to be kicked in the teeth” (Jess)

“I felt bad enough myself without other people beating me up as well, and that’s the feeling that I got as though people were condemning me” (Lisa)

Other mothers discussed the power imbalance between themselves and social work:

“she thrived on power, she thrived on watching me in pain, she fucking got a, to me, a sick sense of pleasure, telling me stuff that she knew I wasn’t going to like and watching me suffer, it was a tough relationship we had.” (Toni)

Some mothers felt this went further than the expected power imbalance between mothers and services and compared this with previous experiences of abuse:

“There has been numerous occasions that it has been the same people on the panel and I felt kind of the bullied into that bloody residency order” (Charlene)

"I went through a violent relationship and I feel as if I was going through one all over again." (Shona)

Battles are not inevitable. Toni was able to make sense of her different experience with her children's new social worker:

"with this current social worker it's an 'us' thing, it's a 'we…it is about working together, she and I." (Toni)

4. Discussion

All the mothers engaged well in their interviews and provided rich and detailed descriptions of their experiences of having their child/ren removed from their care and the support (or lack of) that they received before, during and after. Four Group Experiential Themes were identified – *mothers' sense of feeling safe or unsafe in their lives and services*; *changing identities due to the loss of child/ren*; *the enduring impact of the loss*; and a sense there was *no way for these mothers to 'win'* in the child welfare system.

The mothers discussed their safety or lack of safety and how this permeated both their and their children's lives. Previous research has found high prevalence rates for childhood trauma in women with an addiction and a link between substance misuse and domestic violence (Covington, 2008; Fox, 2020; Harwin & Barlow, 2022). In addition, there is an association between women experiencing childhood trauma and later experiencing intimate partner violence (IPV) (including physical and sexual abuse, and harassment such as stalking) (Barrios et al., 2015; Wahab et al., 2023). This results in their childhood trauma placing them at increased risk of substance misuse, and domestic abuse and IPV as an adult; and their substance use putting them at increased risk of domestic abuse and IPV. This also needs to be considered in combination with other risk factors associated with substance use, such as mental health issues, poverty, homelessness or insecure housing and criminal justice involvement (Agterberg et al., 2020; Canfield et al., 2021; Canfield et al., 2017; Hyatt & Lobmaier, 2020; Ijadi-Maghsoodi et al., 2019; Somers et al., 2015). The mothers in this study reported similar experiences as children and as adults but also linked this to the removal of their children – due to risks from their partner's violence, homelessness, poor mental health and a lack of support from partners and families.

Consistent with previous research, we found that the mothers were wary and suspicious of child welfare services and services they provided or commission (Charlton et al., 1998; Mason et al., 2020; Shockley McCarthy et al., 2022). However, these mothers felt this went beyond just child welfare services and could feel unsafe in any service given their previous experiences. Similar to the findings of Mason and colleagues (2020), mothers in our study discussed safety within services in relation to epistemic trust - the lack of safety throughout their lives resulted in a sense that nowhere and no one is safe. There is a growing body of evidence that substance use is linked to insecure attachment (Parolin & Simonelli, 2016; Schindler, 2019) and traumatic experiences, in childhood and beyond, are strongly associated with problems with placing trust in others (Bell et al., 2019; Kampling et al., 2022). Given their history or ongoing trauma issues, social factors and potential attachment issues, there is a risk these mothers get labelled as 'non-engaging' or 'hard to engage' when in fact they are trying to navigate unfamiliar systems and relationships in the context of chronic difficulties in feeling a sense of trust in others (Mason et al., 2020).

Despite the potential for trust and attachment issues, several of the mothers discussed positive experiences with staff members or services. While the focus for non-engagement tends to be placed with service users or patients (Mason et al., 2020) this may not always be the case and services can benefit from thinking about their service delivery and accessibility. The Civility Saves Lives Project (civilitysaveslives.com) has found that incivility in healthcare settings reduces team functioning, clinical decision making, patient outcomes and has a negative impact on service users views of the organisation (Fryburg, 2023; Katz et al., 2019). This can be seen in mothers' descriptions of when services felt safe(r) and unsafe with examples of high turnover in workers, feeling a connection to a worker or service, being seen as a person and/or as a mother, and situations where staff and mothers felt like equals such as going for coffee rather than meeting in clinics.

Several qualitative studies conducted with mothers that have had children removed from their care have identified themes centred on identity (Baxter et al., 2012; Memarnia et al., 2015; Nixon et al., 2013). Child removal threatens mothers' identity as a 'good' mother and challenges the wider societal view of the naturalness of motherhood (Agarwal, 2021; Broadhurst & Mason, 2013; Morriss, 2018). Substance use in mothers also challenges this narrative (Flacks, 2019; Radcliffe, 2011). Schofield and colleagues (2011) reported how the parents in their study struggled with their identity after hearing descriptions of themselves in meetings or at court. The mothers in this study reported a similar experience and identified the value of the child welfare system giving space to discuss positive aspects of their parenting and relationship with their child/ren. The New Orleans Intervention (NIM) Model is one such approach, that has a level of depth and multi-faceted design to assessment and decision making process in child welfare cases and includes treatment provision for the family and inclusion of health care professionals views in addition to social workers (Turner-Halliday et al., 2017). The inclusion of these additional aspects and professions was felt to add 'clout' to the process; however, it also introduced 'doubt' in a system where social workers and courts were aware of the risks and impact of this information (Turner-Halliday et al., 2017). Ultimately, this is a system that is focused on child wellbeing and risk and this work highlights the main dilemma at the heart of the child welfare system, the inability to balance the needs of children and birth parents equally and do harm to neither (Broadhurst & Mason, 2017).

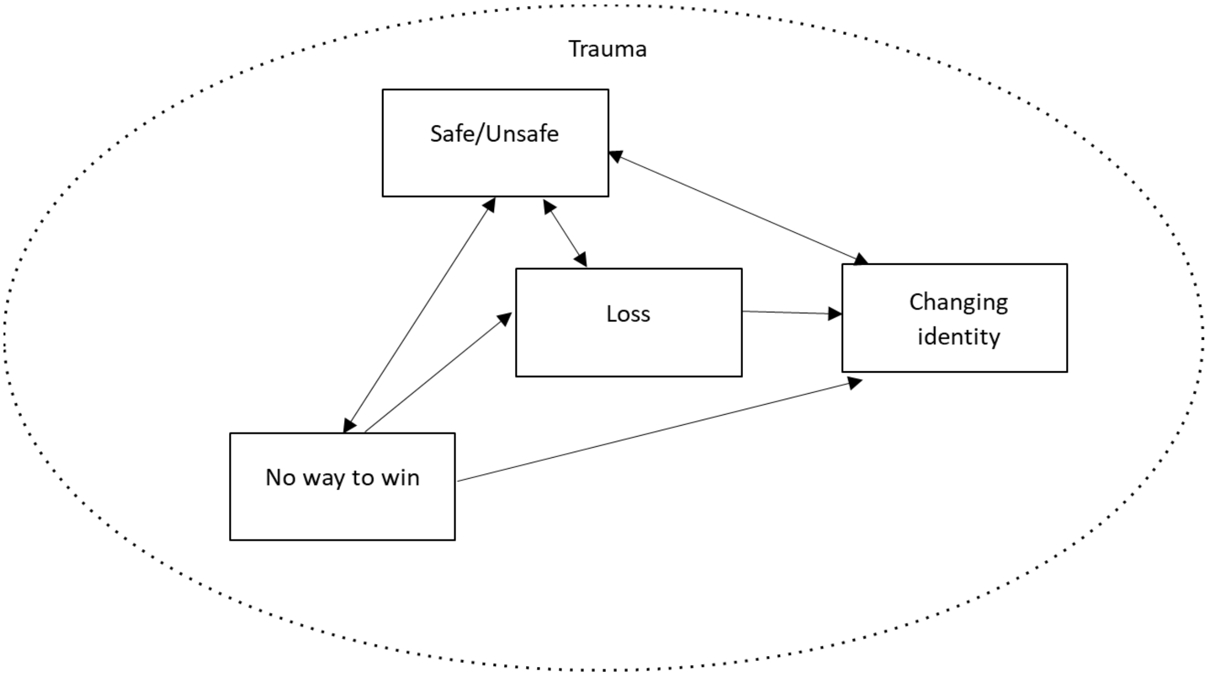
Mothers described the physical and psychological impact of child removal and how it exacerbates their pre-existing mental health issues. This is in agreement with existing research that the removal of children has a significant impact on mothers (Broadhurst & Mason, 2017, 2020; Kenny et al., 2015; Memarnia et al., 2015). Despite this recognition and recommendations that birth mothers need support (Broadhurst & Mason, 2013); mother with experiences of substance use continue to report that they either feel completely unsupported, or that the service provided is not appropriate and fails to meet their needs. This is not unique to mothers with substance use issues as a recent systematic review of support for parents with mental health issues and involvement with child welfare services found that input could exacerbate trauma and mental health issues, that the support that was wanted by parents was not always what services could or did provide and that rigidity in service provision was not helpful to parents (Bacon et al., 2023). As with this group of mothers, the benefits of peer support have also been found in previous research with mothers with substance use following child removal, especially with their limited social support networks due to their trauma experiences (Kenny & Barrington, 2018).

Similar to previous research linking disenfranchised grief and child removal (Broadhurst & Mason, 2017; Cooper, 2002; Memarnia et al., 2015; Schofield et al., 2011), these mothers attempted to make sense of their loss within the context of a bereavement response even when this seemed confusing to them. Some were even in a position to compare the removal with a bereavement, and they highlighted the difference in response and service provision between themselves and parents whose child/ren have died. Parents also highlighted the stigma attached to being a parent whose child/ren have been removed from their care; linking in with the lack of social acknowledgment and validation in disenfranchised grief (Doka, 2002). Stigma has been commonly associated with parental, but especially mothers, substance use and parental loss of custody of children (Agterberg et al., 2020; Kenny & Barrington, 2018; Morriss, 2018; Olsen, 2015; Schamp et al., 2021; Simpson & McNulty, 2007). While support is needed for parents following removal and needs to have a focus on grief, the impact of this may be limited if stigma is not also addressed (Bakos-Block et al., 2022; Broadhurst & Mason, 2020; Kenny & Barrington, 2018).

The mothers in this study reported feeling that the system was unfair and they lacked the ability to 'win' due to a combination of the impact of their own intergenerational trauma and contact with child welfare systems, confusion and a lack of context of their difficulties, a lack of clarity about what is needed to retain custody or get children returned through unachievable standards, a lack of appropriate support and the sense this was a battle between parents and social workers rather than being about the best interests of children. Broadhurst and Mason (2020) have a list of recommendations for services including a need for support at the point when children are removed given the risks associated with removal, improved awareness of the wider issues affecting these women such as housing and poverty and services being aware of mothers' potential mistrust of services and how to work with this. Also, as the mothers' highlighted their own experiences as children involved in the child welfare system or having been looked after and accommodated (LAAC) and wanting to break these repeated patterns with their own children, there is a need for interventions that focus on care leavers and involve the families of those with substance use issues (Alderson et al., 2019; Bakos-Block et al., 2022; Forrester et al., 2016; Holland et al., 2014).

Based on the themes from this study we developed a model (Figure 5) to understand mother's experiences of removal of their child/ren and contact with services which can be used to work with and develop service provision for this population.

Figure 5: Model of mother's experiences of child/ren removal and contact with services



We propose that *no way to win*, with its associated loss of trust in support and services, results in involvement with child welfare services and leads to removal of child/ren. This involvement has an impact on mother's *identity* as does the *loss* of child/ren. Mother's sense of and ability to be *safe or unsafe* not only has an impact of no way to win, loss and identity but further adds to their sense or not of safety. Finally, this all sits within a trauma informed framework where the mother's multiple experiences of trauma must be understood as the context for understanding the women themselves and their experiences of child removal and contact with services.

5. Strengths and limitations

The strengths of this study are the close links to services and the mothers themselves. The use of an IPA allowed for a meaningful perspective of the mother’s lived experience. The learning from this study is part of a larger study around gaps in service provision in Alcohol and Drug Recovery Services for mothers with substance use issues with children removed from their care. This paper adds to the knowledge about service provision but from the mother’s perspective.

Limitations include one of the researchers (LR) worked as a clinical psychologist within the Alcohol and Drug Recovery Service used for recruitment, so to prevent bias current or former patients were excluded from participating, although mothers being seen by other psychologists in the service and receiving therapy from other services were not excluded. As a result, contact with psychological therapy services may be limited or not present in this sample. Only two of the twelve mothers had their children returned to their care and this sample may not be representative of the experiences of mothers who were involved with the child welfare system but did not lose custody of their child/ren or had their child/ren returned to their care. Similarly, all the mothers described challenging and at times extremely adversarial contact with social workers and this might have been a motivation to participate, while mothers with less challenging experiences may have felt less motivated to participate.

6. Conclusion

The mothers in this study indicated that despite their general lack of safety, they can and did develop safe working relationships with either individual workers or with some services. Services that can develop a sense of safety in their clients through continuity in workers, being clear and consistent about boundaries and communication with other services, and mothers feeling respected and validated as a person and as a mother, regardless of whether their child/ren are removed are more likely to engage and have better outcomes these mothers.

References

Adoption UK. (2023). *The Adoption Barometer: A stocktake of adoption in the UK.* Banbury: Adoption UK

Agarwal, P. (2021). *(M)otherhood: On the choices of being a woman*. Canongate Books Ltd.

Agterberg, S., Schubert, N., Overington, L., & Corace, K. (2020). Treatment barriers among individuals with co-occurring substance use and mental health problems: Examining gender differences. *Journal of substance abuse treatment*, *112*, 29-35. https://doi.org/10.1016/j.jsat.2020.01.005

Alderson, H., Brown, R., Copello, A., Kaner, E., Tober, G., Lingam, R., & McGovern, R. (2019). The key therapeutic factors needed to deliver behavioural change interventions to decrease risky substance use (drug and alcohol) for looked after children and care leavers: a qualitative exploration with young people, carers and front line workers. *BMC medical research methodology*, *19*(1), 38-12. https://doi.org/10.1186/s12874-019-0674-3

Aloi, J. A. (2009). Nursing the disenfranchised: women who have relinquished an infant for adoption. *Journal of psychiatric and mental health nursing*, *16*(1), 27-31. https://doi.org/10.1111/j.1365-2850.2008.01324.x

Anda, R. F., Whitfield, C. L., Felitti, V. J., Chapman, D., Edwards, V. J., Dube, S. R., & Williamson, D. F. (2002). Adverse Childhood Experiences, Alcoholic Parents, and Later Risk of Alcoholism and Depression. *Psychiatric services (Washington, D.C.)*, *53*(8), 1001-1009. https://doi.org/10.1176/appi.ps.53.8.1001

Anderson, M., Atkinson, A. M., McAuley, A., Sumnall, H. R., Glancy, M. E., Bloomfield, H. A., & Trayner, K. M. A. (2023). Assessing the reach and engagement with the ‘ How To Save A Life ’ mass media campaign on drug-related death prevention in Scotland. *Drugs : education, prevention & policy*, 1-10. https://doi.org/10.1080/09687637.2023.2262735

Askren, H. A., & Bloom, K. C. (1999). Postadoptive reactions of the relinquishing mother: a review. *Journal of obstetric, gynecologic, and neonatal nursing*, *28*(4), 395.

