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The Ghost in Care: Mothers' Experiences of Mental Health and Involvement with Services Following Separation from their Child(ren)

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The Ghost in Care: Mothers' Experiences of Mental Health and Involvement with Services Following Separation from their Child(ren)

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Declaration

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy.

Valeria Malinen

01.06.2023

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Thesis Summary: Mothers' Experiences of Mental Health and Involvement with the Services Following Separation from their Child(ren)

Chapter one is a systematic review of existing qualitative research exploring maternal mental health experience in the post-separation period. Narrative textual synthesis was used to integrate existing studies looking at women's experiences of the post-separation period from the perspective of their emotional, psychological and social health. Although there are differences in methodological rigour, most studies focused on investigating emotional and psychological well-being. A smaller subset of studies included the social dimension of mental health. All but one of the studies were conducted in Anglo-Centric countries, with most participants being White. Some unique perspectives were included from indigenous communities and other minoritised groups. The results are discussed in the context of a Western psychological understanding of disenfranchised grief, compound trauma, and stigma's role in social exclusion.

Chapter two focuses on the mothers' experiences of services following an involuntary separation from their children due to substance use. Seven mothers who have been separated from their children in the past and have now regained contact with their children reflected on their experiences with the services during the post-separation period. The transcripts were analysed using Interpretative Phenomenological Analysis, capturing an individual's lived experience, which helped develop group's experiential themes. These themes shed light on the numerous challenges associated with the multiple layers of the stigma women encountered throughout their involvement with the services. Furthermore, the experiences highlighted the significant impact that even a single individual made on a their recovery journey.

Chapter three offers a space for reflection on researchers' positioning and their role in the qualitative research process. Clinical implications and future research directions were discussed in light of the above findings.

Chapter 1

Systematic Literature Review

The Impact of Separation from Child(ren) on Mothers' Mental Health: A Systematic Review of Qualitative Evidence

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https://academic.oup.com/bjsw/pages/general_instructions

Abstract

Context: A small but growing amount of research in recent years has focused on maternal mental health experience post-separation period. This review sought to combine qualitative research to comprehensively understand mothers' experiences, considering their emotional, psychological, and social aspects of mental health.

Methods: Systematic review using narrative textual synthesis.

Results: 7,018 papers were identified, with 43 full-text articles reviewed. This review included 12 papers. Findings highlighted the emotional experiences of grief, shame, anger and uncertainty. Mothers often faced feelings of powerlessness, lack of purpose and changes in motherhood identity leading to detrimental coping strategies. However, some women could maintain their motherhood identity, which helped them remain resilient and work towards future contact with their children. The review emphasised the role of stigma in social exclusion experiences, the importance of social support, and effective communication from professionals in breaking the cycle of isolation and hopelessness.

Conclusion: This review contributes to a deeper understanding of the complexities surrounding mothers' mental health following separation from their children. It calls for interventions that consider the emotional and psychological experience of separation and address the structural inequalities perpetuating these challenges.

Introduction

In 2021, there were 7,245 looked-after children in Wales, the highest number recorded since 2003 (Welsh Parliament Senedd Research, 2023). Longitudinal cohort studies have revealed that mothers whose children were taken into care were significantly more likely to experience mental health diagnoses, access services (i.e., mental health and GP), and be vulnerable to social factors such as poverty, homelessness, and domestic violence (Wall-Wieler et al., 2017). To date, research has primarily centred on three areas: a) predictors/reasons for custody loss (Larrieu et al., 2008), b) the experience of adoption (Wiley & Baden, 2005), and c) interventions to keep families together (Fox & Ashmore, 2015). Little attention has been paid to mothers' experiences once separated from their child(ren).

Being separated from a child is a time of uncertainty, grief and loss, often resulting in spiralling substance use and a profoundly shameful and isolating experience (Morris, 2018). Child protection services (CPS) primarily focus on the children once they are removed from their parent's care. Parents will often be kept informed, but service support will reduce once the decision to remove a child from their parent's care has been made (Broadhurst & Mason, 2017). Such an approach fails to address the women's needs around maternal mental health, unhelpful coping strategies such as substance misuse, and social situations, which often deteriorate further (Pearson et al., 2021). This, in turn, can become a barrier to reunification (Wall-Wieler, 2018). Furthermore, without understanding and addressing maternal mental health needs, women are likely to be left in a vulnerable position, and in case of a new pregnancy, their child(ren) will likely be removed at birth (Broadhurst et al., 2015). Thus, it is crucial to understand maternal mental health needs to prevent recurrent court proceedings and failing support faced by families who have found themselves having had a child removed from their care.

Objectives

This review aimed to combine existing qualitative research investigating mothers' experiences of being separated from their children and how this affected their mental health. Three components of mental health, as defined by Bauer, Hämmig, and Keyes (2014), were addressed - emotional, psychological, and social health. Textual narrative synthesis (Lucas et al., 2007) was used to summarise mothers' experiences and places them in the expert position allowing them to tell their stories (Popay et al., 2006; Parr, 2022). These findings can facilitate further research on interventions that support mothers and families impacted by child removal, resulting in better outcomes for both the mothers and children.

In summary, this review aimed to meet two objectives. Firstly, it aimed to combine findings from mothers' experiences and authors' interpretations from primary qualitative studies to better understand the impact on mothers' mental health following enforced separation from a child. And secondly, the review attempted to understand the nuances between mothers' mental health experiences depending on their background.

Methods

General guidelines synthesising qualitative research recommended by Boland, Cherry and Dickson (2017) were implemented whilst conducting and reporting this study. Unlike quantitative systematic reviews, there is no standard approach for synthesising qualitative research (Boland, Cherry & Dickson, 2017). A textual narrative synthesis approach has been chosen to describe the nuances in mothers' mental health experiences after a child has been removed from their care (Gagnier et al., 2013). A systematic review protocol was written using PRISMA-P guidelines (Moher et al., 2015; Appendix A) and submitted to PROSPERO (registration number CRD42023413234; Appendix B).

Eligibility Criteria

To structure the research question for this study, three components of the PICo

(Population, Phenomena of Interest, and Context) mnemonic were used (Porritt, Gomersall &

Lockwood, 2014). Key terms were selected by reviewing article keywords, title language and

consultation with two clinicians working in the field of child welfare.

Table 1. Screening and selection tool based on PICo (Boland, Cherry and Dickson, 2017).

	Include	Exclude
Population	• Women who have been separated from their children following court proceedings. • Including the adult population only (18 years+)	• Studies focusing on mothers aged under 18 years. • Women involved in postpartum adoption proceedings
Phenomena of interest	Any qualitative accounts from women's perspectives about their experience of separation from their child(ren). This will be examined from an emotional, psychological and social perspective (Bauer, Hämmig, & Keyes, 2014). • Emotional perspective including the subjective experience of mental health including emotions and interest in life. • Psychological perspective focusing on self-perception, sense of self-efficacy and ability to cope, being able to create and maintain relationships and life satisfaction. • Social perspective focusing on social integration and social coherence.	• Studies that do not include raw quotes addressing women's accounts of their mental health experience.
Context	• Separation from child(ren) due to concerns raised by child protection services. Location • Worldwide, as long as publication is in English. Setting • Community and outpatient care due to experiences	Setting • Separation at birth • Separation due to incarceration or due to mothers' admittance to long-term psychiatric care. • Separation on the border (papers focusing on refugees) • Excluding papers focusing on the process and experiences prior to court-enforced separation or focusing on the process of child protection investigation
Types of studies	• Qualitative studies that include direct participant quotes. • Peer-reviewed published papers	• Any other study design other than qualitative. • Dissertations, summary articles, position and/or review papers.

In addition to the above, the review search included studies published between the 1st of January 2000 and the 31st of March 2023, with grey literature excluded.

Screening and Selection Tool

Prior to the systematic searches, initial scoping reviews were completed on 02/12/22 and 09/12/22. These included searches via Scopus as well as Google Scholar. Consideration was given to relevant research areas (such as psychology and social work). Following consultation with a librarian, the following databases were included in the systematic search: Web of Science (Core Collection), ProQuest (databases including APA PsycInfo and Social Science Premium Collection) and EBSCOhost (CINAHL Plus).

Boolean operators created the searches, with syntax slightly altered depending on the database. For instance, to manage the search sensitivity, ProQuest required search specifications indicating that only abstract and summary text would be searched for the keywords. This specification was not necessary with the Web of Science. Table 2 provides an example of a syntax used in ProQuest. It was specified that only English-language articles should be included, and only scholarly journals were reviewed.

Table 2. Search term (example) syntax.

Database	Syntax
ProQuest	Wom?n OR mother? OR maternal OR parent? OR "biological mother" OR "birth mother?" AND "mental health" OR health OR anxiety OR depression OR suicidal* OR psychology* OR "well being" OR "well?being" OR "self-esteem" OR "identity" "adjustment" OR "competence" OR "autonomy" OR "life satisfaction" OR "quality of life" OR "QoL" OR "self-efficacy" OR "cope" OR "coping" OR "loneliness" OR "social health" OR "social resource?" OR "social isolation" OR "isolation" OR "stigma" OR "social connectedness" AND "court?enforced separation" OR "child* removal" OR "child* taken in* care" OR "child* removed through court" OR "adoption" OR "foster care" OR "care proceedings" "state? ordered court removal" OR "custody" OR "custody loss" OR "child* protection" OR "child* protection services" OR "living apart from child*" OR "separation" OR "separated" OR adoption OR "placed into care" OR "foster care" OR "removed into care" OR "Child* placed in care" OR "ward of the state"

OR "removed to care" OR "care proceedings" NOT "prison" NOT "separated at the border" NOT "separated at birth" AND qualitative

Searches were saved using the keywords listed in Table 2, and alerts were set up on the following databases: ProQuest, Web of Science and EBSCOhost. To ensure that data was stored systematically, this review followed a record-keeping system proposed by Boland, Cherry and Dickson, 2017. Zotero referencing software stored and managed the search results described below.

In addition to the above-named bibliographic databases, the researchers completed citation chaining for the studies included in the review. This was done both by backward and forward searching.

Data Extraction

The data extraction process was informed by Noyes et al. (2011), and the two questions were kept in mind when extracting data:

1. What is the context of the mother's experiences?

2. Which aspects of mental health are highlighted in this study; a) emotional, b) psychological, and/or c) social health, and what do the findings indicate about those experiences?

The first author focused on the following areas to answer the above questions: context and participants, study design and methods used, and key findings (including emergent themes). The details of the data extraction process can be seen in Appendix C.

Quality Assessment

The first author extracted the data and assessed the eligibility criteria for all retrieved papers. A random subsample was given to the second author, and the third author resolved any disagreements.

The qualitative papers included were quality assessed by (V.M.) using the Joanna Briggs Institute's checklist for qualitative research (Appendix D; Porritt, Gomersall, & Lockwood, 2014). The checklist comprised ten questions assessing the study's methodological quality and the extent to which studies have addressed the possibility of bias. A random subsample was given to the second author (L.H.), and any disagreements were resolved by the third author (C.L.).

Data Synthesis

Following the guidance developed by Popay et al. (2006), three elements were included in this synthesis: (a) developing preliminary synthesis by organising studies to review the context and key findings and their relationship to mental health outcomes; (b) assessing the robustness of the synthesis by providing information on strengths and limitations of the evidence; and (c) exploration of the relationships within the data.