Bacon, G., Sweeney, A., Batchelor, R., Grant, C., Mantovani, N., Peter, S., . . . Lever Taylor, B. (2023). At the Edge of Care: A Systematic Review and Thematic Synthesis of Parent and Practitioner Views and Experiences of Support for Parents with Mental Health Needs and Children’s Social Service Involvement. *Health & social care in the community*, *2023*, 1-33. https://doi.org/10.1155/2023/6953134

Bakos-Block, C., Nash, A. J., Cohen, A. S., & Champagne-Langabeer, T. (2022). Experiences of Parents with Opioid Use Disorder during Their Attempts to Seek Treatment: A Qualitative Analysis. *International journal of environmental research and public health*, *19*(24), 16660. https://doi.org/10.3390/ijerph192416660

Barrios, Y. V., Gelaye, B., Zhong, Q., Nicolaidis, C., Rondon, M. B., Garcia, P. J., . . . Williams, M. A. (2015). Association of childhood physical and sexual abuse with intimate partner violence, poor general health and depressive symptoms among pregnant women. *PloS one*, *10*(1), e0116609-e0116609. https://doi.org/10.1371/journal.pone.0116609

Baxter, L. A., Scharp, K. M., Asbury, B., Jannusch, A., & Norwood, K. M. (2012). “Birth Mothers Are Not Bad People”: A Dialogic Analysis of Online Birth Mother Stories. *Qualitative Communication Research*, *1*(1), 53-82. https://doi.org/10.1525/qcr.2012.1.1.53

Bell, V., Robinson, B., Katona, C., Fett, A.-K., & Shergill, S. (2019). When trust is lost: the impact of interpersonal trauma on social interactions. *Psychological Medicine*, *49*(6), 1041-1046. https://doi.org/DOI: 10.1017/S0033291718001800

Biehal, N., Cusworth, L., Hooper, J., Whincup, H., & Shapira, M. (2019). *Permanently Progressing? Building secure futures for children in Scotland. Pathways to permanence for children who become looked after in Scotland.* Stirling: University of Stirling

Broadhurst, K., & Mason, C. (2013). Maternal outcasts: raising the profile of women who are vulnerable to successive, compulsory removals of their children - a plea for preventative action. *The Journal of social welfare & family law*, *35*(3), 291-304. https://doi.org/10.1080/09649069.2013.805061

Broadhurst, K., & Mason, C. (2017). Birth Parents and the Collateral Consequences of Court-ordered Child Removal: Towards a Comprehensive Framework. *International Journal of Law Policy and the Family*, *31*(1), 41-59. https://doi.org/10.1093/lawfam/ebw013

Broadhurst, K., & Mason, C. (2020). Child removal as the gateway to further adversity: Birth mother accounts of the immediate and enduring collateral consequences of child removal. *Qualitative Social Work*, *19*(1), 15-37, Article 1473325019893412. https://doi.org/10.1177/1473325019893412

Canfield, M., Norton, S., Downs, J., & Gilchrist, G. (2021). Parental status and characteristics of women in substance use treatment services: Analysis of electronic patient records. *Journal of substance abuse treatment*, *127*, 108365-108365. https://doi.org/10.1016/j.jsat.2021.108365

Canfield, M., Radcliffe, P., Marlow, S., Boreham, M., & Gilchrist, G. (2017). Maternal substance use and child protection: a rapid evidence assessment of factors associated with loss of child care. *Child abuse & neglect*, *70*, 11-27. https://doi.org/10.1016/j.chiabu.2017.05.005

Charlton, L., Crank, M., Kansara, K., & Oliver, C. (1998). *Still Screaming: Birth parents compulsory separated from their children*.

Cooper, R. (2002). *Unrecognised losses in child adoption*. Research Press.

Cossar, J., & Neil, E. (2010). Supporting the Birth Relatives of Adopted Children: How Accessible Are Services? *The British journal of social work*, *40*(5), 1368-1386. https://doi.org/10.1093/bjsw/bcp061

Covington, S. S. (2008). Women and Addiction: A Trauma-Informed Approach. *Journal of psychoactive drugs*, *40*(sup5), 377-385. https://doi.org/10.1080/02791072.2008.10400665

Doka, K. J. (2002). *Disenfranchised grief: new directions, challenges, and strategies for practice*. Research Press.

Finkelstein, Y., Macdonald, E. M., Gonzalez, A., Sivilotti, M. L. A., Mamdani, M. M., Juurlink, D. N., & Canadian Drug Safety And Effectiveness Research, N. (2017). Overdose Risk in Young Children of Women Prescribed Opioids. *Pediatrics (Evanston)*, *139*(3). https://doi.org/10.1542/peds.2016-2887

Flacks, S. (2019). Dangerous drugs, dangerous mothers: Gender, responsibility and the problematisation of parental substance use. *Critical social policy*, *39*(3), 477-497. https://doi.org/10.1177/0261018318795573

Forrester, D., Holland, S., Williams, A., & Copello, A. (2016). Helping families where parents misuse drugs or alcohol? A mixed methods comparative evaluation of an intensive family preservation service. *Child & family social work*, *21*(1), 65-75. https://doi.org/10.1111/cfs.12111

Fox, S. (2020). […] you feel there's nowhere left to go: the barriers to support among women who experience substance use and domestic abuse in the UK. *Advances in dual diagnosis*, *13*(2), 57-71. https://doi.org/10.1108/ADD-09-2019-0010

Fryburg, D. A. (2023). Kindness Isn't Just about Being Nice: The Value Proposition of Kindness as Viewed through the Lens of Incivility in the Healthcare Workplace. *Behavioral sciences*, *13*(6), 457. https://doi.org/10.3390/bs13060457

Grant, T., Huggins, J., Graham, J. C., Ernst, C., Whitney, N., & Wilson, D. (2011). Maternal substance abuse and disrupted parenting: Distinguishing mothers who keep their children from those who do not. *Children and youth services review*, *33*(11), 2176-2185. https://doi.org/10.1016/j.childyouth.2011.07.001

Griffiths, L. J., Johnson, R. D., Broadhurst, K., Bedston, S., Cusworth, L., Alrouh, B., . . . John, A. (2020). Maternal health, pregnancy and birth outcomes for women involved in care proceedings in Wales: a linked data study. *BMC pregnancy and childbirth*, *20*(1), 697-697. https://doi.org/10.1186/s12884-020-03370-4

Harwin, J., & Barlow, C. (2022). The co-occurrence of substance misuse, domestic abuse, and child maltreatment: Can Family Drug and Alcohol Courts play a part? *Frontiers in psychiatry*, *13*, 989813-989813. https://doi.org/10.3389/fpsyt.2022.989813

Holland, S., Forrester, D., Williams, A., & Copello, A. (2014). Parenting and Substance Misuse: Understanding Accounts and Realities in Child Protection Contexts. *The British journal of social work*, *44*(6), 1491-1507. https://doi.org/10.1093/bjsw/bcs197

Howe, D. (2005). *Child abuse and neglect: attachment, development, and intervention*. Palgrave Macmillan.

Hyatt, J. M., & Lobmaier, P. P. (2020). Medication assisted treatment (MAT) in criminal justice settings as a double-edged sword: balancing novel addiction treatments and voluntary participation. *Health & Justice*, *8*(1), 7-7. https://doi.org/10.1186/s40352-020-0106-9

Ijadi-Maghsoodi, R., Quan, M., Horton, J., Ryan, G. W., Kataoka, S., Lester, P., . . . Gelberg, L. (2019). Youth Growing Up in Families Experiencing Parental Substance Use Disorders and Homelessness: A High-Risk Population. *Journal of child and adolescent psychopharmacology*, *29*(10), 773-782. https://doi.org/10.1089/cap.2019.0011

Kampling, H., Kruse, J., Lampe, A., Nolte, T., Hettich, N., Brähler, E., . . . Riedl, D. (2022). Epistemic trust and personality functioning mediate the association between adverse childhood experiences and posttraumatic stress disorder and complex posttraumatic stress disorder in adulthood [Original Research]. *Frontiers in Psychiatry*, *13*. https://doi.org/10.3389/fpsyt.2022.919191

Katz, D., Blasius, K., Isaak, R., Lipps, J., Kushelev, M., Goldberg, A., . . . DeMaria, S. (2019). Exposure to incivility hinders clinical performance in a simulated operative crisis. *BMJ quality & safety*, *28*(9), 750-757. https://doi.org/10.1136/bmjqs-2019-009598

Kenny, K. S., & Barrington, C. (2018). “People just don't look at you the same way”: Public stigma, private suffering and unmet social support needs among mothers who use drugs in the aftermath of child removal. *Children and youth services review*, *86*, 209-216. https://doi.org/10.1016/j.childyouth.2018.01.030

Kenny, K. S., Barrington, C., & Green, S. L. (2015). “ I felt for a long time like everything beautiful in me had been taken out ”: Women's suffering, remembering, and survival following the loss of child custody. *The International journal of drug policy*, *26*(11), 1158-1166. https://doi.org/10.1016/j.drugpo.2015.05.024

Knight, C., & Gitterman, A. (2019). Ambiguous Loss and Its Disenfranchisement: The Need for Social Work Intervention. *Families in society*, *100*(2), 164-173. https://doi.org/10.1177/1044389418799937

Konijnenberg, C. (2015). Methodological Issues in Assessing the Impact of Prenatal Drug Exposure. *Substance Abuse: Research and Treatment*, *2015*(S2), 39-44. https://doi.org/10.4137/SART.S23544

Larrieu, J. A., Heller, S. S., Smyke, A. T., & Zeanah, C. H. (2008). Predictors of permanent loss of custody for mothers of infants and toddlers in foster care. *Infant mental health journal*, *29*(1), 48-60. https://doi.org/10.1002/imhj.20165

Lewis, S. (2022). ‘I was putting her first’: Birth parents' experiences of ‘consent’ to adoption from care in England. *Child & family social work*, *27*(3), 490-499. https://doi.org/10.1111/cfs.12901

Mason, C., Taggart, D., & Broadhurst, K. (2020). Parental Non-Engagement within Child Protection Services—How Can Understandings of Complex Trauma and Epistemic Trust Help? *Societies (Basel, Switzerland)*, *10*(93), 93. https://doi.org/10.3390/soc10040093

McElhatton, P. (2004). The effects of drug misuse in pregnancy In R. Phillips (Ed.), *Children exposed to parental substance misuse: Implications for family placement*. British Adoption & Fostering.

Memarnia, N., Nolte, L., Norris, C., & Harborne, A. (2015). ‘It felt like it was night all the time’: listening to the experiences of birth mothers whose children have been taken into care or adopted. *Adoption & fostering*, *39*(4), 303-317. https://doi.org/10.1177/0308575915611516

Morriss, L. (2018). Haunted futures: The stigma of being a mother living apart from her child(ren) as a result of state-ordered court removal. *The Sociological review (Keele)*, *66*(4), 816-831. https://doi.org/10.1177/0038026118777448

Neil, E., Cossar, J., Lorgelly, P., & Young, J. (2010). *Helping Birth Families: Services, costs and outcomes*. British Association for Adoption & Fostering (BAAF).

Nixon, K. L., Radtke, H. L., & Tutty, L. M. (2013). "Every Day It Takes a Piece of You Away": Experiences of Grief and Loss Among Abused Mothers Involved With Child Protective Services. *Journal of public child welfare*, *7*(2), 172-193. https://doi.org/10.1080/15548732.2012.715268

Olsen, A. (2015). Punishing parents: Child removal in the context of drug use. *Drug and alcohol review*, *34*(1), 27-30. https://doi.org/10.1111/dar.12219

Parolin, M., & Simonelli, A. (2016). Attachment Theory and Maternal Drug Addiction: The Contribution to Parenting Interventions. *Frontiers in psychiatry*, *7*, 152-152. https://doi.org/10.3389/fpsyt.2016.00152

Patton, M. Q. (2015). *Qualitative Research & Evaluation Methods: Integrating Theory and Practice*. SAGE Publishing.

Radcliffe, P. (2011). Motherhood, pregnancy, and the negotiation of identity: The moral career of drug treatment. *Social science & medicine*, *72*(6), 984-991.

Russell, L., Gajwani, R., Turner, F., & Minnis, H. (2022). Gender, Addiction, and Removal of Children Into Care. *Frontiers in psychiatry*, *13*, 887660-887660. https://doi.org/10.3389/fpsyt.2022.887660

Russell, L., Gajwani, R., Turner, F., & Minnis, H. (2023). Where Are the Children?: Addiction Workers' Knowledge of Clients' Offspring and Related Risks. *International journal on child maltreatment : research, policy and practice*, *6*(4), 675-686. https://doi.org/10.1007/s42448-023-00158-9

Schamp, J., Simonis, S., Roets, G., Van Havere, T., Gremeaux, L., & Vanderplasschen, W. (2021). Women's views on barriers and facilitators for seeking alcohol and drug treatment in Belgium. *Nordisk alkohol- & narkotikatidskrift : NAT*, *38*(2), 175-189. https://doi.org/10.1177/1455072520964612

Schindler, A. (2019). Attachment and Substance Use Disorders—Theoretical Models, Empirical Evidence, and Implications for Treatment. *Frontiers in psychiatry*, *10*, 727-727. https://doi.org/10.3389/fpsyt.2019.00727

Schofield, G., Moldestad, B., & Höjer, I. (2011). Managing loss and threatened identity: experiences of parents of children growing up in foster care, the perspectives of their social workers and implications for practice. In *The British Journal of Social Work* (Vol. 41, pp. 74-92): Deutsches Zentralinstitut für soziale Fragen/DZI.

Sellick, C. (2007). An Examination of Adoption Support Services for Birth Relatives and for Post-Adoption Contact in England and Wales. *Adoption & fostering*, *31*(4), 17-26. https://doi.org/10.1177/030857590703100404

Shockley McCarthy, K., Price Wolf, J., & Dellor, E. (2022). Promoting permanency in families with parental substance misuse: lessons from a process evaluation of a multi-system program. *BMC public health*, *22*(1), 2261-2215. https://doi.org/10.1186/s12889-022-14528-4

Simpson, M., & McNulty, J. (2007). Different needs: Women's drug use and treatment in the UK. *The International journal of drug policy*, *19*(2), 169-175. https://doi.org/10.1016/j.drugpo.2007.11.021

Siverns, K., & Morgan, G. (2021). 'If Only I Could Have Said, If Only Somebody Was Listening': Mothers' Experiences of Placing Their Child into Care. *Adoption quarterly*, *24*(3), 207-228. https://doi.org/10.1080/10926755.2021.1908473

Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative phenomenological analysis: theory, method and research*. SAGE Publications Ltd.

Smith, J. A., & Nizza, I. E. (2022). *Essentials of interpretative phenomenological analysis*. American Psychological Association.

Somers, J. M., Moniruzzaman, A., & Palepu, A. (2015). Changes in daily substance use among people experiencing homelessness and mental illness: 24-month outcomes following randomization to Housing First or usual care: Substance use and Housing First: results of a randomized trial. *Addiction (Abingdon, England)*, *110*(10), 1605-1614. https://doi.org/10.1111/add.13011

Sweeney, K. (2020). Drug-related deaths in Scotland: Looking beyond the numbers. *InnovAiT*, *13*(9), 561-563. https://doi.org/10.1177/1755738020924071

The Scottish Government. (2022). *Children's Social Work Statistics 2020/21* [Report](Scottish Government Children and Families Directorate, Issue. https://go.exlibris.link/fZsZqwKG

Thor, S., Hemmingsson, T., Danielsson, A.-K., & Landberg, J. (2022). Fathers' alcohol consumption and risk of substance-related disorders in offspring. *Drug and alcohol dependence*, *233*, 109354-109354. https://doi.org/10.1016/j.drugalcdep.2022.109354

Tsantefski, M., Gruenert, S., & Campbell, L. (2015). *Working with substance-affected parents and their children*. Allen & Unwin.

Tuchman, E. (2010). Women and Addiction: The Importance of Gender Issues in Substance Abuse Research. *Journal of addictive diseases*, *29*(2), 127-138. https://doi.org/10.1080/10550881003684582

Turner-Halliday, F., Kainth, G., Young-Southward, G., Cotmore, R., Watson, N., McMahon, L., & Minnis, H. (2017). Clout or doubt? Perspectives on an infant mental health service for young children placed in foster care due to abuse and neglect. *Child abuse & neglect*, *72*, 184-195. https://doi.org/10.1016/j.chiabu.2017.07.012

Tweed, E. J., Miller, R. G., Schofield, J., Barnsdale, L., & Matheson, C. (2022). Why are drug-related deaths among women increasing in Scotland? A mixed-methods analysis of possible explanations. *Drugs : education, prevention & policy*, *29*(1), 62-75. https://doi.org/10.1080/09687637.2020.1856786

Wahab, S., Sivarajah, R., Azmi, A. D., Chemi, N., & Mahadevan, R. (2023). Association between childhood trauma, intimate partner violence, and perceived parental competence among women abusing amphetamine-type stimulant. *Frontiers in psychiatry*, *13*, 994324-994324. https://doi.org/10.3389/fpsyt.2022.994324

Chapter 7

Discussion and Conclusion Summary

Overview of chapters

The overall aim of this thesis was to explore the needs of mothers with an addiction who have had children removed from their care. Four research aims were identified which addressed the current gaps in knowledge and supported the overall aim of the thesis. These were:

Aim 1: Investigate prevalence of parenthood in an Alcohol and Drug Recovery Service, placement outcomes for children following removal from birth parents, and accuracy of staff reporting of child information in parents' clinical notes.

Aim 2: Obtain prevalence rates for child removal from parents in an Alcohol and Drug Recovery Service, investigate if there are gender differences in removal prevalence and patterns, and whether there are factors which predict removal from parents.

Aim 3: Identify themes related to the lived experience of child removal and contact with services in mothers who are current service users of an Alcohol and Drug Recovery Service.

Aim 4: Using the results from papers 1, 2 and 3, develop guidelines for services to support mothers who have had children removed from their care and identify future research directions.

The first three aims were addressed by one of the papers presented in this thesis and the fourth is addressed below. The next section will provide a brief summary of the findings relating to each aim and will be followed by a discussion of the three key messages from this thesis with recommendations for clinical services and suggestions for future research. Finally, this chapter will conclude with a discussion of the overall strengths and limitations of this thesis.

Summary of the findings

Aim 1: Investigate prevalence of parenthood in an Alcohol and Drug Recovery Service, placement outcomes for children following removal from birth parents, and accuracy of staff reporting of child information in parents' clinical notes. (Paper 1)

Paper 1 found that the majority of service users in a large Alcohol and Drug Recovery Service were parents and a significant proportion had children aged 16 years or under while receiving treatment (Russell et al., 2023). When children were removed, they were more likely to be placed in kinship care, i.e with extended family members. Since around a third of the children remained with their birth parents and about a third were living with family in an informal agreement with no social work involvement, this suggests that large numbers of children may continue to have contact with their parent/s who are receiving treatment for substance use. Additionally, the offspring of these service users had a mortality rate roughly twice that of the general population in Scotland, indicating that this is an at-risk group. Despite this, we found a discrepancy between the information recorded in the electronic system and staff knowledge of family units. The records of 53 parents (11.5%) had a discrepancy, which related to 68 children, 56 were recorded on the system but not reported by the care manager and 12 were reported by the care manager but were not recorded on the system.

Aim 2: Obtain prevalence rates for child removal from parents in an Alcohol and Drug Recovery Service, investigate if there are gender differences in removal prevalence and patterns, and whether there are factors which were associated with removal of children. (Paper 2)

Paper 2 found that about a third of parents in the Alcohol and Drug Recovery Service had had children removed from their care. Gender differences were found as over half of mothers in the service had children removed compared with less than a fifth of fathers. Mothers receiving treatment were also more likely to have had a greater number of children removed and were also more likely to have repeated individual removals of children. Several factors were found to be associated with removal of children including younger age, female gender, drug (as opposed to alcohol) use, and the presence of mental health problems and suicide attempts. Mothers open to the service who had not experienced removal of their children were significantly less likely to have a history of suicide attempts compared with mothers who had experienced removal and women who were not mothers. The prevalence of suicide attempts increased as the number of children removed increased.

Aim 3: Identify themes related to the lived experience of child removal and contact with services in mothers who are current service users of an Alcohol and Drug Recovery Service. (Paper 3)

Four themes were identified: ‘Safe/Unsafe’, ‘Changing Identity’, ‘Loss’, and ‘No Way to Win’. Mothers in the service reported a lack of safety in their lives and within their contact with services making them and their children feel unsafe. Despite this most mothers who were receiving treatment also reported occasions when services or individual workers felt safe or safer for them. These mothers discussed the challenges holding their identity through the child removal process and how this inevitably changed from ‘good’ mum to ‘bad’ mum, but at times to nothing and failing to exist. Multiple comparisons were made with others (children, fathers, other parents) to try to make sense of removal and identity issues and finally mothers described how they reclaimed their identity either during or after child removal. Most mothers felt they never recovered from the loss of their children, the impact was felt at a visceral, physical level as well as emotionally, the loss had a ripple effect and also had an impact on children, the loss felt like a bereavement but lacked the support that would be received following a bereavement. That the strategies these mothers used to cope with the impact of the loss was likely to result in not regaining custody of their children. Finally, mothers open to the service felt there was no way to win in a system that felt unfair to them due to the impact of their own intergenerational contact with child welfare systems despite a desire to break these patterns and give their children a better life. They complained of a lack of appropriate services to support them to prevent removal or aiming to return their children, a system that is confusing and lacks nuance and context, vague standards that are unachievable act as a barrier for return of children and a sense that parents feel they are at war rather than working with social workers.

The outcomes from the three papers in this thesis has been to address some of the gaps in knowledge about child removal from mothers in the context of parental substance use and has added to the evidence base regarding prevalence, potential ongoing contact, gender differences and service needs. Three overall messages emerged from this work. These will be discussed with key findings and implications for service development.

Overall message 1

The prevalence of parenthood and child removal is high in Alcohol and Drug Recovery Services, especially in female parents.

Two key findings evidence this overall message:
Key finding 1a: The majority of Alcohol and Drug service users are parents with a sizable minority having children aged 16 years or younger (paper 1). About a third of parents in the service have had children removed from their care (paper 2).

Key finding 1b: Female service users were more likely to be parents than male service users (paper 1). Mothers were also more likely to have children removed, have more children removed, and to experience repeated individual removals (paper 2).

Key finding 1a: High levels of prevalence of parenthood and child removal in Alcohol and Drug Recovery Services

Despite issues with obtaining prevalence and discrepancies in the accuracy of recoding in service user records, this thesis identified that the majority of service users (68.2%) were parents to children, including adult children. Almost 40% of service users had a child aged 16 years or younger; however, this was 61% of the parent subsample. In addition, about a third of parents had children removed from their care (paper 2). Given the potential for harm to children in the context of parental substance use (Guille & Aujla, 2019; Kuppens et al., 2020; Tsantefski et al., 2015), this highlights the need for Alcohol and Drug Recovery Services to ensure staff are trained to work with parents, especially as our affiliated paper (see appendix 10) reported that staff found this aspect of the job challenging emotionally and practically (McFarline et al., 2023).

Key finding 1b: The role of gender and parenthood

As noted above, while significant numbers of service users in the Alcohol and Drug Recovery Service were parents and had children removed, this differed by gender. 78.4% of female service users were mothers compared with 54.7% of male service users who were fathers (papers 1 and 2). Again, while a third of parents in the service had children removed, this is 56.6% of mothers and 17.7% of fathers (paper 2). Paper 2 also found that mothers receiving treatment were statically more likely to have more children removed and to experience repeat individual removals. A similar study investigating parent status in electronic records in women accessing substance use treatment in London, England, found 77.4% of women were mothers, with 37.5% reporting that their child was in alternative care rather than their care (Canfield et al., 2021). While this prevalence is lower than our findings, they reported that over 50% of the mothers did not disclose whether their child was in their care (Canfield et al., 2021). Similarly, a study of opiate using mothers in treatment in Sydney, Australia, found that 63.7% had been reported to child welfare services and 32.7% of mothers had a child who was removed from their care at the time of the study (Taplin & Mattick, 2015). Again, this is lower than the rates in the Glasgow Alcohol and Drug Service and as with key finding 1a, raises important issues about staff asking about children and their living arrangements. Children may return to their parents care (Biehal et al., 2019) and paper 1 indicated that high numbers may live with a substance using parent or remain within the family either formally via kinship care or informally without social work involvement, so it is vital that staff regularly check with parents about direct and indirect contact with children. This is further supported by the mothers' interviews where they discussed working to get children returned to their care, contact visits and letter box contact (paper 3).

Factors associated with the removal of children from parents in the service were female gender, younger age, drug use, and the presence of mental health issues and suicide attempts. Factors found to be associated with child welfare services during pregnancy in Wales were similar: social deprivation, younger age, with mental health and substance use issues (Griffiths et al., 2020), while Broadhurst and colleagues (2015) found that young age was associated with repeated removals of children. Previous authors have also recognised that men and women have different needs from substance use treatment services and that services need to take a gender-sensitive approach to meet women's needs (Agterberg et al., 2020; Andersson et al., 2021; Covington, 2008; Nelson-Zlupko et al., 1996; Simpson & McNulty, 2007).

Overall message 2

Mothers with substance misuse issues who have children removed have unmet support needs before, during and after removal, but it is impossible to understand these needs without understanding them in the context of their children's needs and the family unit.

Two key findings evidence this overall message:
Key finding 2a: Mothers with substance use issues have a complex and unmet needs before and after the removal of children (papers 2 and 3) and removal of children is associated with an increased risk of suicide attempts (paper 2).

Key finding 2b: Mothers felt that systems and services only see their child's needs and miss their needs or the needs of mothers and the family (paper 3).

Key finding 2a: Complex and unmet needs in mothers

As stated above, several risk factors were found to be associated with the removal of children from parents in the service (paper 2). However, the removal of children was, in turn, associated with further risk factors for women receiving treatment such as relapse or an increase in substance use and an increase in self-harm, suicidal thoughts and suicide attempts (papers 2 and 3). This supports existing research associating removal of children to a deterioration in mental health and an increase in risk factors (Broadhurst & Mason, 2020; Memarnia et al., 2015; Neil et al., 2010). In addition, mothers are more likely to have children removed if their needs are more complex and they do not have these needs met by services (Grant et al., 2011; Larrieu et al., 2008; Patwardhan et al., 2017). The findings in this thesis imply this might be a bidirectional or cyclical relationship where the more disadvantaged a mother is and the less support she has with these multiple and complex needs, then the greater risk of child welfare issues and child removal. This in turn adds to her disadvantage and creates more complexity and needs which, if not met, will then make return of children to her care less likely.

The findings in paper 3 add to the knowledge around changes to identity following the removal of children. A common theme is the shift to a negative and unwanted identity as a 'bad' mother (Holland et al., 2014; Kenny & Barrington, 2018; Memarnia et al., 2015), but other terms used for this new identity have included 'maternal outcasts' (Broadhurst & Mason, 2013) and 'non-mothers' (Baxter et al., 2012). The stigma and shame attached to these new and unwanted identities is further exacerbated by the lack of appropriate services and the mother's experiences of disenfranchised grief; creating a sense that they are undeserving of treatment and support due to being a 'bad' mother (Memarnia et al., 2015; Schofield et al., 2011).

Key finding 2b: The needs of mothers must be seen within their context

In paper 3 many mothers discussed their belief that if they had been provided with the appropriate support then they might not have had their children removed. Mothers also described how the services provided did not always meet their needs, for example, were only focused on their child and/or contact rather than their trauma, mental health issues, domestic abuse or grief. Their reports are similar to the findings of Sellick (2007) regarding provision of post-adoption support, where most services were supplied in relation to direct or indirect contact between birth parents and children rather than advocacy and therapeutic support for birth parents. However, only focusing on children or providing services purely linked to the child risks missing the mothers' needs as an individual, which will also have an impact on their child/ren. Parental wellbeing has been associated with child wellbeing, for example a link has been identified between parental stress and responsiveness and child prosocial behaviour and cognitive development in low income families (Ward & Lee, 2020). Previous research has found that intensive family-based support and services have good outcomes and are acceptable to parents (Forrester et al., 2016; Harwin, Alrouh, et al., 2018; Harwin, Ryan, et al., 2018).

Two recent reviews also support the findings in this thesis – a meta-analysis of effectiveness for interventions for parental substance use (McGovern et al., 2022); and a systematic review of support for parents with mental health issues who are involved with the child welfare system (Bacon et al., 2023). McGovern and colleagues (2022) found that interventions that focused solely on substance use or solely on parenting were not effective at reducing substance use but integrated interventions were effective. This is in agreement with the mothers in paper 3 who felt that the focus on their substance use alone was not beneficial and ignored their other complex needs. Similarly in Bacon and colleagues' (2023) thematic synthesis review, the themes they identified (negative impact of service interventions; working together and not against parents; support needed is not what is provided; and that services are constrained by their rigidity) were similar to issues raised by the mothers' in paper 3. Fox (2020) also highlighted that issues with the lack of integration of services and rigidity in service provision meant women had to pick whether to get support for their addiction or their domestic abuse as combined support was not available.

Overall message 3

Services need to consider how to make services feel safer for mothers and to improve connections and relationships between mothers and clinicians which could lead to better engagement and outcomes for mothers and their children.

Two key findings evidence this overall message:
Key finding 3a: Despite their complex needs (papers 2 and 3) and need for services and additional support, services do not feel safe for mothers (paper 3).
Key finding 3b: When mothers feel connected and valued by staff and services, they can feel safe enough to engage with treatment (paper 3).

Key finding 3a: Unsafe services are a barrier to engagement and treatment

Papers 2 and 3 highlighted that mothers had complex needs and a need for additional support from services; however, they raised in paper 3 that their relationships with services were complicated and they frequently felt unsafe. Their sense of a lack of safety came from a combination of their own experiences with services as a child and adult, their trauma experiences and a fear about boundaries and information sharing. Previous research has also found that mothers in addictions services felt unsafe in services as they felt unable to escape their past as new workers were able to review childhood and adult records and due to information sharing between services (Broadhurst & Mason, 2020; Simpson & McNulty, 2007). A sense of safety within an addictions setting has also been found to have an impact on women's engagement with medical treatment for opioid use (Fiddian-Green et al., 2022). A sense of safety within services has also been linked to engagement in services of minority or vulnerable groups such as inpatient mental health patients and therapy groups, unaccompanied youth refugees and mental health services, young women who have been commercially sexually exploited and health services, and LGBT high school students and schools (Barnert et al., 2019; Harris et al., 2021; Majumder et al., 2015; Seelman et al., 2015).

Key finding 3b: Services need to create safety to engage with mothers

As highlighted above, a sense of safety has an impact on service users' engagement with services and this aligned with the mothers' experiences in paper 3. Almost all of the mothers interviewed discussed a worker or service that met their needs and made them feel safe or safer. The factors described by the mothers for increasing safety included getting a range of needs met in one service, feeling seen and understood by workers as a woman and as a mother, feeling valued and workers attempting to minimise power imbalances, and consistency in workers and their role. This supports previous research on epistemic trust and engagement with child welfare systems and related services (Mason et al., 2020; Wright et al., 2022) although the mothers in paper 3 felt this goes beyond child welfare services and touched all services they had contact with.

Similarly, while staff need to have the technical skills to do their jobs, interpersonal skills such as compassion and authenticity also need to be part of workers skill set (Brookes & Baker, 2017; Fry et al., 2013; Pratt et al., 2021). However, staff working in addiction have raised concerns about working with parents, highlighting issues with decreasing resources and service provision and a lack of support for staff at an organisational level (Whittaker et al., 2016), which limits their ability to provide the level of support requested by the mothers in paper 3.

Several mothers also discussed the benefits of peer workers that gave them the sense of someone knowing what they had been through and hope that their lives may improve. The benefits of having peer workers in services links in with the findings regarding connection and authenticity of workers (paper 3), and existing research where their presence makes service users feel seen and safe (Kenny & Barrington, 2018; Lennox et al., 2021; Scannell, 2022).

Recommendations for services

All service users in Alcohol and Drug Recovery Services need to be asked about whether they have children, where those children live, and what level of contact they have with their own and any other children. This needs to be repeated regularly as parents may regain custody of children, start new relationships or having caring responsibilities for other relatives. Services must acknowledge and be aware of the role of gender in parenting responsibility and child removal, especially in younger mothers with mental health issues. Guidelines should be developed for the accurate recording of information about children and caring responsibilities in patient records/notes.

All clinicians who work with mothers with substance use issues should be aware that it is likely that female service users may have a range of other challenges such as housing, poverty, poor mental and physical health, trauma, and domestic abuse in addition to their substance use.

Clinicians should be aware of the link between child removal and suicide and provide increased support immediately after removal and for a period of time afterwards.

Clinicians need to understand the concept of disenfranchised grief, how it applies to child removal and offer support for this loss and subsequent grief response.

Pregnancy and motherhood may provide additional motivation for women to engage with treatment, but this should be integrated rather than focusing only on pregnancy, their child or their substance use.

Alcohol and Drug Recovery Services should review staff training, especially in respect to trauma informed care, and consider whether it would be beneficial to have staff 'in-house' who have additional training in gender-based violence and domestic abuse, sexual and reproductive health, physical and mental health, and housing and welfare rights or where improved links could be made with existing services and third sector organisations.

Given the potential for harm to mothers and their children from maternal substance use, it is essential that services give thought and planning about how to make services feel safe or safer for mothers to support their engagement. The mothers in this study suggested that important changes would include consistency in staffing rather than repeated changes to their workers, services being clear about roles, boundaries and information sharing, especially with child welfare services, and a need for staff to be persistent and provide outreach as they felt it was likely they will refuse support at times and will withdraw following the removal of children.