For the preliminary synthesis, the raw data linking to mental health elements were extracted into tables in a standardised manner (Appendix E; Lucas et al., 2007), including columns for the original study authors' findings and reviewers' notes. Data was organised using Bauer, Hämmig, and Keyes's (2014) conceptualisation of mental health. To identify the three components of mental health (emotional, psychological and social), a line-by-line thematic analysis using NVivo 14 was completed on raw quotes from the studies (Popay et al., 2006; Appendix F and G). Once the raw data was integrated, the analysis outcomes were summarised in light of similarities and divergences between studies.

Results

The search identified 7,018 studies. After duplications and screening of the titles and abstracts, 43 full-text articles were assessed (Figure 1). Two further articles were identified through citation searching. Data was extracted from 12 studies, which were included in the review as they met eligibility criteria.

Figure 1. PRISMA diagram (Page et al., 2021).
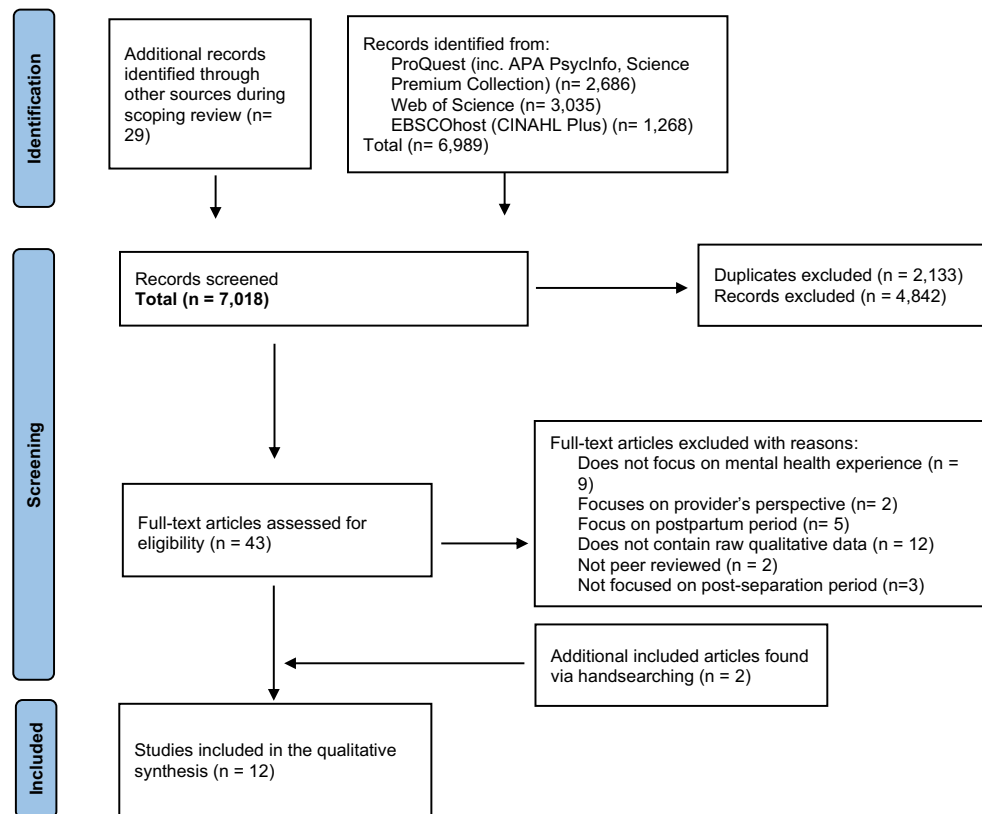
Preliminary Synthesis

All but one study was conducted in Anglo-centric countries; five were conducted in the UK, five in Canada; one in Australia and one cross-national study (with a site in the UK). All studies used either Interpretative Phenomenological Analysis (IPA; $N = 7$) or thematic analysis ($N = 5$, including a study indicative of thematic analysis).

Participant numbers varied across studies from 3 to 72 (a total of 234 participants). It is important to note that the papers by Kenny and Barrington (2018) and Kenny et al. (2015) used the same sample. Women across studies were aged between 18 to 62 years (although

there was missing information for Schofield et al., 2011; Janzen & Melrose, 2017; Honey, Miceli & Mayes, 2021).

Ethnically, the women included in the studies were white ($N = 105$; 44.9%), with some participants from minoritised groups: (17.5%), Asian ($N = 2$), Black only ($N = 5$). Indigenous only ($N = 19$), Black or Indigenous ($N = 8$), Aboriginal ($N = 2$) and 'Other' ($N = 5$). Four studies ($N = 88$; 37.6%; Baum & Burns, 2007; Honey, Miceli & Mayes, 2021; Janzen & Melrose, 2017 and Schofield et al., 2011) did not provide any information on the ethnicity of their participants.

All but two studies (Morgan et al., 2019; Schofield et al., 2011) directly explored mothers' experiences of child custody loss and the impact of this on different aspects of their mental health (emotional, psychological and social experiences). Although Morgan and colleagues (2019) explored the effect of person-centred counselling for this participant group, some aspects of their study matched the inclusion criteria. Therefore, selective quotes were analysed in line with the themes linked to mental health. Similarly, Schofield et al. (2011) considered parents' experiences as opposed to mothers' experiences; however, only selected quotes meeting inclusion criteria were extracted due to a lack of precise quote annotation.

Table 3. Characteristics of papers included in the review.

Authors and date	Methodology	Sample size and population	Aim of research questions	Key findings relevant to the systematic review
Baum & Burns, 2007 UK	Individual semi-structured interviews, IPA	**N = 8** **Age**: 22 to 45 **Ethnicity:** not stated **Population:** Women separated from their children and have a learning disability	Understand the experiences that mothers with learning disabilities have when losing custody of their children	• Managing a disabled identity and separation from children. • Sense of powerlessness and not knowing where to gain support. • Variation in how women identified with their motherhood identity. • Coping with the loss and the intense pain associated with this.
Broadhurst & Mason, 2020 UK	'Analysis was informed by phenomenology's interest in collective accounts of experience and the pursuit of moderate generalisations.'	**N = 72** (from seven local authority areas) **Age:** not stated **Ethnicity:** White N = 62; Black N = 5; Other N = 5 **Population:** Women separated from their children	Analysis of the immediate and longer-term effects of child removal	**Immediate psychosocial crisis:** • Heightened vulnerability and feeling alone • Overwhelmed with loss (including panic attacks), leading to numbing • Self-harm and suicidal ideations **Cumulative and enduring consequences** • The emptiness that pervades the everyday living • Motherhood as a basis for a few positive experiences • Impact on relationships and distorted family roles • Social stigma, isolation and increased risk of homelessness
Honey, Miceli & Mayes, 2021 Australia	Individual semi-structured interviews, IPA	**N = 8** **Age:** Unknown **Ethnicity:** Unknown **Population:** Mothers who have been separated from their children with a previous mental health diagnosis	Understanding mothers living with mental illness experience the phenomenon of having a child removed from their care by child protection services.	• Pain and loss • Having to find ways to cope by either numbing, avoiding or using distractions. • No longer able to follow the same routines • Impact on motherhood identity
Janzen & Melrose, 2017 Canada	Individual semi-structured interviews, IPA	**N = 4** **Age:** unknown **Ethnicity:** unknown **Population**: Mothers separated from their children who are addicted to crack-cocaine	Exploring the grief process for mothers recovering from crack-cocaine addiction who lost custody of their children.	• Three nonlinear stages were identified that the mothers passed through in an iterative manner: betrayal, soul-ache, and reclamation. • Posttraumatic growth associated with recovery
Kenny & Barrington, 2018	Individual semi-structured interviews,	**N = 19** **Age:** 18 to 62 years **Ethnicity:** White N= 11;	To describe women's social relationships	• Disadvantaged social networks after their child was removed • Low support and poverty-related issues • Stigmatization and marginalization of mothers

Authors and date	Methodology	Sample size and population	Aim of research questions	Key findings relevant to the systematic review
Canada	Thematic analysis	Black or Indigenous N= 8 **Population**: Mothers separated from their children who are addicted to substances	and the types and quality of social support in the period following child removal by CPS	
Kenny et al., 2015 Canada	Individual semi-structured interviews, Thematic narrative analysis	**N = 19** **Age:** 18 to 62 years **Ethnicity:** White N= 11; Black or Indigenous N= 8 **Population:** Mothers separated from their children who are addicted to substances	Aims to understand the impacts of child custody loss on the lives of women who use drugs.	• Separation as a traumatic event and the possibility of resulting in further mental health difficulties • Drugs and alcohol as a coping strategy • Challenges with structural vulnerabilities like housing instability, intimate partner violence, and initiation of injection drug use and sex work. • The hope of reunification is essential to women's survival and future aspirations for a better life.
Kenny et al., 2021 Canada	Individual semi-structured interviews, Thematic analysis	**N = 31** **Age:** 27–56 years **Ethnicity:** Non-indigenous White N = 12; Indigenous N= 19 **Population:** women separated from their children and working in the sex trade	Exploring sex workers' health outcomes following child separation.	• Impact on mental and physical health • Implications on women's social conditions such as poverty and social isolation, and displacement add layer to health risks
Memarnia et al., 2015 UK	Individual semi-structured interviews, IPA	**N = 7** **Age**: 29-35 **Ethnicity:** White N = 6; Asian N = 1 **Population:** women separated from their children	Understanding of the experiences of birth mothers whose children are removed from their care	• Feeling isolated and left without support • Coping by disconnecting from emotions • Renegotiating identity • Processing loss: knowing that children are gone but feeling like they are still there.
Morgan et al., 2019 UK	Individual semi-structured interviews, IPA	**N = 5** **Age:** 30-45 **Ethnicity:** White N = 5 **Population:** women separated from their children	Looking at what elements of person-centred counselling are helpful for women whose children are removed from their care	• Feeling alone, judged and let down
Nixon, Radtke & Tutty, 2013 Canada	Unclear, however, the procedure could be indicative of thematic analysis	**N = 9** **Age:** 21 to 43 **Ethnicity:** White N = 7; Aboriginal N=2	To document and analyse these experiences of grief and loss among abused mothers involved with CPS.	• Experiences of loss • A sense of guilt linked to an inability to mother their children • Identity as mothers • Serious health concerns

Authors and date	Methodology	Sample size and population	Aim of research questions	Key findings relevant to the systematic review
		Population: women separated from their children due to allegations of children witnessing domestic abuse		
Schofield et al., 2011 UK, Norway and Sweden	Individual semi-structured interviews + Focus groups (UK only), thematic analysis	**UK N =32; Norway N = 20 and Sweden N= 16** **Age:** unknown **Ethnicity:** Unknown **Population:** parents whose children have been placed in foster care.	Exploring parents' experiences of child welfare systems and the impact it had on them across three countries.	• Despite different child welfare systems (in the UK focus on the child, vs Nordic countries focus on the family) and cultures, the psychological impact of managing loss and a threatened identity were very similar. • Coping strategies vary from low mood, suicidal ideations, substance use and isolation to throwing themselves into activity and abstinence
Siverns & Morgan, 2021 UK	Individual semi-structured interviews, IPA	**N = 3 mothers (x2 interviews)** **Age:** 21-50 **Ethnicity:** White British N=2; Asian British N =1 **Population:** women with trauma histories separated from their children voluntarily	Understand how women make sense of their motherhood and their decision to place their child in care	• A fractured sense of motherhood highlighted the struggle with mothering identities in line with feelings of disconnection and separation • Living with feelings of failure and shame illuminated the underlying feelings of guilt and shame associated with perceived failings • Becoming nothing and no-one alluded to experiences of disempowerment and dehumanization.