Recommendations for researchers

Given the potential for risk and harm to children, further research is needed to get a clearer picture about high-risk families. The high mortality rate found in offspring in paper 1 is concerning and would benefit from further research about the causes of these deaths and whether this is associated with parental substance use. Given that children can and do return to parents, a longitudinal study following children would add to the knowledge regarding placement (for example, where children are placed, duration of placement, any placement changes), and whether they had direct and indirect contact with parents. As children may remain with birth parents or within the wider family on an informal basis, it would be useful to get a better understanding of their experiences and the impact this has on their wellbeing, mental health, and social and educational outcomes especially in comparison with children who are removed.

Strengthening our knowledge about these constellations of parental risk factors would be beneficial to allow identification of mothers at risk for the removal of children. It could also be useful to expand the factors investigated and include other potential risk factors such as mother’s trauma history, mother’s being care experienced themselves, poverty and domestic abuse.

It would be useful to strength the knowledge base around the profile of mothers who have had children removed to aid service development and provision of support.

There is a need for co-production work and having mothers involved in research since, as found in our affiliated paper (Crawford et al., 2023) (see appendix 11), this is a group of mothers who are keen to be involved in research and to have their voice heard. It would be useful for this to go beyond just participation in studies or tokenistic involvement but to have real partnership in development and planning of future research studies and trials.

Further work is needed to understand how to challenge stigma at a population level about female addiction, maternal substance use and the loss of children. This would expand on the previous Scottish Government anti-stigma campaign that just focussed on addiction generally. This in turn may have an effect on disenfranchised grief and make mothers feel less stigmatised and undeserving of support.

There is also a need for better understanding about evidence-based treatment for women, but especially mothers, with substance use issues with acknowledgement that gender factors may have been overlooked in previous research.

Co-production research with peer workers could strengthen the knowledge base around the benefits of employing peer workers for service users, the peer workers themselves and for service development. This also aligns with Scottish Government priorities about the value of lived and living experience in research and service development.

It would be useful to conduct further research with mothers on their understanding of safety and how this has an impact on their lives generally and their engagement with services. It would also be beneficial to better understand how to negotiate and work with mothers in challenging situations, for example if mothers request no contact or information sharing with child welfare systems, to make mothers, workers and services feel safe.

Strengths and limitations

This thesis was developed from working clinically within an Alcohol and Drug Recovery Service and a strength is its direct links to services and mothers. The aim was always to position this group of mothers as experts by experience and use their knowledge and experience to shape service provision. This was aided by the choice of IPA as a method of analysis to allow for depth of analysis and the ability to look for commonalities and differences across mothers' accounts.

The mixed method design allowed for qualitative and quantitative results which add depth and context to each other. The 100% recruitment rate for papers 1 and 2 resulted in a representative sample of the service users. The limited inclusion and exclusion criteria for paper 3 meant that the 12 mothers were heterogenous in their experiences of child removal and were likely to be reasonably representative of mothers within the service.

In terms of limitations, being so closely linked to a service in Scotland could limit the generalisability of the results to other services with more diverse service users or with a different model of healthcare. The use of current staff and service users limits the applicability of these results to parents with less severe substance use, for example those receiving support through third sector organisations or fellowship groups, or those parents who are actively avoiding engaging with services. Finally, being part of the service may introduce bias and there is a risk, particularly if it put the service in a bad light, that results or responses could have been overlooked. However, measures were taken to reduce bias including taking a random sample in papers 1 and 2 and gathering data using a pre-determined proforma (see appendix 1) and the use of supervisors to independently read and review a subset of transcripts and the developing themes.

Conclusion

Going back to the aims of this thesis – to get an understanding of the needs of mothers with substance use issues who have had children removed, it is clear that it is impossible to understand their needs without understanding their trauma experiences, their unmet needs and the exacerbation of these following removal of children. While their needs need understood within this trauma informed framework, they also need to be understood within the context of being a mother with substance use issues, the interaction with their children’s needs and the needs of the wider family unit.

Attention also needs to be paid to their safety, physically and psychologically, as this sense of safety works as a barrier or facilitator to engagement with services. Services need to consider issues such as continuity in workers, clarity and consistency about boundaries and roles, respecting and validating women as a person and as a mother, regardless of whether they have children in their care or removed, as these could ultimately improve the lives of mothers and their children.

References

Agterberg, S., Schubert, N., Overington, L., & Corace, K. (2020). Treatment barriers among individuals with co-occurring substance use and mental health problems: Examining gender differences. *Journal of substance abuse treatment*, *112*, 29-35. https://doi.org/10.1016/j.jsat.2020.01.005

Andersson, C., Wincup, E., Best, D., & Irving, J. (2021). Gender and recovery pathways in the UK. *Drugs : education, prevention & policy*, *28*(5), 454-464. https://doi.org/10.1080/09687637.2020.1852180

Bacon, G., Sweeney, A., Batchelor, R., Grant, C., Mantovani, N., Peter, S., . . . Lever Taylor, B. (2023). At the Edge of Care: A Systematic Review and Thematic Synthesis of Parent and Practitioner Views and Experiences of Support for Parents with Mental Health Needs and Children's Social Service Involvement. *Health & social care in the community*, *2023*, 1-33. https://doi.org/10.1155/2023/6953134

Barnert, E., Kelly, M., Godoy, S., Abrams, L. S., Rasch, M., & Bath, E. (2019). Understanding Commercially Sexually Exploited Young Women's Access to, Utilization of, and Engagement in Health Care: "Work Around What I Need". *Women's Health Issues*, *29*(4), 315-324. https://doi.org/https://doi.org/10.1016/j.whi.2019.02.002

Baxter, L. A., Scharp, K. M., Asbury, B., Jannusch, A., & Norwood, K. M. (2012). "Birth Mothers Are Not Bad People": A Dialogic Analysis of Online Birth Mother Stories. *Qualitative Communication Research*, *1*(1), 53-82. https://doi.org/10.1525/qcr.2012.1.1.53

Biehal, N., Cusworth, L., Hooper, J., Whincup, H., & Shapira, M. (2019). *Permanently Progressing? Building secure futures for children in Scotland. Pathways to permanence for children who become looked after in Scotland.* Stirling: University of Stirling

Broadhurst, K., Alrouh, B., Yeend, E., Harwin, J., Shaw, M., Pilling, M., . . . Kershaw, S. (2015). Connecting Events in Time to Identify a Hidden Population: Birth Mothers and Their Children in Recurrent Care Proceedings in England. *British Journal of Social Work*, *45*(8), 2241-2260. https://doi.org/10.1093/bjsw/bcv130

Broadhurst, K., & Mason, C. (2013). Maternal outcasts: raising the profile of women who are vulnerable to successive, compulsory removals of their children - a plea for preventative action. *The Journal of social welfare & family law*, *35*(3), 291-304. https://doi.org/10.1080/09649069.2013.805061

Broadhurst, K., & Mason, C. (2020). Child removal as the gateway to further adversity: Birth mother accounts of the immediate and enduring collateral consequences of child removal. *Qualitative Social Work*, *19*(1), 15-37, Article 1473325019893412. https://doi.org/10.1177/1473325019893412

Brookes, G., & Baker, P. (2017). What does patient feedback reveal about the NHS? A mixed methods study of comments posted to the NHS Choices online service. *BMJ open*, *7*(4), e013821.

Canfield, M., Norton, S., Downs, J., & Gilchrist, G. (2021). Parental status and characteristics of women in substance use treatment services: Analysis of electronic patient records. *Journal of substance abuse treatment*, *127*, 108365-108365. https://doi.org/10.1016/j.jsat.2021.108365

Canfield, M., Radcliffe, P., Marlow, S., Boreham, M., & Gilchrist, G. (2017). Maternal substance use and child protection: a rapid evidence assessment of factors associated with loss of child care. *Child abuse & neglect*, *70*, 11-27. https://doi.org/10.1016/j.chiabu.2017.05.005

Covington, S. S. (2008). Women and Addiction: A Trauma-Informed Approach. *Journal of psychoactive drugs*, *40*(sup5), 377-385. https://doi.org/10.1080/02791072.2008.10400665

Crawford, K., Russell, L., Graham, S., & Turner, F. (2023). Helping themselves and helping others: how the passage of time influences why mothers with addictions take part in research. *Frontiers in psychiatry*, *14*, 1204882-1204882. https://doi.org/10.3389/fpsyt.2023.1204882

Fiddian-Green, A., Gubrium, A., Harrington, C., & Evans, E. A. (2022). Women-reported barriers and facilitators of continued engagement with medications for opioid use disorder. *International Journal of Environmental Research and Public Health*, *19*(15), 9346.

Forrester, D., Holland, S., Williams, A., & Copello, A. (2016). Helping families where parents misuse drugs or alcohol? A mixed methods comparative evaluation of an intensive family preservation service. *Child & family social work*, *21*(1), 65-75. https://doi.org/10.1111/cfs.12111

Fox, S. (2020). […] you feel there's nowhere left to go: the barriers to support among women who experience substance use and domestic abuse in the UK. *Advances in dual diagnosis*, *13*(2), 57-71. https://doi.org/10.1108/ADD-09-2019-0010

Fry, M., MacGregor, C., Ruperto, K., Jarrett, K., Wheeler, J., Fong, J., & Fetchet, W. (2013). Nursing praxis, compassionate caring and interpersonal relations: An observational study. *Australasian Emergency Nursing Journal*, *16*(2), 37-44.

Grant, T., Huggins, J., Graham, J. C., Ernst, C., Whitney, N., & Wilson, D. (2011). Maternal substance abuse and disrupted parenting: Distinguishing mothers who keep their children from those who do not. *Children and youth services review*, *33*(11), 2176-2185. https://doi.org/10.1016/j.childyouth.2011.07.001

Griffiths, L. J., Johnson, R. D., Broadhurst, K., Bedston, S., Cusworth, L., Alrouh, B., . . . John, A. (2020). Maternal health, pregnancy and birth outcomes for women involved in care proceedings in Wales: a linked data study. *BMC pregnancy and childbirth*, *20*(1), 697-697. https://doi.org/10.1186/s12884-020-03370-4

Guille, C., & Aujla, R. (2019). Developmental Consequences of Prenatal Substance Use in Children and Adolescents. *Journal of child and adolescent psychopharmacology*, *29*(7), 479-486. https://doi.org/10.1089/cap.2018.0177

Harris, L., Lechevallier, Z., & Buhagiar, K. (2021). A qualitative study of service user non-engagement in psychological therapy groups on acute mental health wards. *Counselling and Psychotherapy Research*, *21*(2), 370-381.

Harwin, J., Alrouh, B., Broadhurst, K., McQuarrie, T., Golding, L., & Ryan, M. (2018). Child and Parent Outcomes in the London Family Drug and Alcohol Court Five Years On: Building on International Evidence. *International journal of law, policy, and the family*, *32*(2), 140-169. https://doi.org/10.1093/lawfam/eby006

Harwin, J., Ryan, M., & Broadhurst, K. (2018). How does FDAC Succeed with Parents with Substance Misuse Problems? Exploring Relational Practices within the English Family Drug and Alcohol Court. *Child Abuse Review*, *27*(4), 266-279. https://doi.org/10.1002/car.2521

Holland, S., Forrester, D., Williams, A., & Copello, A. (2014). Parenting and Substance Misuse: Understanding Accounts and Realities in Child Protection Contexts. *The British journal of social work*, *44*(6), 1491-1507. https://doi.org/10.1093/bjsw/bcs197

Howe, D. (2005). *Child abuse and neglect: attachment, development, and intervention*. Palgrave Macmillan.

Kenny, K. S., & Barrington, C. (2018). “People just don't look at you the same way”: Public stigma, private suffering and unmet social support needs among mothers who use drugs in the aftermath of child removal. *Children and youth services review*, *86*, 209-216. https://doi.org/10.1016/j.childyouth.2018.01.030

Kuppens, S., Moore, S. C., Gross, V., Lowthian, E., & Siddaway, A. P. (2020). The Enduring Effects of Parental Alcohol, Tobacco, and Drug Use on Child Well-being: A Multilevel Meta-Analysis. *Development and psychopathology*, *32*(2), 765-778. https://doi.org/10.1017/S0954579419000749

Larrieu, J. A., Heller, S. S., Smyke, A. T., & Zeanah, C. H. (2008). Predictors of permanent loss of custody for mothers of infants and toddlers in foster care. *Infant mental health journal*, *29*(1), 48-60. https://doi.org/10.1002/imhj.20165

Lennox, R., Lamarche, L., & O'Shea, T. (2021). Peer support workers as a bridge: a qualitative study exploring the role of peer support workers in the care of people who use drugs during and after hospitalization. *Harm reduction journal*, *18*(1), 19-19. https://doi.org/10.1186/s12954-021-00467-7

Majumder, P., O'Reilly, M., Karim, K., & Vostanis, P. (2015). 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents. *International journal of social psychiatry*, *61*(2), 129-136.

Mason, C., Taggart, D., & Broadhurst, K. (2020). Parental Non-Engagement within Child Protection Services—How Can Understandings of Complex Trauma and Epistemic Trust Help? *Societies (Basel, Switzerland)*, *10*(93), 93. https://doi.org/10.3390/soc10040093

McFarline, S., White, N., & Russell, L. (2023). The Experience of Alcohol and Drug Recovery Service Staff Working with Mothers Who Have Had Their Children Removed. *Health & social care in the community*, *2023*, 1-8. https://doi.org/10.1155/2023/2983040

McGovern, R., Newham, J., Addison, M., Hickman, M., & Kaner, E. (2022). The effectiveness of psychosocial interventions at reducing the frequency of alcohol and drug use in parents: findings of a Cochrane Review and meta-analyses. *Addiction (Abingdon, England)*, *117*(10), 2571-2582. https://doi.org/10.1111/add.15846

Memarnia, N., Nolte, L., Norris, C., & Harborne, A. (2015). 'It felt like it was night all the time': listening to the experiences of birth mothers whose children have been taken into care or adopted. *Adoption & fostering*, *39*(4), 303-317. https://doi.org/10.1177/0308575915611516

Neil, E., Cossar, J., Lorgelly, P., & Young, J. (2010). *Helping Birth Families: Services, costs and outcomes*. British Association for Adoption & Fostering (BAAF).

Nelson-Zlupko, L., Dore, M. M., Kauffman, E., & Kaltenbach, K. (1996). Women in recovery: Their perceptions of treatment effectiveness. *Journal of substance abuse treatment*, *13*(1), 51-59. https://doi.org/10.1016/0740-5472(95)02061-6

Patwardhan, I., Hurley, K. D., Thompson, R. W., Mason, W. A., & Ringle, J. L. (2017). Child maltreatment as a function of cumulative family risk: Findings from the intensive family preservation program. *Child abuse & neglect*, *70*, 92-99. https://doi.org/10.1016/j.chiabu.2017.06.010

Pratt, H., Moroney, T., & Middleton, R. (2021). The influence of engaging authentically on nurse–patient relationships: A scoping review. *Nursing Inquiry*, *28*(2), e12388.

Risi, A., Pickard, J. A., & Bird, A. L. (2021). The implications of parent mental health and wellbeing for parent-child attachment: A systematic review. *PloS one*, *16*(12), e0260891-e0260891. https://doi.org/10.1371/journal.pone.0260891

Russell, L., Gajwani, R., Turner, F., & Minnis, H. (2023). Where Are the Children?: Addiction Workers' Knowledge of Clients' Offspring and Related Risks. *International journal on child maltreatment : research, policy and practice*, *6*(4), 675-686. https://doi.org/10.1007/s42448-023-00158-9

Scannell, C. (2022). By helping others we help ourselves: insights from peer support workers in substance use recovery. *Advances in mental health*, *20*(3), 232-241. https://doi.org/10.1080/18387357.2021.1995452

Schofield, G., Moldestad, B., & Höjer, I. (2011). Managing loss and threatened identity: experiences of parents of children growing up in foster care, the perspectives of their social workers and implications for practice. In *The British Journal of Social Work* (Vol. 41, pp. 74-92): Deutsches Zentralinstitut für soziale Fragen/DZI.

Seelman, K. L., Forge, N., Walls, N. E., & Bridges, N. (2015). School engagement among LGBTQ high school students: The roles of safe adults and gay–straight alliance characteristics. *Children and youth services review*, *57*, 19-29. https://doi.org/10.1016/j.childyouth.2015.07.021

Sellick, C. (2007). An Examination of Adoption Support Services for Birth Relatives and for Post-Adoption Contact in England and Wales. *Adoption & fostering*, *31*(4), 17-26. https://doi.org/10.1177/030857590703100404

Simpson, M., & McNulty, J. (2007). Different needs: Women's drug use and treatment in the UK. *The International journal of drug policy*, *19*(2), 169-175. https://doi.org/10.1016/j.drugpo.2007.11.021

Taplin, S., & Mattick, R. P. (2015). The nature and extent of child protection involvement among heroin-using mothers in treatment: High rates of reports, removals at birth and children in care. *Drug and alcohol review*, *34*(1), 31-37. https://doi.org/10.1111/dar.12165

Tsantefski, M., Gruenert, S., & Campbell, L. (2015). *Working with substance-affected parents and their children*. Allen & Unwin.

Ward, K. P., & Lee, S. J. (2020). Mothers' and fathers' parenting stress, responsiveness, and child wellbeing among low-income families. *Children and youth services review*, *116*, 105218. https://doi.org/10.1016/j.childyouth.2020.105218

Whittaker, A., Williams, N., Chandler, A., Cunningham-Burley, S., McGorm, K., & Mathews, G. (2016). The burden of care: a focus group study of healthcare practitioners in Scotland talking about parental drug misuse. *Health & social care in the community*, *24*(5), e72-e80. https://doi.org/10.1111/hsc.12249

Wright, H., Morgan, H. C. M., Forbes, C., & Nolte, L. (2022). 'Someone who's there for you . even in your darkest days': an evaluation of a psychotherapeutic counselling service for birth relatives of adopted children. *The Journal of social welfare & family law*, *44*(3), 283-305. https://doi.org/10.1080/09649069.2022.2102762

Appendix 1: Data collection proforma – Parent and child information from records and staff

Gender	Female Male
Age	
Ethnicity	
Substances	Alcohol Drugs Alcohol and Drugs
Number of children 16 and under on system	
Number of children 16 and under from worker	
Child 1 - System Age Location	Home Family Informal Kinship Care Fostered Adopted Residential Care Unit LAC Deceased Information not known
Child 1 - Worker Age Location	Home Family Informal Kinship Care Fostered Adopted Residential Care Unit LAC Deceased Information not known
Child 2 - System Age Location	Home Family Informal Kinship Care Fostered Adopted Residential Care Unit LAC Deceased Information not known

Child 2 - Worker Age Location	 Home Family Informal Kinship Care Fostered Adopted Residential Care Unit LAC Deceased Information not known
Child 3 - System Age Location	 Home Family Informal Kinship Care Fostered Adopted Residential Care Unit LAC Deceased Information not known
Child 3 - Worker Age Location	 Home Family Informal Kinship Care Fostered Adopted Residential Care Unit LAC Deceased Information not known
Child 4 - System Age Location	 Home Family Informal Kinship Care Fostered Adopted Residential Care Unit LAC Deceased Information not known
Child 4 - Worker Age Location	 Home Family Informal Kinship Care

	Fostered Adopted Residential Care Unit LAC Deceased Information not known
Total number of children	
Number of children removed	
Removal pattern	Sibling group Individually Sibling group then individually Individually then sibling group Sibling group then sibling group Information not known
Parent status	Not a parent Parent no removals Parent removals
Adult child 1	
Age	
Location	Home Family Informal Kinship Care Fostered Adopted Residential Care Unit LAC Deceased Information not known
Adult child 2	
Age	
Location	Home Family Informal Kinship Care Fostered Adopted Residential Care Unit LAC Deceased Information not known
Adult child 3	
Age	
Location	Home Family Informal Kinship Care Fostered Adopted Residential Care Unit LAC Deceased

	Information not known
Adult child 4 Age Location	Home Family Informal Kinship Care Fostered Adopted Residential Care Unit LAC Deceased Information not known
Adult child 5 Age Location	Home Family Informal Kinship Care Fostered Adopted Residential Care Unit LAC Deceased Information not known
Adult child 6 Age Location	Home Family Informal Kinship Care Fostered Adopted Residential Care Unit LAC Deceased Information not known
Adult child 7 Age Location	Home Family Informal Kinship Care Fostered Adopted Residential Care Unit LAC Deceased Information not known
Other children in the home	Yes No Not known
Number of other children in the home	
Relationship with other child 1	Stepchild Grandchild

	Niece/Nephew Cousin Sibling Friend of family Information not known
Relationship with other child 2	Stepchild Grandchild Niece/Nephew Cousin Sibling Friend of family Information not known
Relationship with other child 3	Stepchild Grandchild Niece/Nephew Cousin Sibling Friend of family Information not known
Current or history of mental health issues	Yes No
History of suicide attempts	Yes No

Appendix 2: NES REC Ethical Approval letter

WoSRES
West of Scotland Research Ethics Service
Dr Lynda Russell
Principal Clinical Psychologist
NHS Greater Glasgow and Clyde
North West Glasgow Alcohol and Drug
Recovery Services
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Glasgow
G22 5AP

West of Scotland REC 1
West of Scotland Research Ethics Service
Clinical Research and Development
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Glasgow G3 8SJ
www.nhsggc.org.uk
Date 20 December 2017
Direct line 0141-232-1806
e-mail WosRec1@ggc.scot.nhs.uk

Dear Dr Russell

Study title: Study to investigate the feasibility of developing a psychological intervention to support mothers within NHS Addiction Services who have had their children removed
REC reference: 17/WS/0255
IRAS project ID: 211262

Thank you for your letter of , responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a Sub-Committee of the REC. A list of the Sub-Committee members is attached.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion
The REC favourable opinion is subject to the following conditions being met prior to the start of the study.
Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

17/WS/0255 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.
Yours sincerely
On behalf of
Dr Malcolm Booth
Chair

Appendix 3: Interview topic guide

1. Can you tell me about your experience of having your child/ren removed?
2. What services were you involved with before, during and after your child/ren was/were removed
3. From these services, were they beneficial or helpful?
    What made these services helpful?
4. When services have not been helpful, why was that?
5. Are there any services you think should have been involved either before, during or after the removal?
6. What is your experience of the Alcohol and Drug Recovery Service
    Generally
    And in relation to the removal of your child/ren
7. What could the Alcohol and Drug Recovery Service do to help you in relation to the removal of your child/ren?
8. What support needs to be offered to mothers before, during and after the removal of their child/ren?
9. Based on your experiences, what should other service, such as maternity, GPs, social workers, know so that they can support mothers who have had their child/ren removed?

Appendix 4: Example of coding

Descriptive coding in red

Linguistic coding in green

Conceptual coding in orange

Experiential Statements	Mother 2 Text	Exploratory notes
Not getting needs met. Childhood trauma. Impact of process. Lack of support provided to help with bonding. Violent metaphors	I just let people hear what they wanted to hear rather than standing up for myself because I didn't know how to, because even as a child I just always wanted people to like me, and I just, I find it extremely hard and I wanted to love this wee boy as well, you know, like I did my older girls and I didn't want him growing up with the feelings that I had grown up with, and the harder I was trying for that, the harder I kept feeling as though I was being pulled down.	Inability to get needs met, people pleasing from childhood. Is it possible to be 'liked' during this process? Not just hard – extremely. Desire to love son but unable to do this? Pulled down compassion to drowning?

Appendix 5: Personal Experiential Themes (PETs) for all 12 participants

Mother 1

Invisible in process

- No support before, during or afterwards
- Not seen or heard in process
- Became ‘nothing’ due to process

Impossible to keep ‘good’ identity

- Different standards for mums
- Self blame and ambivalence
- Renegotiating new standards for ‘good’ identity (pets, carer)

Removal process interacts with previous trauma

- Impact on engagement (men, people pleasing, trust)
- Exacerbates previous trauma and MH issues
- Coping strategies ineffective or weaponised

Mother 2

Confusion and understanding

- Mum’s lack of understanding
- Not feeling understood by services
- Recovery leads to increased understanding
- Paranoia or perception of others motivations

Process is traumatic

- Feelings like a bereavement
- Traumatic to mum and child
- Battle metaphors
- Link between process and alcohol use/coping strategies

Less deserving

- Comparison with son
- 2nd class
- Services don’t meet needs

Lack of identity

- Not seen in the process

- Split identities – good/bad mum, addict/recovery
- How to maintain identity as mum after removal

Mother 3

Long term impact of childhood SW involvement
- Suspicion of SW and their motivations
- Submission or challenge
- Judgement and knowledge
- Personal attacks from SW
- Infantilised and lack of power/agency

Removal as an act of violence
- Process "same as domestic abuse"
- Weaponised her trauma history
- Invasiveness of process
- Dehumanising
- Process creates trauma and distress

Confusion throughout the system
- Language, jargon, processes
- SW use of old information and reports
- Roles, rights and responsibilities
- Confusion of others – researcher, children, partner, etc,
- Authenticity of process and assessment

Shifting identities
- 'Good mum' conflicting with own needs and wants
- 2nd class and less that others
- Dirty home = dirty mum
- Fear children's views will change due to system
- Adultification of children due to process

Unachievable standards in a rigid system
- Lack of understanding of mum and her needs
- Unable to change SW decisions
- Misunderstanding of coping strategies
- Lack of acknowledgement of positives and change

- “How do I get my children back?”

Mother 4

Engaging with SW involves risk and dilemmas

- Risk from disclosing information
- Multiple dilemmas

Child removal as a threat to ‘good’ identity

- Justification and ‘proof’ of good mum and person identity
- Challenged as SW reports and removal mean ‘bad’ mum
- ‘Good’ mum doesn’t mean keeping or return of child

Interaction between trauma and removal process

- Need for praise and approval
- Impact of DA on removal and decision making
- Own childhood experiences leads to minimising and muted response to removal
- Own trauma impacts on ability to interact and engage with SW and services

Less than others

- Treated differently from parents without addictions
- Different stories and need for evidence
- Ex-partner’s DA and paternal kinship

Confusion versus knowledge and power

- Services hold power but lack knowledge about what she needs
- What services should do versus actually do
- What is good enough for SW and is this achievable
- What is her focus/motivation for change – self, child, SW?
- Powerless to make some changes or change service

Mother 5

Fluctuating levels of safety

- Rarely feels safe
- Desire for safety but unable to achieve
- Impact of safety on engagement with services

Long term impact of childhood trauma

- Lack of skills and resources to care for children and “cope”

- Legacy of lying to services and wary of services
- Impact of additional trauma as an adult
- No family support

Expects poor service and treatment from others

- Challenges services and workers
- Confused and overwhelmed by concept of ‘good’ service
- Treated differently to others
- Conditional support versus ‘brilliant’ support

Knowledge is needed by mums and services

- Mum unaware of own needs, diagnosis or MH issues
- Services don’t understand mums and their needs
- Improving knowledge and understanding benefits mums and services

Mother 6

Context is everything

- SW and mums lack an understanding of the impact of removal and process
- Responsiveness of services and getting needs met

Challenges of being a ‘good’ mum in a complex situation

- Different processes for each child depending on situation
- Ability to have or maintain power and agency
- Adoption as ‘good’ act

Physical impact of removal

- Heart break metaphors (link to son)
- Sickness and pain

Mother 7

Isolation due to addiction and removal

- Limited service and family support
- Connection and recovery

Identity and agency

- Good mum accepts blame and gives up children

- SW process is a threat to identity
- Only deserving of support if linked to child
- Public aspect of removal and embarrassment

Ambivalence

- Removal is good and bad
- Request and reject support and services
- Services are good, bad, good, unsure

Mother 8

Invisible Mother

- Not seen or heard in the process
- Not offered support and organised her own
- No recognition of work or work with family

There are no positives

- Only negatives in reports
- Process physically and mentally traumatic
- Personal attacks from SW

Risky engagement

- Transparency and engagement with services
- Power imbalance and responsibility
- Threat to identity as a mum

Mother 9

Removal changes your identity

- Justification and renegotiation of ‘good’ mum identity
- Multiple threats to identity
- Different standards applied

Wide impact of removal

- Whole family affected
- Mum feels invisible and unheard in process
- Old and new trauma
- Confusion about rights and MH

Relationships and connections with services

- Normality and coffee
- Turnover of staff and pass-the-parcel
- Need support that understands and meets needs

Mother 10

Confusion

- Mixed messages from system
- Unclear goals and targets for return of children
- Comparison to own childhood experience and other parents experience

Passivity and agency

- Who is to blame or responsible
- Difference between own view versus other's – helpless versus aggressive
- Risks and consequences of assertiveness
- Experience with services as a child and adult

Impact of removal

- "Never ending"
- Negative impact on mum and children
- Exposure of own trauma experiences and history
- Unwanted identity as mum without children
- Owned by social work

Mother 11

Multiple threats to identity

- Flexible concept of 'good' mum
- Process leads to an eradicated sense of self
- Bad to the core
- SU and removal = bad mum
- Who is to blame

No sense of safety

- Context and childhood trauma
- SW are not safe
- Death and violence metaphors

Challenges with engagement with services

- Confusion about rules and standards
- Services not designed for complexity
- What is offered is not what is needed

Mother 12

Holding multiple competing identities

- Good mum but minimises risk to children
- Resources and resilience due to different childhood
- 2nd place – children a priority over her
- Undeserving of services

Impact of removal

- Vicious cycle with substance use, coping and removal
- ‘Battle’ with social work
- Bereavement and grief

Unachievable safety

- Confidentiality and support
- Ongoing substance use
- Substance use makes children unsafe

Relationships are essential for engagement

- Peers and similar experience
- Seen as ‘human’ and not judged
- Need for a bond and connection

Appendix 6: Group Experiential Themes (GETs)[10]

GETs	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Safe/Unsafe												
Lack of safety across their lives	Yes		Yes	Yes	Yes	Yes			Yes		Yes	Yes
Services don't feel safe		Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes
Safe(r) service provision and connections					Yes	Yes	Yes	Yes	Yes			Yes
Changing Identity												
Not just a bad mum but a bad person	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes
Eradication of the self by child removal processes	Yes	Yes	Yes					Yes	Yes	Yes	Yes	
Upward and downward comparisons	Yes	Yes	Yes	Yes	Yes				Yes			Yes
Reclaiming their identity	Yes	Yes		Yes		Yes	Yes		Yes		Yes	
Loss												
Impact of the loss of child/ren	Yes	Yes	Yes			Yes	Yes	Yes	Yes	Yes	Yes	
Removal is like a bereavement		Yes		Yes					Yes			Yes
Link between coping strategies and loss	Yes	Yes	Yes									Yes
No way to win												
Intergenerational contact with services		Yes	Yes	Yes	Yes			Yes		Yes	Yes	Yes
Lack of appropriate support	Yes	Yes		Yes			Yes	Yes	Yes	Yes	Yes	Yes
Confusion and context		Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	
Unachievable standards			Yes	Yes						Yes	Yes	
Being at war over the child/ren		Yes	Yes	Yes		Yes		Yes		Yes	Yes	Yes

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[10] Yes indicates whether this GET was present in each mothers PETs

Appendix 7: Examples from reflective diary

After first interview

Felt unprepared for the rawness and distress. Was surprised at the length of time the interview took. Felt mum wanted the opportunity to tell her story, her way, regardless of the questions asked. Found it different to assessments as a clinical psychologist and unusual to get a huge amount of information and then not offer treatment or signpost to other services – need to be aware of this and different role as researcher.

Listening to interview 6 to proof check transcript

Remember this interview well – it was just before Christmas and both of us were unwell and coughed throughout. Remember lots of swearing and her apologising to the Dictaphone for her language. At the time I remember us laughing and coughing and was aware of some anger at times but listening back the anger was much more obvious and just below the surface at multiple points. Prompt to check for this in the other interviews.

During analysis

Feel overwhelmed – by the richness and volume of the data, the amount of distress and trauma but also the pressure I am putting on myself to do this right – for the mothers more than myself. Feel extra pressure now that 3 of them have died to especially do them justice and get their stories into the world. Supervision is really helpful and grounding when I feel like this and so are the sessions where we check theme development.