Quality Assessment

A quality assessment checklist and an analysis of the strength and limitations of each study was implemented to assess the quality of the studies. All 12 included studies were assessed for quality using Joanna Briggs Institute's Checklist for qualitative research looking at congruity between the examined elements (see Table 4 for details).

Table 4. Quality assessment summary table.

	Philosophical statement and research methodology	Research methodology and objectives	Methodology and data collection	Methodology and analysis	Methodology and results	Researcher culture or theoretical position	Acknowledging the influence of the researcher on the research and vice versa	Participant voices adequately represented	Ethical?	Conclusions drawn based on analysis and interpretation	Decision
Baum & Burns, 2007	X	√	√	X	√	X	X	X	X	√	SAT
Broadhurst & Mason 2020	√	√	√	√	√	√	√	√	√	√	KP
Honey, Miceli & Mayes, 2021	X	√	√	√	X	X	X	√	√	√	SAT
Janzen & Melrose, 2017	X	√	√	X	√	X	X	√	√	X	SAT
Kenny & Barrington, 2018	X	√	√	√	√	X	X	√	√	√	SAT
Kenny et al., 2015	√	√	√	√	√	√	√	√	√	√	KP
Kenny et al., 2021	X	√	√	√	√	√	√	√	√	√	KP
Memarnia et al., 2015	X	√	√	√	√	X	X	√	X	√	SAT
Morgan et al., 2019	√	√	√	√	√	√	√	√	√	√	SAT*
Nixon, Radtke & Tutty, 2013	X	X	X	X	X	X	X	√	√	X	INS
Schofield et al., 2011	X	√	√	√	√	X	X	X	√	√	SAT
Siverns & Morgan, 2021	√	√	√	√	√	√	√	√	√	√	KP

Note. KP (key paper- conceptually rich); SAT (satisfactory paper); INS (methodologically of insufficient quality) (Malpass et al., 2009)
*Despite the high quality of the paper, it was ranked satisfactory as only part of the paper focused on mental health experience

In general, all but one paper (Nixon, Radtke & Tutty, 2013) had chosen a research methodology appropriate to the objectives outlined for their studies. Namely, Nixon, Radtke and Tutty (2013) did not explicitly state any methodological approach, nor did it position researchers within the analysis process. Most papers demonstrated congruity between the research methodology, the following analysis and the interpretation of results: three exceptions lacked evidence of core principles of their chosen approach, in these cases, IPA.

Firstly, Baum and Burns (2007) and Janzen and Melrose (2017) failed to demonstrate the idiographic nature of IPA, showing little attention to individual stories and the context of participants. Secondly, Honey, Miceli and Mayes (2021) had little evidence of the hermeneutic process of IPA, as there was little interpretation at times beyond the addition of raw quotes.

Few authors (Broadhurst & Mason, 2020; Kenny et al., 2015; Morgan et al., 2019 and Siverns & Morgan, 2021) outlined their philosophical statement and cultural/theoretical position and were able to acknowledge the influence of the researcher on the research (or vice versa); with Kenny and colleagues (2021) failing to report on the philosophical statement. As four of these papers (except for Morgan et al., 2019) directly addressed the systematic review questions, they were identified as key papers. Two (Kenny et al., 2015 and 2021) out of the four key papers were written by the same research group meaning that the outcomes of this review were heavily influenced by their findings. Due to either the methodological weaknesses (more than one area of quality assessment not being met) within the papers or the limited focus on mental health, nine papers were classified as satisfactory quality. This meant that they were analysed after the key papers, and the themes derived from them were likely inevitably influenced by the key papers (Malpass et al., 2009).

Data Richness.

Conceptually all studies offered a meaningful contribution towards the knowledge base (full strength and limitations table can be found in Appendix H). In addition to the methodological strengths and limitations (discussed above), it is worth noting that Broadhurst and Mason (2020), Schofield et al. (2011) and Kenny et al. (2015; 2018; 2021) all had above-average participant numbers ranging from 19 to 72 participants, adding richness to the data. These papers included minority representation from Indigenous, Black and Asian people.

However, the majority of the data was gathered from Anglo-centric countries conceptualising mental health in the context of Western understanding.

Further attempts were made by Siverns and Morgan (2021) and Morgan et al. (2019) to add to data richness. The former offered two interviews to every participant to further deepen their understanding and ensure that participants had time to build trust and rapport, which is essential to sharing sensitive information (Smith, Larkin & Flowers, 2009). The latter ensured that they had active service-user involvement throughout the process to negate researchers' bias.

Providing Differing Perspectives.

Several studies provided differing perspectives on the mother's experience of being separated from their children, although many of the studies did not specify whether the separation was voluntary or involuntary. Siverns and Morgan (2021) specifically focused on women's experiences of voluntarily placing their children into care, adding a valuable understanding of how mothers made sense of this experience. Although many studies focused on the overall impact of losing their child to care, Janzen and Melrose (2017) and Nixon, Radtke & Tutty (2013) explicitly focused on the grief process, adding a layer of understanding to the emotional processing.

Despite most studies focusing on any mothers separated from their children, three studies focused on subpopulations adding a layer of heterogeneity to the sample. Firstly, Baum and Burns (2007) looked at the experiences of women with learning disabilities. It was noted that this population experienced an added sense of powerlessness and feeling lost in the process. Despite these themes being present in other studies, participants in this study felt that they were unable to challenge the authorities due to a lack of understanding of the process and not knowing how to fight for their rights. Secondly, Honey, Miceli and Mayes (2021) explored the loss experience for women with a previous mental health diagnosis. However,

despite this focus, the themes explored in the study were very similar to themes in other studies (see Table 3). Lastly, Kenny et al. (2021) focused on a hard-to-reach and often vulnerable participant group of sex workers, including indigenous communities. Their study found unique experiences for indigenous people who did not conform to Western ideas of mental health. They described the impact more in terms of physical health ('physical sadness'), loss of spirituality and implications on women's social conditions such as poverty and social isolation and displacement, giving an additional layer to health risks.

Findings: Relationships within the Data

All twelve studies included after the quality analysis highlighted themes in line with emotional and psychological well-being (see Table 5), and seven papers explored the impact on the social aspect of mental health.

Table 5. 1st and 2nd order themes present in studies.

1st and 2nd order themes	Number of studies (out of 12) identifying the theme
Emotional	12
Mixture of emotions	3
Emotional impact	12
Psychological	12
Lack of anchors in life	3
Motherhood identity	8
Making sense of emotions	11
Coping	11
Social	8
Breakdown in personal relationships	6
Challenging interactions with professionals	7
Change in social status	6
Social support	2

The following sections explore the concepts behind the themes identified in the studies by looking at 1st- (the emotional, psychological and social aspects of mental health), 2nd- (as highlighted in Table 5) and subsequent 3rd-order themes, which are *italicised* in the findings (Figure 2).

Figure 2. Key themes extracted from the studies.
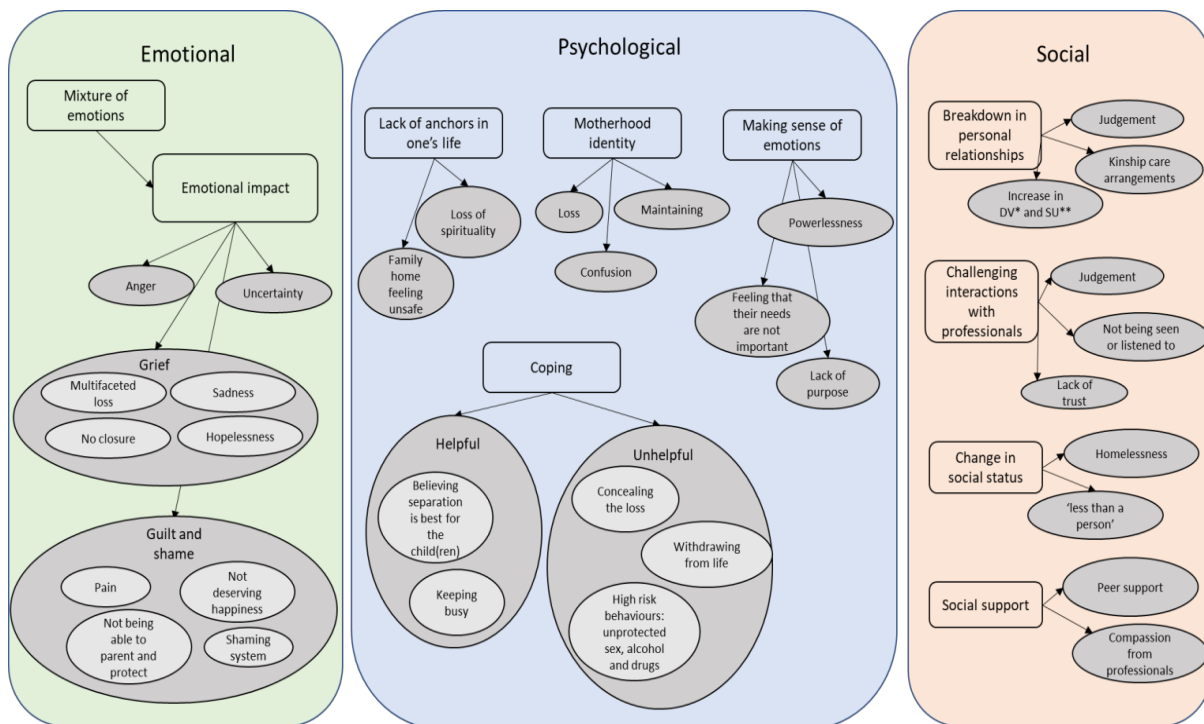
Note. 1st order themes are represented as overarching themes encapsulating three aspects of mental health.

2nd order themes are represented by a rectangular shape underneath the first-order themes.

3rd order themes are represented in circular shapes including grey core themes as well as lighter sub-themes.

*DV = domestic violence

**SU = substance use

Emotional.

All papers included themes around a mixture of emotions and/or emotional impact.

Four major emotional experiences were conceptualised as follows: experience of grief,

ongoing sense of uncertainty, guilt/shame and protecting self with anger.

Table 6. Studies including an emotional element of mental health.

	Baum & Burns, 2007	Broadhurst & Mason 2020	Honey, Miceli & Mayes, 2021	Janzen & Melrose, 2017	Kenny & Barrington, 2018	Kenny et al., 2015	Kenny et al., 2021	Memarnia et al., 2015	Morgan et al., 2019	Nixon, Radtke & Tutty, 2013	Schofield et al., 2011	Siverns & Morgan, 2021	Total
Emotional	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12
Mixture of emotions				✓					✓			✓	3
Emotional impact	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12
Grief	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12
Ongoing sense of uncertainty			✓							✓	✓	✓	4
Guilt/shame		✓			✓	✓	✓	✓				✓	6
Anger				✓		✓				✓			3

Note. N=12.

Mixture of Emotions.

Three papers highlighted a mixture of emotional experiences, including a sense of confusion and conflicting emotions of relief of knowing that it was best for their children and not wanting to let them go at the same time.

Emotional Impact.

Experiences of *grief* were discussed in all papers, including exploration of the multifaceted nature of loss, experiencing repeated triggers of grief years down the line, a lack of closure, intense sadness and hopelessness; '*I felt like for a long time like everything beautiful in me had been taken out. . . I felt like an empty husk.*' (Kenny et al., 2015). Four studies highlighted an ongoing *sense of uncertainty* of not knowing about their children's lives post-separation and the impact this had on these women's ongoing worry and sleepless nights.

Having to cope with these difficult experiences brought up high levels of *guilt and shame*. Six papers talked about the intense pain associated with being unable to parent and protect their children, feeling that they did not deserve happiness after being separated from their children and feeling that the child protection system was set up to shame birth mothers. To cope with the above experiences, women turned to *anger* in an attempt to deflect the blame they were feeling either from themselves, other people or the system:

> '*I hate them [child protection services] so much, and I don't like using that word hate. [crying] It's such a strong word. I know I had a part in it, I know I had a part in what I did. I know. But it—what they said to me, I will never, I will never, I will never forget it. Never.*' (Janzen & Melrose, 2017)

Psychological.

Although almost all studies examined how people made sense of their emotions and coping (except Morgan et al., 2019), only three papers looked at contextual information, such as having anchors in one's life and seven papers focused on motherhood identity.

Table 7. Studies including the psychological element of mental health.

	Baum & Burns, 2007	Broadhurst & Mason 2020	Honey, Miceli & Mayes, 2021	Janzen & Melrose, 2017	Kenny & Barrington, 2018	Kenny et al., 2015	Kenny et al., 2021	Memarnia et al., 2015	Morgan et al., 2019	Nixon, Radtke & Tutty, 2013	Schofield et al., 2011	Siverns & Morgan, 2021	Total
Psychological	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12
Making sense of emotions	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	11
Powerlessness	✓	✓		✓	✓			✓		✓		✓	7
Feeling that their needs are not important		✓		✓	✓			✓				✓	5
Lack of purpose			✓			✓	✓			✓			4
Coping	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	11
Unhelpful	✓	✓	✓	✓	✓	✓	✓			✓		✓	9
Helpful	✓		✓		✓			✓			✓	✓	6
Lack of anchors in life						✓	✓			✓			3
Loss of spirituality								✓					1
Family home feeling unsafe						✓				✓			2
Motherhood identity	✓	✓		✓		✓		✓	✓	✓	✓		8
Loss	✓	✓		✓					✓	✓	✓		6
Confusion						✓		✓		✓			3
Maintaining	✓							✓					2

Note. N=12.

Making Sense of their Emotions.

The first psychological experience sub-theme focused on women's attempt to make sense of their emotions which almost all papers (except for Morgan et al., 2019) focused on. A sense of *powerlessness* (N = 7), feeling that their *needs were not important* (N= 5), and *lack of purpose* (N = 4) were the most common themes. As a result, there was a sense of wanting to give up and withdraw; *'[my children] are not here with me to drive me to do it every morning. You know, my initiative's gone when I wake up.*' (Honey, Miceli & Mayes, 2021). For one woman, there was an ongoing fear of a relapse, and although this had a motivating effect, at times, this meant an increasing amount of pressure on herself; '*Don't fall. Because if you fall. Your kids gonna come and see you on the street and she's gonna like, she's just gonna hate you even more.*' (Kenny & Barrington, 2018). There was a single deviation from this narrative highlighted by Siverns and Morgan (2021), where a few of the

participants felt that they were now in a different space and wished that they could '*could turn back the clocks'* and be the mother they knew they could be now for their children.

Coping.

Unhelpful.

As a result of the majority of the women feeling powerless, unsupported, and lacking purpose, most women were overwhelmed by the emotional impact of the separation from their children described above. As a result of the intense feelings associated with shame, many women tried to conceal their loss in various ways, such as pretending not to have children or that children were with their families; '*I was really ashamed, to say, okay, I've lost my children. I'd just always say, 'oh they're staying with family'* (Kenny et al., 2021). Another widespread coping strategy was associated with withdrawing from life; *'Once they took her away . . . I went into a very deep, deep depression. I didn't talk to nobody . . . just wanted to be left alone'* (Kenny et al., 2015). Such withdrawal manifested in difficulties connecting to people (Kenny et al., 2015; Kenny & Barrington, 2018; Broadhurst & Mason, 2020; Baum & Burns, 2007), loss of a routine (Kenny et al., 2015; 2021; Broadhurst & Mason, 2020; Nixon, Radtke & Tutty, 2013) and trying to run and hide (Kenny et al., 2015; Siverns & Morgan, 2021, Nixon, Radtke & Tutty, 2013). When none of the above worked, there was a sense of giving up, and some women turned to suicidal ideations and self-harm: *'When they take children away, they leave you feeling, like, empty, you've got no reason to wake up in the morning, you've got no reason to, say, live'* (Broadhurst & Mason, 2020). Sense of hopelessness, entrapment and associated pain of being separated from their children meant many women did not see a way out of their situation.

Despite only two papers (Janzen & Melrose, 2017; Kenny & Barrington, 2018) focusing on the substance-misusing population, more than half of the studies highlighted substance misuse and high-risk behaviours such as unsafe sex as one of the main coping

strategies that escalated following separation from children: *'It's what kept me stuck in my addiction because I didn't want to face the reality of it; I had to give up my boys'* (Janzen & Melrose, 2017). As the urgency to soothe and numb increased in response to intense emotions, some women turned to new substances (Broadhurst & Mason, 2020; Honey, Miceli & Mayes, 2021; Kenny et al., 2021; Janzen & Melrose, 2017).

Helpful.

Although initially, the majority of the women needed to turn to any coping strategies available to them, over time, some women were able to identify more helpful coping strategies. To maintain hopefulness for a better future, women seemed to either keep hoping for reunification (Baum & Burns, 2007; Siverns & Morgan, 2021; Memarnia et al., 2015) or that their children had a placement that was able to offer a better life than they could: *'Putting them into care (…) was the right thing to do, it gave them that structure and everything that they, they needed.'* (Siverns & Morgan, 2021).

Some women found more practical ways to cope by keeping themselves busy. Multiple studies highlighted the motivational aspect of working towards a better life or a better version of themselves (Kenny & Barrington, 2018; Memarnia et al., 2015; Schofield et al., 2011; Honey, Miceli & Mayes, 2021) and others talked about volunteering as a helpful strategy to maintain hopefulness and belief that they could still look after children: *'It feels good looking after little kids when someone's looking after your daughter'* (Honey, Miceli & Mayes, 2021). An underlying commonality about keeping themselves busy was a sense of purpose and working towards a goal that helped their well-being.

Lack of Anchors in One's Life and Motherhood Identity.

Losing anchors was an experience described in three of the studies. Two of these studies touched upon a theme of feeling unsafe at home as women described the experiences of hypervigilance and wanting to escape: *'I went insane. I broke down, nearly died. I couldn*

' t stay in my house. I couldn' t be around their clothes . . . I found myself just wandering around looking for them. Even though, you know, they are not there.' (Nixon, Radtke & Tutty, 2013). As a result, these women felt more able to cope in women's shelter than in an environment that carried so many reminders of their loss. One of the studies described a struggle to reconnect with their spirituality; 'I don't think even think I had a spirit, to be honest, you know, I totally lost it.' (Kenny et al., 2021).

In addition to losing the above-described parts of themselves, for many women, there was also a sense of lost motherhood identity and not feeling worthy to be a mum; 'I weren't, you know, good enough to be a mum.' (Schofield et al., 2011). The sense of having lost a part of themselves was across different populations regardless of ethnicity or diagnostic label. Some women experienced confusion about their motherhood role coming from the sense that they no longer knew their children or referred to themselves as a 'part-time mum' (Memarnia et al., 2015). Two studies (Memarnia et al., 2015; Nixon, Radtke & Tutty, 2013) also talked about the challenges their children were experiencing as they no longer knew how to refer to their birth mother during visits resulting in them feeling more like a friend or an aunty. For a small minority of women maintaining their motherhood identity helped their mental health as they continued to feel like; 'I'm still . . . I'm still part of his life' (Memarnia et al., 2015), whether by being updated about their children's activities or receiving photographs as updates. Continuing contact helped these mothers maintain hope for future contact and motivated them to continue working on this.

Social.

Eight papers (Honey, Miceli & Mayes, 2021; Janzen & Melrose, 2017; Kenny et al., 2015; 2021; Kenny & Barrington, 2018; Broadhurst & Mason, 2020, Nixon, Radtke & Tutty, 2013; Siverns & Morgan, 2021) focused on the social aspect of mental health. Four second-order themes were identified from those papers as a contributor to social well-being: a)

breakdown in personal relationships, b) challenging interactions with professionals, c) changes in social status and d) the presence of social support. These elements impacted how well women could adjust to life without their children and make a difference, whether they felt entrapped and isolated or motivated and hopeful towards the future.

Table 8. Studies including the social element of mental health.

	Baum & Burns, 2007	Broadhurst & Mason 2020	Honey, Miceli & Mayes, 2021	Janzen & Melrose, 2017	Kenny & Barrington, 2018	Kenny et al., 2015	Kenny et al., 2021	Memarnia et al., 2015	Morgan et al., 2019	Nixon, Radtke & Tutty, 2013	Schofield et al, 2011	Siverns & Morgan, 2021	Total
Social		✓	✓	✓	✓	✓	✓			✓		✓	8
Breakdown in personal relationships		✓	✓	✓	✓	✓	✓						6
Judgement			✓	✓	✓								3
Kinship care arrangements		✓			✓								2
Increase in domestic violence and substance use					✓	✓	✓						3
Challenging interactions with professionals		✓	✓	✓	✓		✓			✓		✓	7
Judgement		✓			✓								2
Not being seen or listened to			✓		✓							✓	3
Lack of trust		✓		✓			✓			✓			4
Change in social status		✓		✓	✓		✓			✓		✓	6
Homelessness		✓					✓			✓			3
'Less than a person'				✓	✓							✓	3
Social support			✓		✓								2
Peer support			✓		✓								2
Compassion from professionals					✓								1

Note. N = 8

Breakdown in Personal Relationships.

Six studies highlighted an increased strain on women's personal relationships following separation from their children. Three key reasons were identified from the studies. Firstly, some women noticed increased judgement from their family members as they struggled to understand the full complexity of the separation: '*I thought they understood. They didn't understand. I felt so alone at those times.*' (Janzen & Melrose, 2017). As a result, women felt unsupported and alone going through this experience. Secondly, increasing relational strains were noted due to kinship care arrangements as the kin started to hold more power over the child's welfare: '*I thought well...because he's with family, he'll be fine with family, he'll flourish with them. [...] it'll be lovely [...] they said they were going to adopt him. [...] So*

that caused a huge rift within the family' (Broadhurst & Mason, 2020)'. Initially, feeling they had made the best decision for the child and the consequent shift in power dynamics left women in such arrangements feeling powerless and frustrated without knowing how to resolve these challenges. Lastly, women talked about the increase in domestic violence and co-dependent addiction: *'We started cheating on each other, hurting each other, beating each other. [...] We stayed alone… in our little room -all the time'* (Kenny et al., 2021). There was a sense of isolation and not knowing how to process the emotions in a different way apart from numbing or redirecting the blame of the ongoing stressors of judgement, shame, and pain both partners were experiencing. Due to isolation and withdrawal, there was little to no alternative support network available.

Challenging Interactions with Professionals.