Appendix 8: Consolidated criteria for reported qualitative research checklist (COREQ)

Topic	Item No.	Guide Questions/Description	Reported in Chapter 6, section -
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	LR – 2.3
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	Title page
Occupation	3	What was their occupation at the time of the study?	2.5
Gender	4	Was the researcher male or female?	2.5
Experience and training	5	What experience or training did the researcher have?	2.5
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	No – 2.3
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	2.3
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	2.5
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	IPA – 2.4
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	2.3
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	2.3
Sample size	12	How many participants were in the study?	2.1, 2.3
Non-participation	13	How many people refused to participate or dropped out? Reasons?	2.3
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	2.3
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	2.3
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	2.1
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	2.2
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	No – 2.3
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	Audio – 2.3
Field notes	20	Were field notes made during and/or after the inter view or focus group?	Yes – 2.4
Duration	21	What was the duration of the inter views or focus group?	2.3
Data saturation	22	Was data saturation discussed?	No
Transcripts returned	23	Were transcripts returned to participants for comment and/or	No

Appendix 9: Procedure for risk disclosures during qualitative interviews

All participants were either current service users of the Alcohol and Drug Recovery Service and had care managers or were attending the Women's Recovery Group which has a staff member and peer volunteers to link in with. During the consent process the limits to confidentiality were explained and that information may be shared.

All participants were contacted by LR within 3 working days of their interview to check in. Either LR or their care manager checked in again roughly a month after the interview. At both check in points no mothers reported any deterioration in their mood, no relapse or increase in substance use and no additional input from any services. Most mothers reported that the interview was difficult, but they were pleased they had the opportunity to discuss their experiences.

Risk issues were raised – especially about children of other parents with substance use issues. In some cases, care managers had mentioned this prior to the interview as they felt the participants would discuss this and explained that services were aware of this situation. In the other cases, LR raised this with care managers to follow up.

Appendix 10: Link for paper 4

McFarline, S., White, N. & Russell, L. (2023) The Experience of Alcohol and Drug Recovery Staff Working with Mothers Who Have Had Their Children Removed. *Health & Social Care in the Community*, 2023, 2983040. doi: 10.1155/2023/2983040.

https://doi.org/10.1155/2023/2983040

Appendix 11: Link for paper 5

Crawford, K., Russell, L., Graham, S. & Turner, F. (2023) Helping themselves and helping others: how the passage of time influences why mothers with addictions take part in research. *Frontiers in Psychiatry*,14:1204882. doi: 10.3389/fpsyt.2023.1204882.

https://doi.org/10.3389/fpsyt.2023.1204882

Appendix 12: Supplementary material for paper 3 – extended results section

3. Results

Four group experiential themes (GETs) were identified in relation to mother's lived experience of child/ren removal and contact with services: (1) safe/unsafe, (2) changing identity, (3) Loss, and (4) No way to win.

3.1 Safe/unsafe

In their interviews, all mothers discussed aspects of safety, but mainly about feeling unsafe. Three subthemes were identified: (1) lack of safety across their lives; (2) services don't feel safe; and (3) safe(r) service provision and connections.

3.1.1 Lack of safety across their lives

The mothers discussed being unsafe due to domestic abuse and a lack of partner/family support, and a lack of safety via their substance use. All of the mothers except one reported experiencing trauma, usually multiple traumatic incidents, in childhood and as an adult and the resulting lack of safety that they feel. The mothers disclosed varying experiences of abuse and neglect as children. In addition, several also experienced domestic abuse in their adult relationships and had experienced incidents such as rape and assault like Charlene who revealed "*I can't get rid of that fear factor since I was stabbed*".

Their interpretation of their trauma experiences appeared to add context to the removal of their children beyond their own addiction, and the difficulties they had parenting in unsafe situations. The impact of the mothers not being safe meant it was difficult for them to create or maintain safety for their children. For example, Rachel's experience of domestic abuse and the role it played in the removal of her child:

"I shouldn't have put up with the things I did and now I have lost my daughter through it and it is killing me" (Rachel)

Or Julie's struggles to safely parent due to her postnatal depression and the loss of support from her partner:

"I had bad postnatal depression with him [son] and then obviously I still had it when I had my wee lassie [youngest daughter], so it got even worse, emm and my partner got the jail and things just fell apart" (Julie)

In both cases, Rachel and Julie reflected on the impact of their partner on their sense of safety and stability for themselves and for their child/ren. Julie also considered the effect of her mental health problems and having two children within a short period of time, which, without the safety and support provided by her partner lead to the collapse of their family unit.

"It was as if I I was too chaotic for them [services], but obviously they didn't see that I had complex post-traumatic stress back then" (Samantha)

Here Samantha highlights the lack of understanding from services about her background and childhood trauma; and the impact of her resulting complex post-traumatic stress disorder on her ability to safely parent and care for her children. Her childhood trauma and lack of safety was also apparent when talking about her lack of family support, including instances where her sense of safety was threatened by them:

Int: "what sort of help do you think you needed, what would have helped to keep you and your children together?"
Samantha: "Emm I don't know maybe a mother and baby unit. Not my mum screaming at me all the time, I had I had post-natal depression an all and I didn't know. The uh the nurse that comes to the house, my wee midwife said to my mum 'Could you help her out? She is suffering from postnatal depression', my mum didn't care."

Similarly, when another participant, Jess, was trying to explain the lived experience of having her children removed, she felt that it was essential to understand the risk she was at while living in the family home due to experiencing domestic violence:

“there was a lot more than just kids getting took, I mean I had to walk away, I was getting…I would probably not be here now, took my own life or my husband would have took it, I was getting beat like a man every day of my life” (Jess)

However, due to her childhood trauma and that lack of safety within her own family, when she left her husband and returned to live with her family, she and her children were unsafe there too indicating a complete lack of safety for her and her children:

“I moved them here [own childhood family home location] but there was a fight the first night and my foster mum, well wasn’t really my foster mum, but she cared for us all a lot and she went ‘just go back home and just don’t put the kids through this’. They were terrified, they were fucking really in a bad way, I’d never seen them like that, and I did it, I went back, but my husband came back when I went back and he beat me” (Jess)

Jess was unable to achieve safety for herself and her children either with her husband or with her family and felt her only option was to voluntarily place her children with social work while she was homeless as she knew they would be safer in foster care. Her perceived lack of any alternative was clear:

“What have I to do? Put the kids under a wee bush?” (Jess)

The only mother who did not report experiencing childhood trauma or abuse within relationships was Toni. Toni can see that this upbringing and support was beneficial when she became involved with social work and her children were removed:

“I only got through that because I got a good childhood, so I got taught skills, I also had a partner who was supportive” (Toni)

Toni has a sense of safety that the other mothers lacked, and she is one of the two mothers who have had children returned to their care. However, this is contrasted with Toni discussing her substance use and the lack of safety she has when either obtaining substances or while under the influence.

"I don't go out to score, I stay home because I want to stay safe and [Partner] wants me to stay safe" (Toni)

This lack of safety is highlighted further when she talks about going out to obtain substances after giving her children their Sunday dinner:

"So needless to say I take Heroin intravenously and obviously I don't know if I got overdosed, but I fucking conked out or whatever because I've no memory of it. I was then carried to somebody else's house, so I remember waking up on a couch with a blanket over me and I am like 'Where the fuck am I? What happened?'" (Toni)

Despite Toni having safety from her past and present relationships, she conveyed how her substance use puts this safety at risk, and inevitably the safety of her family. Toni explained how social work then removed her children when she is under the influence of heroin and her reflective accounts of these times underscored the stark instability of the children in this situation who went from having Sunday dinner with mum and dad one minute to potentially losing their mum to an overdose the next.

3.1.2 Services don't feel safe

Given their trauma experiences, and addiction and mental health issues, many of the mothers acknowledged that they needed additional support from services:

"And then I told them that I was really, really depressed, but I had been going to the doctors before that…so they knew about the depression" (Julie)

"I had distanced myself from him [baby] and spoke to a couple of the nurses asking for help" (Lisa)

Despite asking for help, mothers often found that their needs were not met or referrals for appropriate support were not made:

"I was wanting to go to the Women's Aid [domestic abuse organisation], you know things like that… but it never got done" (Rachel)

Although staff across several statutory agencies knew about her domestic abuse, and it was detailed in reports about her child and she was actively discussing this with services, Rachel found that while staff would offer to link her in with specialist domestic abuse services, this was never followed up by services. This was echoed by other mothers who found that staff made promises of support and referrals, but did not always keep their word or act on this quickly, making services feel unsafe and unpredictable.

"I went to my doctor first and I would have been waiting for months and I kept saying I can't wait that long [for a referral and then go on a waiting list for mental health services]" (Shona)

In addition, the mothers needed to balance their need for support with their fear that engagement with services risked bringing attention to themselves and their children, particularly from social work. Most mothers discussed fears around confidentiality and information sharing between services:

"I just felt they were there to be nosy [support service arranged by social work] more than anything else. So I stopped letting them in and that was another thing that went against me" (Julie)

Lynne mentions this fear several times in her interview:

"like scared to talk to people because the first thought is if I open up and say that I am feeling depressed, down or whatever, even if I was talking about cutting [self-harm], I would be like, the first thought would be [child removal] and that petrifies me" (Lynne)

"I would love to be able to just come and go like 'Look I am feeling like shit and need somebody to talk to', but I just really struggle with that. I mean maybe just now my barriers have come down a wee bit, but I still feel that I can't open up like with [addiction worker]. I maybe get there, but still right at this moment it is still all raw that I feel that I can't because of all that [child removal]." (Lynne)

Even with new services and after her child was returned to her care, Lynne continues to worry about information sharing with social work:

"Yeah it's something I think about daily. New school I am like do they have social work? It is always at the back of my mind, thinking 'the social work, the social work', always" (Lynne)

As a result of this fear about information sharing and further child removal, the mothers revealed a desire for what had so far been impossible within their experiences with services – safety via a service or worker who would be completely confidential and not share information with social work:

"like a worker that is there for you, who you can talk to, that guides you and you say 'Look I am scared of this, is this going to get used against me?'" (Rachel)

"there is an element of not wanting to speak to your addiction worker for fear of things you talk about being passed back to social work and then being used against you. So it's needing a service provider that… you just needing a someone who you can comfortably and confidently talk to without your information being passed back and used against you." (Toni)

As services cannot keep information confidential where children are involved, the mothers end up in a dilemma of needing support but feeling unsafe and concerned about child removal if they are open about their issues.

3.1.3 Safe(r) service provision and connections

Despite all the mothers discussing their lack of safety in their personal lives and within their contact with services, some of the mothers had positive and safe or safer experiences, sometimes with a service or with a particular worker or group of workers. Here Samantha contrasts her addiction worker with her family:

"She is my rock. I look at her more than I do my own family" (Samantha)

She then describes her worker as *"my world"* indicating that there is something grounding about their relationship and the support her worker provides. When mothers discussed their positive experiences, they reflected on the importance of safety within relationships and the value they placed on connections. Mothers appeared to value "normality" and connection, at times, over specific types of support. For example, Sonja had a worker provided by an Addictions Third Sector Organisation but due to her isolation while in recovery this safe relationship became increasingly important and valued to her:

"I would sort of look forward to [worker] coming down. So to her she was doing her job, and to me it was like 'ah good I am going to get to talk to somebody', so I sort of made a friendship out of that" (Sonja)

When asked what the worker did that made this experience positive, Sonja does not describe the work they did on her addiction, but instead focused on "*we would go out and have a coffee and stuff"*. Although this relationship was time limited due to the service provision and they no longer meet, it had a long-term impact on Sonja :

"I still think of her fondly" (Sonja)

Coffee and spending time together was also raised by Charlene when discussing her previous addiction worker. The connection in this relationship and change of dynamic when going beyond usual experiences of care and service provision was apparent in her description of their work:

"She was amazing. She used to take me out for coffee, she would come and pick me up and take me out all the rest of it. Oh she was great, and she would take me along to groups" (Charlene)

This relationship felt safe to Charlene as it supported her on two levels, support to attend addiction groups but also on a personal level to feel valued and have and be worthy of time from another person. Both Charlene and Sonja reflected on workers who not only spent time with them but would be seen in public places and not just in their work environment. This can be compared with Charlene's experience where her children's social worker and her addiction worker were changed frequently and the relationship changed from a connection and safety to feeling objectified and not known:

“I was getting another new social worker and then you were getting another new drug worker. So, it was like you are consistently having to start from the beginning again. Honestly, it was like pass-the-parcel" (Charlene)

The lack of time and feeling like an object (“*parcel*”) that was passed from worker to worker can be interpreted as feeling unsafe when compared to Charlene’s accounts of a worker who she has a relationship and connection with, who knew her and spent time with her.

However, whilst clearly valuing and appreciating this safety, it could feel unfamiliar due to their previous experiences with relationships and a lack of safety. In addition, the nature of service provision and the temporary nature of relationships with workers (due to time limits on pieces of work, referral criteria or turnover of staff) could make these safe relationships and connections feel unsafe. Here Jess discusses the impact of thinking that her workers will leave now she is in recovery:

“I am a size 6 because I thought my workers were leaving me because I’m not in addiction anymore, so why should they stay with me? Because I was told on the build-up that’s what happens and I just thought they were leaving, without even asking them I just thought and I just faded away to this horrible size, but they’re not” (Jess)

The impact of Jess’s previous relationships meant she assumed that people would leave her and once she realised that this would include her workers, she stopped eating. Despite reassurances from her workers, they have acknowledged that at some point they will need to stop working with her, either as she is in recovery and no longer needs their input, or due to role or service pressures limiting how long they can work with people. This leaves these mothers with another dilemma, engage with services and workers and there is a chance of developing a safe connection and relationship, but these relationships may feel unsafe due to the unfamiliarity of feeling safe and by their temporary nature.

3.2 Changing Identity

All of the mothers discussed how they felt their identity changed due to the child removal processes and the removal of their child/ren. Four subthemes were identified: (1) Not just a bad mum but a bad person, (2) eradication of the self by child removal processes, (3) upward and downward comparisons, and (4) reclaiming their identity.

3.2.1 Not just a bad mum but a bad person

Almost all the mothers reflected on the challenge of trying to maintain their identity as a 'good' mum and felt this was not possible within the child removal process. While the mothers acknowledged their role in the removal of their children, they felt that the information gathered and conveyed by services (e.g. in reports, official documents and in meetings) only reflected negative aspects of their parenting. They felt a strong sense of disappointment that any positives, in their ability to care for and love their children, were missing.

"There's none of the good side of it that's in the reports." (Shona)

"I felt everything I'd done wasn't ever good enough to that social worker, I felt that I was always this bad mammy, you know that's the way I felt." (Rachel)

Lynne described herself as *"the worst mother"* when reflecting on the circumstances following her relapse and the removal of her child. She acknowledged this was how she felt due to her guilt but also reported that this was a phrase also used by professionals. In addition, Lynne reflected on how she struggled with regulating her emotions during meeting where the negative aspects of her parenting were reportedly the only focus:

"You have got somebody sitting in front of you talking bad about you and that was really hard to take. Like people put me down as quite loud and aggressive because I think I did really struggle with they kind of meetings and I think it was just all the emotion"
(Lynne)

For some mothers this perceived identity went beyond just being a ‘bad’ mother to also making them feel like a bad or worthless person:

“Basically, you are a piece of garbage, you don’t deserve to be a mother, that’s the way I felt” (Vivian)

Lisa felt that being a parent with an addiction made her undeserving of support and the process felt like a punishment for her addiction:

“Almost like a consequence to the fact that I had an addiction, it was almost like ‘you made your bed, lie in it’, end of” (Lisa)

The mothers have indicated that it is challenging to hold a positive identity during a process that focused exclusively on their flaws and weaknesses and failed to acknowledge if there were any positives in their caring abilities or relationships with their children. For some mothers, this acknowledgement would have allowed them to maintain some aspect of a ‘good’ mum identity. However, for others their meaning making of this process went beyond just challenging their identity as a mother to also challenging their wider identity, leaving them feeling ‘bad’ and worthless in a more general sense.

3.2.2 Eradication of the self by child removal processes

Some of the mothers noticed that, despite the process being invasive and all aspects of their lives being questioned and examined, they felt overlooked, unseen and less than human in a process that they perceived as reducing them to nothing. This left some of the mothers with no identity or sense of self following the removal of their child/ren.