The lack of alternative support structures was further complicated due to challenging interactions with professionals (N = 7). It was felt that judgements often preceded professional interactions as women were expected to be '*at their best during the worst time of their life'* (Honey, Miceli & Mayes, 2021). As previously discussed, shortly after separation from their children, women were trying to survive the period of intense grief and loss, which made it challenging to fulfil the expectations set by child protection services. However, even once they started working on themselves and making changes, it was felt that they were rarely given a second chance: *'They [CPS] are still judging me and keep dragging up about (child 1). I mean I don't how they expect me to, like, make sure things go right with (child 2), when they keep dragging up about his brother'* (Broadhurst & Mason, 2020). There was a sense that professionals were often unwilling to hear what was said and instead were following the information in the files. As a result, a mutual lack of trust further isolated women from any potential support networks.

Changes in Social Status.

For some women, there was a deterioration not only in their emotional and psychological well-being but also changes in their social status and how they felt they were viewed by other people (Broadhurst & Mason, 2020; Kenny et al., 2021; Kenny & Barrington, 2018; Siverns & Morgan, 2021; Janzen & Melrose, 2017; Nixon, Radtke & Tutty, 2013). For some, this has meant a loss of home either due to changes in benefits entitlement, depleted finances following increased substance use or trauma-related symptoms stopping them from being able to return to the house that was once a family home: *'Every time I got paid, I started smoking crack and I started drinking a lot and I lost my housing. We had a beautiful townhouse two-bedroom home […] and… ended up homeless.'* (Kenny et al., 2021).

It was felt that others started to see them as '*less than a person'* (Siverns & Morgan, 2021) as they felt ostracised from the communities and experienced inflexible prejudices from the general population as well as friends and family: *'They [friends] could never look at you with the same eyes again, and then people are always thinking in the background of their minds…how bad a mother could she have been.'* (Kenny & Barrington, 2018). These beliefs and experiences stopped many women from reaching out to people who have previously been there to support them, leading to having to cope with the fallout on their own.

Social support.

For a minority of women, effective social support became a key recovery factor. Two elements were identified from the two studies mentioning helpful factors following separation from the child (Honey, Miceli & Mayes, 2021; Kenny & Barrington, 2018): peer support and compassion and open communication from professionals. Having someone there to normalise their experience helped ease the sense of shame forcing so many women to isolate and withdraw: 'There is someone who has been through what I have been through and knows what I have been dealing with. *It's just, like, a lifeline.'* (Honey, Miceli & Mayes,

2021). Moving from the internalised stigma of '*what's wrong with me?*' (Kenny & Barrington, 2018) towards understanding that this experience was more complex than women's interactions with professionals and other people initially led them to believe.

Women also found it helpful when they were treated as human beings with elements of '*sensitivity, support and compassion*' (Kenny & Barrington, 2018). A general lack of judgement combined with clear communication about the child's well-being and safety helped birth mothers to feel valued and understood by professionals. As a result, this fostered a sense of trust and cooperation, a rare experience during this emotional and challenging period of having one's child removed from their care.

Discussion

This systematic review aimed to understand mothers' experiences of mental health by examining key components of emotional, psychological and social health (Bauer, Hämmig, & Keyes, 2014). A textual narrative synthesis was chosen to aggregate qualitative research to understand the nuances of mothers' experiences of mental health following separation from their children. The systematic nature of the review enhanced the robustness of this review's findings, the standardised quality assessment of the included studies and ongoing quality checking between the research team (Porritt, Gomersall, & Lockwood, 2014; Boland, Cherry & Dickson, 2017). Despite variations in methodological rigour, most studies examined emotional and psychological well-being, with a subset of studies exploring the social aspect of mental health (Honey, Miceli & Mayes, 2021; Janzen & Melrose, 2017; Kenny et al., 2015; 2021; Kenny & Barrington, 2018; Broadhurst & Mason, 2020; Siverns & Morgan, 2021). Some studies provided unique perspectives, such as exploring the experiences of women voluntarily placing their children into care (Siverns & Morgan, 2021), grief processes (Janzen & Melrose, 2017), experiences of women with learning disabilities (Baum & Burns, 2007), experiences of women with previous mental health diagnoses (Honey, Miceli &

Mayes, 2021), and experiences of sex workers, including indigenous communities (Kenny et al., 2015; 2021; Kenny & Barrington, 2018).

The key concepts of separation experience appeared very similar across the studies. Findings included the emotional impact of loss and the shame accompanying this, the psychological experience of changes in motherhood identity, trying to make sense of and cope with these emotional experiences and the social complexities following separation.

Complex emotional responses to the separation have had some evidence in the existing literature (i.e., Broadhurst & Mason, 2017). Women described the sense of grief that people around them did not understand, and there was a sense that they did not deserve to grieve and should move on. This hidden grief led to concealing the loss to the best of the women's abilities, which meant that no support was available. Literature refers to this as disenfranchised grief that occurs when '*loss is not or cannot be openly acknowledged, physically mourned or socially supported*' (Doka, 1999, pg. 4). Such grief combined with uncertainty towards the child's future and a sense of shame led to intense emotional experiences, which for many women, felt intolerable. To manage these emotions, women either turned to short-term solutions to regulate emotions such as substance use, high-risk sexual behaviour, or completely withdrawing from life. In the moments when this was not possible, and women were faced with a threat, such as professional judgement and anger helped to redirect the sense of blame and protect themselves from an intensifying sense of shame (Tangney et al., 1992).

Making sense of emotions in the context of individual pathology implemented by current child protective services (Lewis & Brady, 2018) meant that women internalised the blame. As a result, women described a sense of powerlessness, losing aspects of themselves such as spirituality and motherhood identity and lacking the purpose to continue. A state of hopelessness and entrapment led to trying to find coping strategies that were often effective

in the short-term but ineffective and even life-threatening in the long term due to high levels of suicide attempts (Wall-Wieler 2018; Wall-Wieler et al., 2018). A small minority maintained their motherhood identity, which helped them to hold onto the idea that separation was the best thing for their child(ren) at the time. This, in turn, enabled them to keep busy by working on themselves in hopes of future contact with their children. These findings echo conclusions drawn in Rajesh's (2022) study that for some women separating from a child can have a beneficial impact on their mental health.

Understanding the nature of compound trauma can help to contextualise the psychological processes women have described in the studies. Compound trauma is a cumulative process starting from someone experiencing adverse experiences (often in their childhood), which they have not been able to recover from and being re-exposed to follow-up traumas where its impact is added or held alongside previous traumas (Cockersell, 2018). These experiences could be viewed in the context of the stress process model (Pearlin et al., 1981), where separation from children not only impacted severe mental distress but also gave rise to secondary adversities such as being stuck in benefits systems, homelessness and increasing domestic violence and substance misuse well evidenced in longitudinal research (*i.e.,* Wall-Wieler et al., 2017).

Subtle variations in the narrative were seen within discussions in Kenny et al. papers (2015; 2021) and Kenny and Barrington's paper (2018), including indigenous communities and Baum and Burns' (2007) paper exploring mental health impact for mothers with learning disabilities. Within indigenous communities, some mothers diverged from Western notions of mental health, emphasising the impact on physical well-being (referred to as 'physical sadness'), loss of spirituality, and the consequences for women's social circumstances, including poverty, social isolation, and displacement. Being bound by several layers of stigma, including systemic neglect of minoritised populations (National Inquiry into Missing

and Murdered Indigenous Women and Girls, 2019) and increased adversities among sex workers (Thumath et al., 2020) meant that child separation for this population may have added stressors impacting on their mental health. Furthermore, living in an individualised Western culture made it challenging to achieve a common language when explaining one's distress, risking underrepresentation of the impact of this group's experiences (Westerman, 2004). Although only one study included people with learning disabilities (Baum & Burns, 2007), it was noted that this population experienced an added sense of powerlessness and feeling lost in the process.

Similarly to the indigenous group, people with intellectual disabilities were a minoritised group who experienced discrimination in multiple areas of their lives, including avoidance or rejection in different contexts (Werner, 2015). An additional challenge for mothers with intellectual disabilities was reliance on other people (often professionals) to explain their rights to full social inclusion. However, stigmatisation by themselves and/or professionals could have prevented access to support (Werner & Scior, 2022).

This review has allowed an increased understanding of the role stigma plays in such social exclusion experiences. A breakdown in personal relationships, challenging interactions with professionals, and increased substance use led to increased isolation, a lack of trust, and a sense of hopelessness from both mothers and professionals. To break this narrative, mothers found it helpful to fall back on social support, including peer support as well as effective and compassionate communication from the professionals. In line with Morris (2018), women found it an empowering experience to start tackling stigma and move away from internalised blame towards understanding their experiences in the context of structural inequalities.

Limitations

A critical limitation of this study due to the narrative textual synthesis methodology is the lack of an extensive literature base. Although this systematic review aimed to use the best

guidance and evidence available, the researchers have implemented this approach to aggregate and interpret the available data. Due to the subjective nature of this methodology, the outcomes are heavily influenced by the authors' critical realist approach and the discussions held within the research team. The second technical limitation was that to provide the highest quality evidence available at this time, this study focused only on published articles that included raw data addressing mental health experiences from mothers' perspectives. This meant that no grey literature, dissertations, opinions or review articles were included, arguably resulting in a loss of a diverse voice.

As only English language studies were included, this may have impacted the type of evidence reviewed within this study, potentially losing nuanced understanding in culturally divergent understanding/conceptualisation of (mental) health. Furthermore, as seen in Schofield et al. (2011), each country has its own ethics committees with very different priorities and risk tolerance for such sensitive topics. This might mean that the evidence summarised in this review is heavily influenced by countries whose ethics committees value the importance of such a topic whilst taking into account participants' safety. Lastly, it is important to note that this study excluded studies focusing explicitly on perinatal loss due to already existing evidence including this population (McGrath-Lone & Ott, 2022). However, due to methodological challenges, not all studies specified the child's age at removal, so it is important to note that the current results might include some participants who had a perinatal loss. Thus, the generalisability of this study is understood in terms of its relevance to individuals and their ability to identify with the aspects of experience (Larkin & Thompson, 2011).

Future research should focus on bringing in differing voices, including different cultural backgrounds and stakeholders' groups and bringing in professional and policymakers' perspectives. Cultural differences in conceptualising and coping with the loss emerged during

this review. Further investigation of these processes can aid in understanding the mental health conceptualisation in different cultures.

Conclusion

In summary, this systematic review explored the qualitative evidence base looking at women's experiences of post-separation period. The review highlighted the profound emotional impact of concealed grief, compounded by societal stigma and disempowerment. The complex interplay between individual trauma, separation, changes in identity and secondary adversities highlighted the multifaceted challenges mothers have to grapple with during this period. Unique perspectives from indigenous communities and populations with learning disabilities offered invaluable insights into the intersectionality of mental health experiences. The role of stigma was apparent in perpetuating isolation and hopelessness, however connecting to a supportive professional or a community showed promise in mitigating these effects. Acknowledging limitations tied to methodology, language bias, and excluded populations, this review underscores the need for further research to embrace diverse voices and cultural nuances, ultimately enhancing our comprehension of mental health experiences within varying contexts.

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Chapter 2

Empirical Study

'Underneath the Addiction, There was Me': Mothers' Experiences of Services

Following an Involuntary Separation from a Child due to Alcohol or Drug use

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Abstract

Context: Due to child protective service procedures focusing on the child, little attention has been given to women's experiences with the services following separation from their children. This knowledge gap has meant a lack of evidence for an effective reunification process for this often hard-to-reach population.

Methods: Seven British mothers separated from their children participated in semi-structured interviews. Data was analysed using Interpretative Phenomenological Analysis.

Results: Five group experiential themes were generated: *power struggle* highlighted the interpersonal challenges and stigma women experienced with professionals; *navigating health and social care systems* emphasised the systemic challenges; *judgement from society* provided context to the above-named themes; and *changing sense of self* illuminated the struggles with motherhood identity. Regaining *a sense of humanity* started to build an understanding of how the smallest meaningful interactions with peers and/or professionals helped to tackle the stigma pertinent throughout the process.

Conclusion: Understanding women's experiences with services increased the understanding of the interplay between the sense of threat and perceived stigma during the post-separation period. This was evident on interpersonal to intrapersonal level and highlighted the importance of professionals understanding their own biases and being able to see women's experiences in the context of their histories.

Introduction

According to the 2020 evidence-based briefing (Wales Centre for Public Policy), Wales has consistently had a higher proportion of children entering care than other UK nations, with a 25% increase from 2014. This difference was attributed to deprivation in the local areas, differences in safeguarding practices and parental challenges, one of which was substance misuse. In addition to the risk factors such as mental health difficulties and domestic violence, substance misusing mothers were more likely to have additional factors contributing to a separation from a child (Canfield et al., 2017). These included the younger age of a first child, criminal justice involvement, mental health difficulties, adverse childhood events and the absence of informal support (Canfield et al., 2017).

Stigma and Substance Misuse

Since mental health difficulties and substance misuse problems often co-occur (Wogen & Restrepo, 2020), it is essential to consider the intersectionality of the stigma experienced by mothers with substance misuse. Intersectionality theory highlights the interaction of social identities within multiple social contexts at the individual, relational, and institutional levels (Collins, 2015). The recent scoping review (Wolfson et al., 2021) identified three layers of external stigma: interpersonal level (i.e., familial and relational influence on accessing services), institutional level (i.e., professionals' attitudes and behaviours and restricting opportunities) and population level (i.e., the negative stereotype of mothers with substance misuse difficulties). In addition to external stigma, it is theorised that women experienced additional internal barriers contributing to self-stigma, such as the interrelationship between substance use, motherhood status, poverty and utilisation of services (Gueta, 2017).

In the context of self-stigma, it is important to note that there is limited evidence focusing on mothers who have been separated from their children due to substance misuse and the impact this had on their motherhood identity. One of the few available studies

conducted by Virokannas (2011) proposed that there might be four motherhood identity categories that were linked with differing behavioural responses: responsible motherhood (asking for help), giving up motherhood (submitting to the outside forces), strategic motherhood (learning to cope) and stigmatised motherhood (fighting back). From this study, it was concluded that a mutually trusting relationship was the key to cooperative partnership. However, it also raised questions about whether current service processes might be excessively threatening to mothers in this predicament. This initial limited evidence can provide a framework when considering parental identity in relation to engagement with services following separation from a child.

Legal Context

For an increased understanding of external stigma and the service context, it is important to put this study into the UK and Wales legal context. Driven by high-profile child death cases and evolving multi-agency safeguarding hubs (MASH), which require an in-depth understanding of families' circumstances, confidentiality limits are often stretched (Munro, 2011). Professionals and family members are scrutinised to ensure children's safety, and information sharing between professionals takes priority over family involvement and ethical considerations (Meysen & Kelly, 2018).

The UK and Wales place importance on securing permanent placements as soon as possible for children who cannot remain with their families through kinship care, long-term fostering, or adoption (Broadhurst & Mason, 2017). This is a stark difference from Nordic countries like Sweden, Denmark and Norway, where more emphasis is placed on the continuing responsibility of birth parents (Wales Centre for Public Policy, 2020). As a result, more effort is put into working with the families to 'repair,' when possible, in those countries. This starkly contrasts British and Welsh policies, where child protection services focus more on 'rescuing' children and placing them in permanent homes.

Previous Research

In the context of current child protection practices and heightened risks of emotional, social and behavioural difficulties (i.e., Brown, Waters & Shelton, 2017) experienced by children in care, it is not surprising that a large proportion of research has focused on understanding and supporting children's needs (NICE, 2015). Less research has been conducted to understand the experiences of birth parents (Enlander, Simonds & Hanna, 2022), and very limited research focuses on the experiences of birth parents who have been separated from their children due to substance misuse (Kenny, Barrington & Green, 2015). Within the UK, Bell and colleagues (2021) were part of action-based research that placed mothers' voices at the centre of support initiatives for birth mothers who experienced successive losses of their children to public care in London. From interviewing 10 mothers, they highlighted the following 'key messages for professionals': mothers wanted clear and honest conversation and more respect as they felt let down by procedures and services once the children were removed. Their study identified the need for developing social work interventions and family support. Despite being a small study, it supplies a good starting point to begin to understand and raise the voices of this population.

Current Research

This study aimed to give a voice to women who have been separated from their children during court procedures and understand their subsequent interactions and engagement with different services.

To do so, three of the following areas were examined. Firstly, the study aimed to understand how mothers made sense of their interactions with different services following separation from their child(ren) due to substance misuse. Secondly, it focused on the impact interaction with the services had on mothers and what they may have needed at the time. Lastly, women's motherhood identity was explored in light of these experiences.

Method

Design

An Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2022) approach was used to analyse a homogenous group in-depth to make sense of women's lived experiences. The methodology drew upon hermeneutic phenomenology, emphasising the importance of understanding the individual within their specific contextual framework (Horrigan-Kelly, Millar & Downing, 2016). Given that so little is understood about the experience of having a child removed for women with substance misuse difficulties and what the service engagement looks like following this event, it was appropriate to begin bridging this gap in knowledge with the experiences of the women themselves. The idiographic nature of IPA has helped to understand individual participant narratives in the broader context of substance misuse, loss process, and subsequent changes and service set-ups.

The researcher's critical realist epistemology (Madill et al., 2000) was well-suited for such a reiterative analytic approach as it acknowledged that the researcher's background and experience would impact the interpretation of participant experiences within their context. As this research was conducted by a researcher's group with experience working in substance misuse services and who have not had personal substance misuse experiences, reflexive discussions and a diary were kept to minimise potential biases and influences on the analytic and interpretative process.

Ethics

Due to the potentially emotive nature of the topic, ethical approval was granted by the following committees: University School Ethics Committee[1], Health Research Authority and Health and Care Research Wales (HCRW)[2] and Research Ethics Committee (REC)[3].

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[1] Proposal number: 2022 17161
[2] IRAS project ID: 316303
[3] REC Reference: 22/NI/0149

Additionally, approval has been granted by a local Research and Development team. This allowed ethical recruitment from both NHS and non-NHS sites.

It was also essential to ensure that participants' confidentiality and anonymity were granted throughout the process, and thus no feedback was provided to participants' case workers regarding their involvement. A distress protocol (Appendix F) was developed as a precautionary measure.

Participants

Purposeful sampling techniques were implemented to recruit a homogenous sample utilising the inclusion and exclusion criteria outlined in Table 1. Participants were recruited via NHS or Third Sector Recovery Community providers.

Table 1. Inclusion and exclusion criteria.

Inclusion Criteria	Exclusion Criteria
- Female, aged between 18-99 - Have been involved in court proceedings within the jurisdiction of the United Kingdom. - Accessed services within North Wales. - Mothers who have had their child(ren) removed through court proceedings. - Mothers who have been in contact with at least one of the following services: substance misuse service, mental health services and/or social services. - Mothers who have (re)gained access to their child(ren). - At least 12 months in recovery from substance misuse as identified by individuals' primary keyworker/third sector worker.	- Ongoing substance misuse and/or unmanaged mental health difficulties requiring active intervention. - Current ongoing custody queries and/or active involvement with a legal dispute in relation to child welfare.

Procedure

Seven participants were recruited via a two-stage opt-in system. Researchers contacted several recruitment sites covering the ethical implications and inclusion/exclusion criteria with professionals to ensure a homogenous group of participants. Participants identified by their charity or case worker were given an information sheet and an initial contact form (Appendix B and C). This allowed the participants to contact researchers independently

without affecting their relationship with their workers. As it was acknowledged that this was a sensitive topic, an additional pre-interview phone call was arranged to develop rapport and to help the participants feel safer speaking about their personal experiences (Larkin & Thompson, 2011). Following the pre-interview phone call, participants were provided with an informed consent form (Appendix C) and followed up by a researcher after 48h to offer an interview time.

The data were collected from semi-structured online interviews (via Microsoft Teams) ranging from 32 - 67 min. The interview schedule was developed and refined in partnership with an expert by experience who had a history of substance misuse difficulties and whose child had been at risk of being placed into care in the past. The interview schedule questions aimed to explore women's experiences of services in the post-separation period. Follow-up questions were asked to elicit the interplay between relational experience with professionals and the potential threat to self (/motherhood) – identity. (Appendix D).

Each transcript was read multiple times to ensure idiographic focus. Initial notes focused on language usage, recurring themes, and interesting points (Appendix G). These were further developed into a series of concise 'experiential statements' (Smith & Nizza, 2021) that captured the significant aspects of the participant's account (Appendix H). Next, the patterns and connections between these themes were examined by grouping statements that seemed to have a meaningful relationship based on the narratives' similarity or divergence (Appendix I). Throughout this clustering process, researchers referred to the original transcript to ensure that interpretations were based on the participant's wording. As a result, a set of clusters were conceptualised, representing experiential themes and sub-themes that were personal to each individual. Once all seven anonymised transcripts were analysed, patterns across participants were identified and clustered into group experiential themes (Appendix J), forming the findings for this research.

Methodological Rigour.

Researchers followed Levitt et al. (2018) criteria for reporting qualitative research to ensure the highest reporting standards. Regular discussions were held between the research team at different stages of the study to ensure that the study aims, data collection, analysis and write-up adhered to principles of the hermeneutic phenomenological framework. Discussions and the research diary helped the first author use reflexivity as a tool for interpretation (Smith, Flowers & Larkin, 2022). To ensure the transparency of the process each step of the analysis was documented (Appendix G- I) and discussed with all authors. Lastly, to maintain an idiographic element of IPA, the researchers committed to the close analytic reading of the quotes and ensured that those were used to illustrate each theme (Nizza, Farr & Smith, 2021).

Results

Demographics

All participants were White British aged between 25 and 49. The mothers had between one and four children (7 mothers had 12 children between them). The legal status ranged from children being returned home to full adoption orders with in-person or letter contact. Most children were separated from their mothers for less than a year, with some ranging from more than one year to indefinitely (see Table 2).

Table 2. Participant characteristics summary.

Characteristics	Value	*N*
Age range (years)	20-29	1
	30-39	4
	40-49	2
Number of children	1	1
	2	4
	3	0
	4	1
Women whose children	Yes	4
were cared for by others	No	3
	≤ 1	6

Separated from child(ren) for (years)	1-2	1
	2-3	1
	3-4	1
	over 4	3

N =7

Most participants started misusing substances at an early age, while two participants

started in their early to mid-20s. Participants' substances of choice were a mixture of alcohol

and polysubstance use. At the time of the interviews, most participants had been substance

free for several years (ranging from one to five years). Participants mainly had the social- and

substance misuse service (SMS) involvement in the past. Only one participant received acute

mental health service involvement soon after being separated from her children (Table 3).

Table 3. Substance misuse specific characteristics summary.