The assessment process was thorough; to the level that some mothers felt it was invasive with nothing being off limits:

“You’re kind of ‘under the light’. They [social work] are always watching you” (Jess)

“They [social worker] would go through your cupboards, through your fridge, through the freezer, they tell you how neat your house was” (Shona)

Yet despite that intensity, mothers often felt that they lacked a voice and did not feel seen or heard during the process. Charlene described herself as a *"spare part"* at panel meetings and described how she felt excluded from discussions and decisions between the panel members and her child's kinship carers. In addition, she reflected on apparent comments made by the kinship carers, which she described as attempts at 'erasing' her from the child's life:

"They [kinship carers] said 'When we took [child] on we didn't tell… we don't mention Charlene's name in our household. We don't mention the word. We don't talk about mum. We don't talk about her, so we've never mentioned…we don't talk about Charlene in our household'" (Charlene)

The repetition suggested that Charlene felt that she was not only erased by name; but any mention of her being a mum or related to her child was also erased by the kinship carers. At a later point in her interview, Charlene described how this eradication not only affected her sense of self but also limited contact and support from family as the kinship carers apparently banned her from family events; resulting in her child asking if she was in heaven.

While for other mothers, although they described the process as thorough, they felt that the focus on their child came at the risk of not fully understanding the family unit:

"Their role was to come in and speak to [daughter] and to get other people's opinion and then they were to make their own opinion, yet again another person that didn't know us as a family." (Lynne)

"There should be support for us, like the mums or the dad, do you know what I mean? Because nobody bothers with them, all the attention just goes to…like yeah the kids should be safe, but what about the parents?" (Sonja)

While some mothers also described how the process left them not only feeling unseen but made them feel less than human with several using animal metaphors, including "*used as* *a Guinea Pig*" (Lisa), "like putting *a tiger in a cage and poking at it*" (Samantha) and "*sticking a rabbit in a hutch and watching it*" (Shona). Several mothers requested that services see them as 'human'.

Vivian conveyed that her interactions with her child's social worker made her feel as if she was nothing and did not exist at all:

"I remember that one social worker down here. That man that came to my home. He looked at me as if it was nothing" (Vivian)

Mothers perceived that, through the process of removal, they became dehumanised, invisible, or ceased to exist in a system that focused only on their child. However, some mothers described experiences that went beyond not being seen or heard but to also convey that they failed to exist in the eyes of the professionals involved with their child.

3.2.3 Upward and downward comparisons

Throughout their interviews, the mothers compared themselves to their children, their partners or ex-partners and other parents. The mothers made sense of their experiences through these comparisons.

The mothers understood that there was a difference between their experience and that of their children, but the comparison only served to underscore the disparity between the experiences of mother and child.

"I actually had to put my wee boy in the car and watch him drive off and that was him adopted emm and I was left to go and get the bus home." (Lisa)

Lisa compared her son's experience of being driven and having support to her own experience of saying goodbye to her son and getting the bus home alone. At a different point in her interview, she also acknowledged and understood that the process focused on her son and not her, yet she too needed support:

"I just felt as though there was absolutely zero support for me when I was going through the whole process from start to finish, it was all about my child. Which is understandable" (Lisa)

Lynne reported a similar experience of desperately needing information and support but being informed that the social worker was only her daughter's. Her repetition of the word "no" in the extract that follows also implied that this was an issue she had raised but one that had not been reciprocated by services:

Int: "So nobody was identified as being somebody you could go to for information or somebody to support you?"
Lynne: "No, no, no, no [social worker] was [daughter]'s social worker not mine, yeah there was nobody."

The comparisons were not only linked to the removal process. Shona spoke positively about her children's foster family, who she saw as providing stability and extended family support for her children in comparison to the instability and limited contact she has with her family:

"They were happy where they were living, and they were starting to get into that routine of where they've got like aunties, uncles and that" (Shona)

Mothers also regularly compared themselves to their children's fathers. Some felt that fathers were held to lower standards than mothers. Such as Vivian's perception that her drinking was viewed differently from her then husband's.

Vivian: "Then he would finish work at 3:30pm and then he would be up in the pub drinking away, and is that alright because he is a man? But at least I've admitted, at least I know I am to blame."
Int: "Do you feel you were judged differently with you being female."
Vivian: "Oh yes, very, very. Without a doubt."

Vivian reflected on the socially acceptable aspects of alcohol use in Scottish culture, especially for men. She felt this was used against her when both she and her ex-husband had used alcohol problematically and despite acknowledging the harm her alcohol use was doing to their child, she lost custody of their son to her ex-husband. She returned to this at a later point in her interview again with the view that different standards are applied to mothers:

"See if it is a man, because a woman, no way should a woman be addicted, and she has got children. No way." (Vivian)

Similarly, Rachel felt that despite the role of his domestic abuse in the removal of their child, her ex-partner was receiving better support than her from social work:

"They [social work] are making all the priorities for [ex-partner], but they are not doing any for me and I think it is not fair because he is the one that still look fill-of-it [still appears to be under the influence] and I am doing good' (Rachel)

Not all mothers felt fathers were held to easier standard. Jess discussed her solo visits to the contact centre to see her son after he was removed:

"I'm just so thankful for the time I got with him, because they [social work] didn't allow my husband to see him because he was beating me at the time and he was quite aggressive with the kids, so they didn't let him" (Jess)

Jess came back to this at a later point in her interview when she further conveyed a sense of enjoyment at spending time with her child at contact times without her husband present:

"And I loved that because I wasn't around my husband, there wasn't violence, there wasn't drug taking, just me in a contact centre, and I'm sorry but I loved it, every minute of it." (Jess)

Despite ultimately having her son permanently removed, she felt that she and her husband had been assessed fairly resulting in only Jess having contact visits. This allowed her some limited one on one contact time with her son, which left her with positive memories of their time together.

Most of the parents tried to make sense of why their child was removed by comparing themselves to other parents, usually who had custody of their children. Many expressed concern and anger when they talked about a friend or acquaintance who use substances and still have care of their children:

"I know a lassie who has got a child, she uses Heroin, she uses alcohol, she uses emm that street Valium, and she lets Tom, Dick and Harry all in and out of her house with this wee lassie, going to nursery and she walks out and she talks like that [slurring her words] all the times and she wears sunglasses to hide her eyes." (Charlene)

"I was like that wow how come cunts like that get to keep their weans and I can't." (Annie)

"There are some people I know that do get their weans back that have got addictions and I say to myself 'why have they got that wean?', 'why have you got that wean?', because there is people I know, see, don't know, but they stay next to me, walk about and they are fill-of-it [under the influence of substances] with their wean" (Rachel)

"Like my neighbour, I know this is nothing to do with this, but her wee boy is 9-month-old, he eats dog food and emm he is like lactose intolerance and gives him fucking Ensures [nutritional drink] and I reported it and she's [social worker] still no went out. And I'm like 'oh well' but, so that's what I was saying to [addiction worker] 'I'm waiting until the wean's [child's] dead and then they'll go out fuck sake'" (Julie)

3.2.4 Reclaiming their identity

Although they described the threats and challenges to their identities, several of the mothers also discussed how they had either challenged or changed these views.

Annie had an older child in kinship care when she found out she was pregnant with her second child. Following discussions with her family, she decided she was unable to care for this child and the kinship carers were unable to take on a second child:

"I had to give him up for adoption because I thought it was better losing one child than rather than two" (Annie)

Annie decided to give her child up for adoption through an adoption agency and was able to pick the adoptive parents. Here she talks about the moment she told the adoptive parents in a meeting:

"I've made my decision. I says emm 'I pick yous'. And see the joy it brought to that couple. I could, I could see it. It was unbelievable and even though it was hard for me, I had to think of [son]. I couldn't have gave him the life that they've gave him." (Annie)

Annie was able to acknowledge the sadness of having to give her son up for adoption but was also able to balance this with the knowledge that she made the adoptive parents happy and felt that she was doing the best for her son. Annie was able to reclaim an identity as a 'good' mum and 'good' person by considering the needs of her son and seeing the joy she brought.

Jess viewed her decision to place her children voluntarily into foster care in a similar way:

"I didn't run thinking 'oh I will leave them with him [husband]'. I didn't do that. I left them in good care" (Jess)

By accepting that neither she nor her husband were able to care for their children, she could reclaim the notion of being a 'good' mum by making a decision to place them into foster care where she believed they would be safe and cared for.

Vivian reclaimed her 'good' mum identity by coming to a decision to stop applying for custody, which meant her son did not have to attend court. She spoke about the impact that she felt that the process was having on her son's health, and felt positive about her decision to stop it because she felt that she was putting his needs first:

"he was full of eczema everywhere, body, hands, everywhere, and it was bad on his face, bad. I mean I am not daft; I know that's stress and would I do that? No, that's what I don't want to do. People might say that me being a bad mother, that's not me being a bad mother" (Vivian)

These examples show the ways that mothers had thought about their children's wellbeing and how to be a 'good' mother; even if that means giving up care of your child.

3.3 Loss

All mothers discussed some aspect of loss, which was interpreted to be a main theme (GET) made up of three subthemes: (1) The impact of the loss of their child/ren; (2) accounts of removal feeling like a bereavement, and (3) the link between their coping strategies and loss.

3.3.1 Impact of the loss of child/ren

All mothers described the impact of removal, on themselves and their children. When asked about the removal of their children, the devastation of the removal was generally the first area they discussed:

"Traumatic" (Vivian)

"It's the worst thing in the world" (Annie)

"I wouldn't wish it on my worst enemy" (Sonja)

Several mothers also described the visceral and physical impact of removal that resulted from the feelings of devastation:

"because how it then impacts on your life is difficulties with eating, the difficulties with sleeping, difficulties with just concentrating" (Toni)

"It's just fucking heart breaking" (Annie)

"See like that greeting [crying] like [gasping for breath] pure like that, that's the way I was" (Lynne)

In addition, the removal process exacerbated pre-existing mental health issues:

"I suffer from panic attacks anyway, well before any of this, and obviously that's made it worse" (Vivian)

Several mothers reported that they felt suicidal or made attempts to end their lives after their child/ren were removed:

"I was in a homeless unit after an attempted overdose, no tried to throw myself in the river. My life had just got to a stage where I wanted my wee boy back and life had just become so unbearable that I just didn't want to be here anymore" (Lisa)

"I have wanted to take my life" (Jess)

"I was in the house trying to kill myself, trying to choke myself, trying to hang myself. Anything I could do I was trying to do it. I ended up breaking my spine" (Julie)

Mothers felt that the removal of their children had a significant impact mentally and physically; with some mothers becoming suicidal and making attempts to end their lives.

While most of the mothers could acknowledge the reasons why their children were removed, they reflected on the impact of the removal on their child/ren. Here Shona felt that attending meetings exposed her children to information that was potentially confusing or distressing for them and possibly not age appropriate:

“they bring them in and I think it’s a dead adult world…they’ll talk to the weans and then they’ll go right into this big in-depth conversation and sometimes I think it is too much for weans” (Shona)

Attendance at meetings or children having contact with professionals were not the only aspects of the removal process that the mothers felt had an impact on their child/ren:

“But my wee boy has started to take things out his granddad. I think he thinks that his granddad is keeping us away from him. Emm he is biting him and slapping him.” (Julie)

While removal of children is essential for their safety and well-being, the mothers felt that the impact of removal went beyond themselves and had a ripple effect on their children.

3.3.2 Removal is like a bereavement

Several mothers discussed the loss of their children using metaphors or comparisons with bereavement:

“you go through the stages of grief, that you go through that, so you go through a grieving process” (Toni)

“you know what it feels like? It is like a grieving process, you are grieving for something that’s still there and you see them, you are walking by your own weans [children] and you can’t say ‘hello’, you are not allowed to say ‘hello’, you are not allowed to touch them, you are not allowed to speak” (Charlene)

The sense-making of the pain and the impact of removal felt close to that of a bereavement for these mothers despite knowing that their child/ren were still alive and some having levels of contact. The mothers also conveyed that a grieving process was present after their loss.

Some of the mothers directly compared their loss experiences with bereavement experiences:

"it has been like a bereavement because I didn't understand why the pain was so bad, I just know that I had gave birth to this child and then he was no longer there and I could no longer talk to him, I could no longer see him…I didn't understand why I felt so bad and I could only associate with the feelings when I lost my grandad" (Lisa)

Lisa was trying to make sense of her pain and associated it with a bereavement she had previously experienced. Rachel had lost a child to cot death and was also able to compare both experiences:

"I thought losing my son, that was hard, but having my daughter removed from my care and I can't kiss or cuddle her. It's hard, it's the hardest thing I've ever been through." (Rachel)

Similarly, other mothers discussed grief and mourning at missing out on 'firsts':

"Like ma wee lassie [little girl] is doing so much, emm like yesterday I handed her something and she just took it right out of my hand, and I was like 'oh my God man she can actually do that', it's all that wee stuff that you are missing out on." (Julie)

"when she first goes to nursery and all that, school and all that, you know her first everything, you know be there for when she cut her leg and tell her is it going to be alright, you know when she gets her heart-broken, you know be there, just be a just be a real good mum to her, you know and I've missed all that" (Rachel)

For the mothers, they conveyed a sense of loss not only their children but also for the future and life they thought they would have together. Their grief was multi-faceted and covered many different losses not just the loss of custody.

Comparisons between death and child removal were also made in terms of support and service provision:

"You will get help around that. There will be specific dedicated support services for people who lost their child. The parents of accommodated children do not have a go-to service that they can go to." (Toni)

"there are bereavement places all over the place, but yet there is nothing, there is absolutely nothing for adoption" (Lisa)

3.3.3 Link between coping strategies and loss

Mothers reflected on the aftermath of their child being removed from their care and identified coping strategies that they used that were often maladaptive:

"I emm starting drinking after the weans [children] were away." (Julie)

In addition to her alcohol use Julie also disengaged from services:

"I stopped going after the weans [children] got took off me because I was just rebelling against everything." (Julie)

Julie described a vicious cycle where she started misusing alcohol to cope with the loss of her children but was unable to regain custody of her children due to her subsequent alcohol use and disengagement from services. Lynne also described this vicious cycle although her substance use started before her child was removed:

"I wanted to numb myself, but yet it is a vicious cycle because that's the reason why [daughter] got taken in the first place." (Lynne)

Similarly, when Shona was feeling overwhelmed and wanted to numb the negative feelings she was experiencing since the removal of her children, she used drugs. However, she conveyed that with time she came to understand that was not a useful coping strategy and now advises other mothers against this.

"I want to numb some of it and don't get me wrong, I'm one of the biggest speakers now to tell anybody, that's the worst idea in the world. But it felt as if it was the best idea at that time. Something to numb the feeling" (Shona)

Not all mothers made sense of their drug or alcohol use as a way to cope with removal. Sonja reflected that although she was distressed following removal, without caring responsibilities she and her partner were able to use substances more often than when caring for their child:

"Yeah things got quite bad, because there was nothing stopping us then" (Sonja)

Although these mothers wanted to numb and avoid painful memories and emotions connected with the loss of their children, over time they have realised that this was not the best coping strategy for their wellbeing. They conveyed that they perceived that this delayed or stopped the return of their child/ren to their care and their ability to process their grief.

3.4 No way to win

The mothers all conveyed a sense that the system was set up so they could not 'win'. This theme contained five subthemes: (1) their intergenerational contact with services, (2) a lack of appropriate services for mothers, (3) confusion and context in the child removal process, (4) unachievable standards for mothers, and (5) being at war over the child/ren.

3.4.1 Intergenerational contact with services

Several of the mothers discussed their own childhood experiences with social work and the care system. They felt this influenced their views on social workers:

"I used to have to lie" (Samantha)

Samantha discussed how her mother made her and her siblings lie to social workers and at school about the abuse they were experiencing and the fact she was claiming benefits as a single parent while living with her partner. When she became a mother and social work were involved with her and her children, she felt that honesty was not working:

“I was trying to be honest with them at the start, like telling them I didn’t have this - and then, when [Social Work Manager] threatened me, that’s when things changed for me personally. Then I saw that I had to be hiding things” (Samantha)

Samantha mentioned this incident with the social work manager multiple times throughout her interview. Her repetition conveyed that she made sense of her hiding information as she felt threatened and unsupported when she was honest and that she realised that honesty was not working for her or her children.

“I’ve always struggled with them [social work] because it’s always been bad experiences” (Lynne)

“mostly all of them that I’ve worked with are all my old social workers, and I don’t think it is right. It’s like a conflict of interest. I feel it is anyway with them like they know things that I’ve done that they could probably use against me" (Julie)

Mothers also felt that their childhood experiences with social work had an impact on their ability to trust and work with them as a mother. Julie also perceived that having the same social workers as her children felt like a conflict of interest to her, and there was a sense of exposure with previous knowledge of her and access to her childhood records. This also highlighted the shift that occurs for this group of women when they move from the position of being the child whose needs are at the centre of the system to being a mother whose child/ren are the focus of the system.