Participant pseudonym	Age bracket	Substance of choice	Started daily use (age)	Substance free (years)	Services involved at the time	Recruited from (NHS or third sector)
Helen	40-49	Alcohol	Since 'teenage years'	4 years	Social services, probation, SMS	third sector
Ali	30-39	Polysubstance- inc. class A drugs	15-year-old	2 years	social services, SMS	third sector
Anna	30-39	Polysubstance- inc. class A drugs	17-year-old	5 years	social services, SMS	NHS
Sandra	40-49	Polysubstance- inc. class A drugs	14-year-old	4 years	social services, SMS	third sector
Gina	30-39	Alcohol	12-year-old	4 years	social services, SMS	NHS
Jen	30-39	Alcohol	Mid-20s	3 years	social services, acute mental health services	third sector
Ffion	20-29	Alcohol	21-year-old	14 months	social services	NHS

Note. Pseudonyms have been used to protect participant identities.

Findings

Women's narratives were influenced by different layers of stigma, including the most pertinent theme of feeling judged by professionals for their substance misuse and loss of custody. Thus, whilst honouring the inductive nature of IPA, the hermeneutic process resulted in researchers interpreting participant group themes in the context of more subtle stigma experiences discussed by participants. As a result, five group experiential themes (see Table 4) were identified linking to different layers of stigma: 1) power struggle (interpersonal stigma), 2) navigating the health and social care systems (institutional stigma), 3) judgement from the society (population level stigma), 4) intersectionality of motherhood and addictions (self-stigma) and 5) regaining a sense of humanity.

Table 4. Summary of Group Experiential Themes and Sub-Themes.

Themes	Sub-Themes
Power Struggle	a) Broken Promises b) Being Perceived as a Lower-Class Citizen c) Reclaiming Power
Navigating Health and Social Care Systems	a) Carrying the Added Burden of Proof b) Inflexibility of the Systems c) Feeling Rejected by the Services
Judgement from Society	
Changing Sense of Self	a) Mother in Name Only
Regaining a Sense of Humanity	

Power Struggle

The first group theme focused on the experiences of power within the system. All women felt that the custody removal process was intimidating and was not there to support their needs. For most women, going through child protection processes meant being accompanied by professionals judging their behaviour and often discussing sensitive

information without their knowledge. Jen described her experience of case conferences as follows:

> *'it's as if you're a ghost and they're all sort of talking about how you parent and what I should do and what's been going on and… I- you're just powerless.'*

Such experience was shared by all women who felt a lack of transparency, collaboration and a sense of powerlessness in that space. Due to women's previous experiences of domestic violence, childhood adverse events and substance misuse-related interpersonal risks, a state of vulnerability was greatly feared. And yet, the child protection service processes put them in a position of vulnerability. In this context, three sub-themes represented interpersonal stigma and stark power differentials between women and professionals: a) broken promises, b) being perceived as a lower-class citizen and c) reclaiming power.

Broken Promises.

All women felt lost and confused, and as Helen put it, '*felt like a rabbit caught in headlights*' following separation from their children. For some women, there was a sense of desperation and guilt in knowing they needed to stop their substance use to reunite with their children. Still, they could not do this without support: '*I loved my children, and I would have done anything for them [but] I couldn't stop using them [drugs].*' (Sandra). Such sense of being controlled by the substances and needing support to break free was shared by Ali, Helen and Jen. Jen said she '*begged them, […] If there's something you can do for me today, regardless of you taking my child, at least help me and put me through rehab.*' The sense of powerlessness, whilst in the depths of addictions, was replicated within the child protection processes and then carried forward into the post-separation period, where women felt left to deal with the reality of living without their children as '*social services just withdrew'* (Anna).

Following intense emotions and worsening substance use, all women came to a point where they felt something needed to change. However, at that point, no more support was available for them. For some women, like Jen, there was a sense that no one cared or believed in her as she did not receive even the support she was entitled to:

'I didn't see anyone. They took her [my daughter] and went and that was it.

Erm, I didn't see social services [...] The social worker was on holiday for four

[out of six weeks of probation]. Yeah. (Laughs) Didn't see anyone.'

Not being followed up or checked upon felt like a message that nobody cared what happened to them next. So, when the mandatory meetings were not scheduled, the women had only themselves to rely upon. In a position where no support was available, women had a sense of 'me versus them' as Gina put it: '*I felt like everyone was against me'.*

It was felt that professionals' beliefs and the service focused on children instead of the family, which meant that little consideration was given to women's experiences. For example, little preparation was given to any changes in custody, and women had to live on the timeline dictated by social services, with little power to influence what was going to happen next. Helen talked about her experience of little consideration being given to how the reunification was done; instead, it felt circumstantial: '*The girls are coming home.' When I was like, 'oh, my God. Amazing, when?' And they [social services] were like 'today*'. Increasing pressure, humiliation and isolation from relationships that may have existed before child separation meant that women felt utterly alone and turned to their only solution – their substance of choice.

Being Perceived as a Lower-Class Citizen.

In their interactions with professionals, all women experienced a sense of othering. For example, Sandra talked about being seen by professionals as a '*lower-class citizen*', indicating that she felt marginalised and devalued as a person. There was a sense that

professionals viewed her as having little hope to improve: '*People look at heroin addicts and crack cocaine addicts like, um, there isn't really any hope here. That people like me don't get better*' (Sandra). This belief was strengthened by the fact that any attempt to be honest about using substances and requesting help meant that women were less likely to see their children, creating a punishing system and discouraging change. Helen, Gina, Ali and Sandra all talked about how following their honest disclosures about using/drinking they felt they were punished through the withdrawal of contact and support: '*It's just like right, 'You cannot see the kids because you're being honest about your drinking which is, which is bad*' (Ali). Being honest seemed to confirm professionals' prejudices. Thus, instead of seeing this as a cry for help, disclosures relating to substance misuse were punished and mutual distrust between the women and professionals ensued, reducing the ability to work together. As a result, in their interactions with professionals' women felt that professionals wanted to get rid of them. For example, Anna shared a view that her request to access methadone was rejected as: '*they [substance misuse] sort of just wanted me off the system, so I wasn't getting it*'. Helen also talked about being seen as stuck in '*a revolving door*' of people who did not want to get better. On reflection, Helen felt that in the context of so few people reaching recovery, it was understandable why professionals were unlikely to hold hope. However, having prejudices about recovery from substance misuse and being seen as '*another addict*' (Ali) meant that professionals were less likely to engage with women beyond their primary professional duty to children.

Such patterns were seen across services, including probation, social services, mental health, substance misuse and within contact centres. Women felt that professional interactions lacked compassion, potentially due to perceived threats from the women and interpersonal stigma attached to substance misusing mothers.

Reclaiming Power.

In response to feeling powerless and judged, women attempted to reclaim the power in one of the few ways accessible to them at the time, either aggression towards or withdrawal from the services. As a result of a lack of communication and certainty throughout the post-separation period, Anna, Gina, Ffion, Helen and Ali all talked about going into self-protection mode, which paradoxically meant that at the time of highest vulnerability and increased substance use, women felt that no service was willing to engage with them. They were seen as '*the big bad one'* (Ffion) or, as Helen put it:

'*I would like myself now… to a street dog, [...], if you prodded me, I would have bitten you. You know, I was really angry.*' (Helen)

Instead of being able to see the aggression as a response to complex circumstances, multiple women, such as Helen, Ali and Gina, got '*red marks'* on their case notes indicating that they were a risk to professionals: '*I was perceived as not a very nice person. Erm, quite aggressive, antisocial.*' (Gina).

A similar pattern of service disengagement was seen with a different coping strategy - withdrawal. Ffion, Ali and Jen described overwhelming numbness: '*I was so numb and broken. [...] You could look at me and you can see me but inside me, I was just… it's just empty.*' (Ffion). Such numbness robbed some women of any fight that other women could rely on, and as a result, they withdrew from the services. Professionals interpreted this as women not caring for their recovery, resulting in reduced engagement from them.

All women attribute their ability to return from these difficult places to '*luck'* and meeting the right professionals: '*I couldn't have done that without them, like, being there'* (Ffion). Meeting professionals who were aware of their own biases and were willing to give them a chance allowed women to feel that there was someone in their corner who was able to use their power to support them: '*she [child's guardian who was sceptical about Gina] made*

a big point of coming to the rehab and seeing how well I'd done and seeing what's what and

what she's going to recommend next. And she really did help me in my corner' (Gina). With

the support from people who held more power, such as judges, charity workers, and

individual professionals, they could start fighting for their children 'by the rules'. They had to

be patient, humble, and do what was expected of them: '*I absolutely had to just do what they*

said when they said it and I'm still doing it to this very day.' (Gina). Thus, even though

multiple women have regained custody and others have had contact with their children, they

had to do this by playing a role in the system. The women's sense of regained control

developed day-by-day as they worked on their recovery, not because of the system but

despite it.

Navigating Health and Social Care Systems

The second group experiential theme addressed women's challenges in navigating the

health and social care systems following separation from their children while facing

institutional stigma. Three subthemes were conceptualised when exploring the challenges

associated with navigating the health and social care systems that seemed to be heavily

influenced by institutional stigma: a) carrying the additional burden of proof, b) the

inflexibility of the system and c) feeling rejected by services.

Carrying the Added Burden of Proof.

It was a common experience for women to have to prove their credibility once they

were seen as an addict and a mother who was '*incapable mum'*. For example, Ffion believed

that she had not been taken seriously by either the police or social services when she

expressed her concerns about her daughter's safety and needed the court to order a repeat

investigation to uncover suspected abuse. She felt that to gain credibility, she needed to get

sober and get the court on her side for the safeguarding process to begin properly: *Having to*

prove credibility 'Look, I'm back. I'm okay. I'm staying clean. I'm alright. You can blood test

me'. Trying to achieve trustworthiness and credibility with the system she did not trust was challenging but necessary. The fact that she said, '*You can blood test me'* indicated Ffion's attempt to achieve an objective measure of credibility as she knew she was unlikely to be believed on her own due to her history.

Ffion, Jen, Sandra and Gina discussed needing to prove that they had made changes and were now in a better position to provide care for their children. However, they all felt that the professionals held on to the historical information written in their files instead of attempting to see them as the people they were at the time:

> '*You don't really get a shot once they've already got a bit of paper in front of them to tell them you're an alcoholic, you're a drug addict, you've got mental health problems*.' (Gina)

Having those labels meant that everything they did was seen through that lens. There was an element of frustration in the face of the stigma and discrimination that they experienced. Human emotions started to carry a meaning that aligned with the narrative professionals already had about the women, and nothing they said or did seem to shift it for a long time:

> '*If I didn't cry or didn't get upset, it would be used against me saying that, um, you know, I don't have any emotion about it. In times when I did cry and I did get upset. It would be said that I'm emotionally unstable.'* (Sandra)

In this excerpt, there was a sense that even in grief and pain, women were expected to play a '*capable mother'* role. However, whatever they did was seen as '*manipulation*' (Gina). This meant that they were not listened to, even after they achieved abstinence. For instance, in Sandra's experience, she was not listened to until a professional intervened and threatened to put in a complaint: '*They [social services] wouldn't return my calls for the first kind of*

nine months when I got into recovery.' Communicating that they have made changes

independently, held little power and were not followed up by social services.

The Inflexibility of the Systems.

A lack of responsiveness from services was understood in light of the system's '*one size*

fits all' approach, showing little flexibility in the processes. For example, Helen reflected on

her experience of seeing her children in '*clinical rooms'* following the same procedure every

time. Such processes felt impersonal and did not facilitate the connection with the children

who were already '*cross*' with their mothers and struggled to come to the contact centres.