Mothers also reflected on the changes in social work between their generation and their children’s generation:

“so the rules changed since the years have went on, do you know what I mean, because my social worker when I was a kid could help. She put me to live with my older sister and

took my mum's 'Monday' book and family allowance book [benefits books] and gave it to my sister" (Jess)

Jess conveyed a sense that there was flexibility in the system that allowed social workers to support her as a child, but that flexibility was not available when she was a mother, resulting in her feeling her options were limited to placing her children into the care system. However, Julie had a different experience and was left in the care of her mother despite a court decision that she should be removed. Julie reflected on the difference between her experience and her children's:

"Doing this to me and they left me with my mum and I was going through a drug bust before I could even get to school nearly every second day. Emm I was staying in people's houses, like drug user's houses, needles lying about, with a jacket just shoved over me to go to sleep. My mum ended up leaving the house and leaving me with a 14-year-old brother and social work still didn't take me into care, but they are doing this to me [removing her children]" (Julie)

Julie felt stuck and struggled with her sense-making about the lack of protection as a child and then subjected to firmer rules and conditions with her own children. She described an incident at a meeting about her eldest child where these changing standards were discussed:

"they were saying 'oh you were neglected by social work' but the guy that was saying it was my social worker and I am like 'well what happened because you were my social worker?', 'oh err we've learned new things these days', 'no I'm paying for everybody else's mistakes that you have messed up with, that's what I'm doing'." (Julie)

Julie had a sense that neither her mum or social work were being held responsible for their actions in her childhood, while she was being held to higher standards for her own children and made to feel responsible for their removal from her care.

While Sonja hoped that services had changed over time and that young girls in a similar situation to hers would be protected, unlike her experience with social work where she felt they were uncomfortable about her forced marriage and did not intervene; even suggesting kinship care for her child:

"I really hope that it wouldn't be the same, like if there was a wee girl, do you know what I mean, who was to go into social services or yeah that they would do more for her and not just think 'oh it is a cultural thing, let them, we don't want to sort of over-step our boundaries or offend somebody'." (Sonja)

These mothers felt like a 'lost generation', not protected as children and then watching social and cultural changes as they became adults and mothers.

Some of the mothers felt that their own abuse and trauma experiences were used again them when they became mothers:

"they were going back to when I was 7, and I was, what, 23, 24, and I'm going seriously that was years and years ago, days I can't even remember and it was about my mum, there was things getting dragged up about her and to me it didn't make any sense cause I was going 'right well I get the point of looking at me as a child', but then starting to dig things up that I didn't even know about and then flinging them in reports to make it look a lot worse than what it is. I would have got the point if it was happening there and then and everything, but I grew up, I didn't even know about certain circumstances." (Shona)

Here Shona discussed going to a meeting with social work where she was provided with information about her childhood trauma and her mother that she was unaware of. She conveyed that she felt the information was weaponised to support the removal of her children rather than to provide her with support or services.

Rachel also felt that her mental health and trauma history was used against her by social workers as a way to justify the removal of her child; again, rather than a reason for providing support:

"they knew all the illnesses that I had and I felt that they used that" (Rachel)

Due to their own experiences, several mothers had wanted to break intergenerational patterns and give their children a better life:

“I hated myself for it, especially because of I think growing up in that situation myself as a child and I wanted never ever to be putting my own children through that, you know and yet this wee one was going through the same things” (Lisa)

“I know with me getting brought up so badly I should have done better about my kids” (Jess)

Despite good intentions to break these patterns, mothers ultimately found this challenging and were unable to change these repeating patterns.

Mothers also had concerns generally about the impact of being a child of a parent with an addiction:

“That worries me because you read so many stories of children that get bullied or parents are addicts and stuff” (Charlene)

Charlene worried about the impact of her and her ex-partner's addictions on their child and the links between parental addiction and bullying; which in turn made her concerned about her child’s mental health and wellbeing.

Toni also had concerns about her children:

“you hear the statistics and you hear things said, so like if you look at my children they live in the high flats, they live in social housing, parents are on benefits, both parents are addicts, so it could be portrayed that their future is bleak, but on the other hand I can look at it as I’ve heard other statistics that children whose mother has a degree will do well, so I am degree educated”

Toni hoped that having a parent who has a degree would mitigate the other risk factors for her children.

Most of the mothers who had social work contact as a child felt this had a negative impact on their engagement and ability to work with social workers as a mother. Many found these intergenerational patterns difficult to break and that they had become a 'lost generation'; feeling penalised as children and adults by shifting priorities and focus by services.

3.4.2 Lack of appropriate support

This was a group of mothers with addiction issues; however, many also had co-occurring mental and/or physical health issues. Several women also needed support in relation to domestic abuse or due to the impact of current or previous trauma. Many of the mothers felt that services did not meet their needs, and this also had an impact on their ability to meet their children's needs:

"if I got more help round about my mental health, I don't believe they would ever have been removed." (Julie)

While the mothers generally were positive about their support from addiction services, several mothers mentioned that there was a focus on medication and prescriptions, and their other needs could be missed:

"It is as if they just gave me a prescription and sent me on my way" (Samantha)

"the clinic is busy, its full, so sometimes the appointment would be just in, get your script [prescription] and out the door again. So there was, you know, minimal supports offered and available" (Toni)

However, some mothers acknowledged that additional support was available but not always utilised:

"I would just come in and talk shite just to get my script [prescription] and then go" (Sonja)

The mothers highlighted the challenge for services; service pressures might reduce staff's focus to medication and prescription management, but mothers may have told staff that they thought they wanted to hear; making it difficult for staff to provide mothers with the appropriate support.

Some of the mothers even acknowledged this and felt that staff who were persistent and kept offering services after they refused were essential:

"[Addiction worker] is like a dog with a bone" (Sonja)

Julie: "maybe force it on us a wee bit."
Int: "Force you?"
Julie: "I know that sometimes that can be too much like uh like I was saying that I didn't want to see anybody"

The mothers begrudgingly accepted that without their workers 'doggedly' persisting in offering services then they may not have engaged with treatment.

Service remits were also discussed by several mothers, either due to the lack of joint up working or feeling unable to meet referral criteria due to their addiction:

"I think there is a vicious circle, it is like with seeing psychologists, [addiction workers] telling you that you need to be a good place and they say 'oh you can't do stuff like that'" (Lynne)

"The way I see it is they more see you as just the addict and somebody that is pregnant, and they support you on that a wee bit right, but they don't realise there's a lot of mental health issues going on" (Charlene)

Both mothers conveyed that they perceived their contact with services was frustrating: in Lynne's case she was using substances to cope with her trauma but was unable to access psychological therapy for her trauma while she was using. Similarly, Charlene also felt her needs were not met as the focus on her addiction during her pregnancy meant that her mental health needs were not met.

Not all mothers had the experience of services not meeting their needs, Samantha discussed a "*brilliant*" service with links with addictions, criminal justice and mental health services which meant that Samantha was able to get her needs met in one place:

"They get you, your trauma; they get you linked in with mental health, everything, your addictions, emm the courts, everything, it is just a one-stop-shop" (Samantha)

Several mothers also mentioned the benefits of peer-based services:

"when I went into the recovery stuff, it was other people who had been through exactly the same things and changed their life around, they didn't judge me, they just put their arms round me, gave me a hug and told that everything would be alright, you know 'just keep coming back and doing what you are doing', and every time I went back I just felt like I was at home" (Lisa)

"I was able to talk and chat about how I was feelings with all the stuff with the kids being away because she had been in that situation herself, and now got through it and is working in the field and was doing bloody well and still is" (Toni)

Peer workers and recovery services allowed mothers the opportunity to work with someone who had similar experiences but did not judge them and gave them hope for the future; either that return of child/ren was possible or that life can have value, meaning and worth after child/ren were removed.

3.4.3 Confusion and context

All mothers discussed confusion and context in some form. Going through their transcripts it was clear that many used their interview as a way to try to make sense of the removal of their children but were unable to do so. Many reported finding the process confusing and not fully understanding why their children were removed or how to get them back:

"I can honestly look and say I don't know why they are, even the social worker says it, sitting in the car, his words where 'Shona, people would look at us right now and wonder why we are doing this to you'" (Shona)

Shona was unable to fully understand why her children were removed and indicated that their social worker was also confused. However, despite this confusion there was no plan to return her children to her care.

Julie repeated mentioned her confusion about why her children were removed from her care. Here she compared her childhood experiences with her children's:

"just gave money to stay out all day so as they can smoke Crack and do whatever they want to do and I was left to my own devices, but I look after my kids, they're fed, they're bathed, they're loved, but they got took away from me, I just can't. I just don't get it" (Julie)

To try and clarify this, she discussed this with her children's social worker and asked for clarification and a reason for removal:

"I said to her [social worker] last week 'am I a bad mother? I want you to say it. Am I a bad mother?' and she went 'no', and I went 'did I look after my kids, were they neglected?' and she said 'nope'" (Julie)

Julie's inability to makes sense is apparent when she gets clarification that her children were not neglected, she was not a bad mother and she believed they were loved and cared for, yet her children remained in kinship care without a plan to return them to her and her partner's care.

Mothers also highlighted a lack of understanding of rules and processes, and issues with 'jargon':

"At the beginning it was more confusing to be honest cause I didn't really know what my rights were, what I was allowed to do, what I wasn't allowed to do" (Shona)

As highlighted by Shona, without understanding their rights, mothers were at risk of making mistakes at a time when these mistakes might have an impact on the return of their children.

In addition to not understanding their rights, mothers also struggled with the language and ‘jargon’ used in reports and at meetings:

“not understanding it properly, like I say all these big jargon words that I didn’t have a clue about, nobody being there to be able to sit down and explain step-by-step what was happening, why it was happening” (Lisa)

“it’s all these big complicated words, having that lawyer there she dumbs everything down for me. And it does, it makes you feel better ‘cause you know what you are going into then, you know what you’re sitting talking about, you're not just sitting there hearing all these people talking round about you and feeling exclude excluded from the conversation” (Shona)

The mothers felt this acted as a barrier to their understanding and ability to engage in meetings. The language used meant they felt unprepared for meetings and needed lawyers to act as ‘interpreters’. Without this understanding the mothers were unable to navigate a complex system; where the risk of this confusion could be the return or not of their children.

The mothers also felt that services and workers were confused and lacked context about them and their lives:

“you don’t just get up and go I’m going to become an addict, there’s a lot of shit in there that you have suppressed all the years” (Charlene)

“I didn’t wake up one morning and say that I am going to be this mad raving alky [alcoholic], you know, and make my children’s lives hell. It is something that happened

and I think people in that type of work should have an understanding of both sides" (Lisa)

Mothers also felt that important details and context was missing in reports. For example, Annie discussed the decision by social work to stop her contact visits. She described her anger at this decision and the description of her actions:

"I went 'do you know what you didn't take into consideration that day the fact that when I got raped last year, I locked myself in my room for eight fucking weeks', I says emm 'and then through the trial that lasted two weeks I couldn't fucking make it', and I went 'and you are just putting all that down as if I don't give a fuck', and I said 'there were reasons'" (Annie)

Annie's anger and frustration is apparent here where she feels that the lack of context leads to confusion about her motivations and reasons for missing contact visits. She fears that others will make sense of her absence as a lack of care or desire to spend time with her child, rather than being unable due to the impact of the rape and having to attend court.

Finally, mothers expressed frustration about confusion with endings and continued work with social work. Here Shona describes her confusion about the fact she was informed that she would not get custody of her children but needed to continue to work with her children's social workers:

"they [social work] told me there's no point in fighting 'cause you'll never get them back and I'm like 'well what's the point of me doing all this work then if I'm never going to get them back, then why am I constantly at hearings, why am I constantly at panels', why am I? I was in and out court for the first two year and I was going 'what's all this for then if you are never intending to give me them back?', then why I am going through all these hoops and jumps and doing everything" (Shona)

The mothers felt that confusion had a negative impact on their ability to understand and navigate systems, but confusion about their actions and motivations was used without appropriate context at times disadvantaging them, their children and services ability to work with them.

3.4.4 Unachievable standards

In addition to confusion about the process and language used, mothers felt there was a vagueness about what was needed to either stop their children from being removed or to have them returned to their care. Most of the mothers described feeling there was no plan or description about what was needed, only that what they were doing was wrong.

Several mothers conveyed how even their emotional response to the loss of their children was ‘wrong’. Mothers described feeling punished for being ‘too extreme’ in their responses of either sadness, anger or numbness:

“because I asked for respite, she [social worker] feels that I wasn’t coping, but they were getting me at my lowest point and then I was greeting [crying] and that was showing them that I wasn’t coping.” (Julie)

“I was bawling my eyes out every time I left ma wee boys an I put this wall right in front of me so that when I did leave them I wouldn’t be greeting [crying], I could just let them go into the car, and then I’d bawl [cry] when I got home, but then I’d get told this, told that I had this façade in front ‘ah, you look like a robot, you look cold, you look’. And it wasn’t it was more to protect myself and to protect my boys and I think people take that as well she has no feeling” (Shona)

Mothers felt it was impossible to win and were stuck without an ‘appropriate’ emotional response for the loss of their children and the ongoing challenges associated with the process.

Many mothers felt that nothing they did was good enough for social work:

“I felt like even though I was giving clean urines it still was never good enough, what I was doing, you know, I was never doing anything that suited her [social worker]” (Rachel)

"I think in the past I'd got that like they [social workers] would say one thing and I then I would get a completely different thing, like 'no that's not what we want'" (Sonja)

The mothers described a set of moving goalposts and struggled to work out what social workers wanted from them. This at times resulted in frustration and difficulty with working with social workers, creating a vicious cycle where mothers were unable to meet their standards due to their vague or shifting nature.

3.4.5 Being at war over the child/ren

Most of the mothers made sense of the removal of their children as a battle or war between themselves and social work. Shona, Lisa and Lynne described themselves and their family feeling "*bombarded*" by social work while Toni described the periods of not knowing what was happening with her children as *"no-man's land"*.

"I just felt as though I was always constantly fighting a battle with everybody" (Lisa)

"I felt as if it was more like a war, it was like a battle between who could do the right thing first." (Shona)

Some mothers felt that this could become all-consuming to the point where they lost sight of what they were battling for:

"then I thought 'wait a minute, you are losing sight of why you are here, Toni, you are here for your son'…it had become this huge battle between me and social work." (Toni)

"a battle of the wits, I think that's what it feels like, more just well who can look better, who can come out looking better and for a wee while it didn't feel as if it was for the boys" (Shona)

Mothers also made sense of their responses from social work as punishment for fighting with them; indicating that they believed social workers felt this was a personal battle:

"It got so personal, that's how I felt, they didn't like it that we were fighting against them, I seen, I noticed that they don't like it when you fight against them." (Lynne)

Metaphors were frequently used; often evoking violent imagery. For example, Jess when discussing her interactions with her children's social worker:

"I put a lot, a lot of trust into that woman [social worker] to be kicked in the teeth" (Jess)

"I felt bad enough myself without other people beating me up as well, and that's the feeling that I got as though people were condemning me" (Lisa)

These metaphors were not only used by the mothers. Julie was also described in a violent manner by her children's social worker:

"she says the only way she can describe me at at that point was a ticking tim time bon bomb" (Julie)

Julie stuttered and she struggled to say the words *'ticking time bomb'* as she found this such an offensive description. She returned to this at a later point, conveying anger and offense at this description.

Other mothers discussed the power imbalance between themselves and social work:

"she thrived on power, she thrived on watching me in pain, she fucking got a, to me, a sick sense of pleasure, telling me stuff that she knew I wasn't going to like and watching me suffer, it was a tough relationship we had." (Toni)

Some mothers felt this went further than the expected power imbalance between mothers and services and compared this with previous experiences of abuse:

"There has been numerous occasions that it has been the same people on the panel and I felt kind of the bullied into that bloody residency order" (Charlene)

“I went through a violent relationship and I feel as if I was going through one all over again.” (Shona)

Battles are not inevitable. Toni was able to make sense of her different experience with her children’s new social worker:

“with this current social worker it’s an ‘us’ thing, it’s a ‘we’…it is about working together, she and I.” (Toni)