Similarly, Ali did not feel supported or empowered in her recovery journey as she felt that

staff were dictating what the recovery journey '*should look like'*:

> *'the doctor was saying that you know, you have to do it like this. You know, this is*
>
> *how it is gonna work'*

What she felt was missing was the understanding that each individual might find

different approaches helpful. For Gina, following an inflexible '*protocol*' meant a high

emotional drain when she was already struggling with intense emotions. In the context of high

levels of emotion, loss of their children and constant sense of surveillance, additional pressure

from the services meant that women did not feel that their voice mattered. For instance, Anna

explained that she had asked for support from social services for a long time before her

children were removed, and her concerns were not listened to: *"Oh, it's fine. It looks okay.*

Everything's fine here." 'I didn't agree to, but it was taken out of my hands.'

Feeling Rejected by the Services.

All women felt that services, particularly social and mental health services, could not

see addiction for what it was to women- an illness. Instead, it was supposed that professionals

saw addiction as a choice—a factor they could control—and if they failed to attain

abstinence, they could be held accountable and blamed:

'Social services seem quite quite sort of stuck in the past, innit. […] And they

don't see it as an illness that it is. They see it as a choice that people are just,

that are just, you know, they're using as a choice.' (Ali)

This notion was shared by every woman interviewed, feeling that this bias may have

contributed to a lack of onward referrals and providing mental health provisions.

In the women's experiences, it seemed that every statutory service involved in their

care worked in isolation, with rare onward referrals and little co-working between services.

For example, Anna, Helen, Gina and Sandra talked about the sense that social services

prioritised their children's safety and any immediate risks but struggled to plan any follow-up

support for mothers. It was felt that you had to be '*bad enough'* to gain additional support

from mental health or addiction services. This prevented service involvement at the earlier

stages: *'I don't remember anyone talking to me about alcohol dependency. I don't remember*

anybody talking to… You know, it was suggested that I had a drinking problem. But because I

wasn't drinking 24 hours around the clock. There were certain elements of services that

couldn't help me.' (Helen).

The notion that substance misuse was separate from mental health meant that women

who needed support could not access therapy unless they went to rehab. Only then did they

feel they could understand their patterns and substance use in the context of their past: '*in*

rehab you got hefty counselling. Every day was like peeling an onion […] you were just

getting stripped down by, bit by bit which was not attractive at the time but I'm very thankful

for it.'. For women who could access mental health or peer support, focusing on

understanding and managing emotions was an invaluable step towards ongoing recovery.

Judgement from Society

Judgement from society was not as explicitly talked about as challenges in interaction with professionals and the systems. Only Sandra and Ffion spoke about their experiences of how they were viewed by general population:

'*When it's a mother [struggling with substance misuse], um, people look at you very differently. […] Everybody in society does*' (Sandra)

The societal perception of a mother was often that they should be nurturing, responsible, and in control, so when a mother struggled with substance misuse, it was felt that she was judged more harshly. Sandra also highlighted how she was seen as lesser than others by not meeting the societal ideal for a mother. This also meant that any attempts to make changes were an uphill battle, as society did not believe she could improve. She was seen as a '*statistic*', one of many drug addicts who would not get better: '*It's really difficult to change your life around when society believes that people like me do not get better*'.

Although only two mothers talked about population-level stigma, the impact could be seen in the above sections discussing the burden of proof and the experiences of othering women in interactions with professionals. Thus, although women sometimes attributed blame to individual professionals, some women, like Helen and Sandra, acknowledged that professionals' biases were understandable in light of their experiences with other women and societal stigma.

Intersectionality of Motherhood and Addictions

In addition to the external stigma faced by the women in the study, another significant finding was the presence of self-stigma. Self-stigma refers to internalising societal stereotypes and negative beliefs about oneself, leading to a diminished sense of self-worth and personal agency (Matthews, 2019). There was a sense for all women that after separation from their children, they had a lot of shame for some time, which made them withdraw and

isolate. This cycle continued as they felt that professionals held little hope for their recovery and saw them mostly through the lens of addiction. Further inflexible service systems and no support meant that this strengthened women's belief that they were not worth helping. This notion was repeated, if not exacerbated, in the general population as some women noticed changes in how people 'on the street' viewed them. The increasing shame cycle meant these prejudices were internalised and/or confirmed previous beliefs about being a '*not good enough*' mother (Sandra, Helen and Ali). This section explores the initial impact on motherhood identity and how this changed over time.

Mother in Name Only.

Different levels of stigma (discussed above) resulted in all of the mothers' internalising a sense of '*not being good enough*' in the early stages of separation. All women felt judged and repeatedly told that they were '*incapable of being a mum*' (Gina). There was a sense that although they were mothers, that was only in name, as they no longer had any control over their children. For example:

> '*I felt like I wasn't a mum like they'd [social services] made me feel that that was it now. […] Like I brought her into the world. I felt like they'd stripped me of that. Like I'd brought her into this world, and that was it.*' (Ffion)

The sense of shame became too much, and as a result, all women reported deterioration in their substance use to numb and increased isolation. However, after some time, women dealt with this sense of identity in different ways. For Helen, it took some time to see herself as a mother as her children were returned unexpectedly, and they had to learn to live together again:

> '*I did feel like I'd been stripped right back. So, when they came home, it was like having to grow newborn babies, really. And not knowing how to manage it.*'

From her experience, there was a sense of trying to re-establish who she was as a sober mother. There was a shift from someone numb and unavailable to someone present and experiencing life with all the accompanying emotions. Helen felt that by going through everything she did, she could '*wake-up*' and see that she was not a good mother for her children at the time and now had an opportunity to change things for her and her children.

For others, regaining their motherhood identity meant having to fight. For instance, Anna and Ffion experienced similar patterns of shame as described above:

> '*I do feel a lot better about myself now than I did before. I suffered a lot of guilt, stuff like that. I blamed myself for everything, but then I realised it wasn't just me; I was let down as well.*' (Anna)

Understanding that she was not the only one who had gone through this experience helped her to recognise that she was let down by the system and regain some energy to fight for her kids again. Similar normalisation processes were experienced by all women, either with the help of professionals or peer support groups. There was also a recognition that things beyond their control may contribute to their difficulties, and it is not as simple as the fact that they were not a good enough mother.

Regaining a Sense of Humanity

Changes in perceived stigma were linked to recovery and support provided by individual professionals (both in statutory and non-statutory services). A few professionals were willing to take their time to understand these women and their experiences and to show them compassion and encouragement throughout their journey. As a result, mothers felt that they were finally seen as human beings:

> '*[I needed] to be seen as a mum, as a woman. You know, as a daughter, as a, as a sister as… Yeah, as me, you know and underneath the addiction there was me.*' (Helen)

In Helen's exert, motherhood was an important, but not the only part of her identity. There was a sense that addiction was often part of someone that people saw, but beneath that, a mother and family member had the same need to connect and engage with a meaningful life. By being able to see beyond addiction, some professionals were able to see a person who needed their support and unwavering encouragement:

> '*it felt like someone wanted to help finally. Someone looked at me and gone,*
>
> "*You're worth helping. I'll fight for you and we'll get you better*" *and I owe*
>
> *her [substance misuse worker] so much*' *(Jen)*

Conveying the belief that someone was worth helping meant this was internalised over time, and women were more likely to feel like they could fight for their recovery and their children. Ffion highlighted that it was not just the unwavering belief and encouragement that was important. Still, she also valued having boundaries and someone expecting her to do things without threatening with punishment:

> '*They've been lovely and great, but they have been- don't get me wrong,*
>
> *they've been stern and hard and I've needed that role model*' *(Ffion)*

It was important for Ffion to see professionals as consistent, available and supportive to start tackling the interpersonal stigma that was so pertinent in most parts of the system. This conveyed that she mattered and that there was nothing inherently bad or wrong with her, tackling the shame associated with stigma.

Discussion

This study identified five group experiential themes: *power struggle, navigating health and social care systems, judgement from society, changing sense of self and regaining a sense of humanity*. The first four of the themes were closely interlinked with different levels of stigma and the last theme focused on the helpful elements that allowed the mothers to regain a sense of humanity. The discussion section will look at these themes in the context of

understanding women's experiences of the services as well as exploring the sense of motherhood identity and helpful elements.

Understanding Women's Experiences of Services

Similar to Canfield et al.'s (2017) findings, many of the interviewed women had experiences of childhood adverse events, and domestic violence, as a result of which they were no strangers to feeling powerless and rejected. These experiences were mirrored during the custody removal process, where a lack of transparency, collaboration, and powerlessness were common. Social services priority was the child's well-being, as opposed to the family unit as a whole (Meysen & Kelly, 2018); the effect of this was that when a child was removed from their mother's care, and after months of intensive work with professionals, all support for the women was withdrawn.

Women's experiences of this period can be understood in the context of Gilbert's (2010) theory for emotional regulation systems: soothe, drive and threat. According to this theory, the threat system refers to activating the body's stress response and the experiences of negative emotions in the face of threats such as child removal, stigma and rejection. The drive system involves pursuing goals and desires when in balance; however, paired with a highly activated threat system, it can result in a 'threat-based drive'. This state uses the drive system to escape the sense of danger, often by using substances (Irons & Lad, 2017). Lastly, soothe system is known as the 'rest and digest system', associated with slowing down and feeling a sense of soothing and calmness. However, accessing this system can be especially challenging for people with past adverse experiences, especially shame-based trauma emerging from different layers of stigma (Irons & Lad, 2017).

The Interplay of Stigma and Threat-Based Responses.

For participants, stigma played out in multiple settings, from personal and professional relationships to strangers, highlighting all four stigma levels discussed by Wolfson et al.

(2021). It was evident that women experienced interpersonal and institutional stigma from professionals and when interacting with the child protection systems. For women who experienced abandonment and high levels of distrust, going through court processes and seeing that their needs were not prioritised further fed into a belief that they were not worthy of support – *a lower class citizen*. As services *broke their promises* to deliver on the post-separation support, this may have further compounded the trauma of child removal and reaffirmed women's belief that they were unimportant (Deblasio, 2018), feeding into self-stigma.

Two systemic challenges hindered women's ability to engage*: inflexibility* and *feeling rejected by the services*. Firstly, women felt that services had a one-size-fits-all approach, lacking responsiveness and personalisation. This meant that women lacked a sense of agency in their recovery and perpetuated the cycle of feeling devalued, going into a threat state, and as a result, trying to get out of it by either being aggressive or giving up, a pattern of coping strategies evidenced in existing literature (Janzen & Melrose, 2017; Kenny et al., 2015). The construct of what a 'good mother' should look like in Anglo-centric culture influenced how service providers viewed mothers without access to their children due to the erroneous belief that substance use was a choice (Nichols et al., 2021). As a result, women's stigmatised identities were evident in their notes (Broadhurst & Mason, 2017), resulting in prejudice and challenges to regain contact even after women recovered. Women felt they had to carry *the additional burden of proof* to be heard by the system. Returning to Gilbert's three-system theory (2010), this can be seen through the lens of accessing the drive system responsible for pursuing goals and accompanied by little wins such as professionals' encouragement. This made women feel hopeful and keep pursuing their goal of regaining access to their children (discussed in more detail below). Achieving this was challenging as extensive stigma experiences perpetuated a sense of shame, an emotion that many women experienced as

threatening. As a result, especially in the initial stages of separation from the children, all women found themselves in the 'threat-based drive system' where they used substances to escape from intense emotions.

Interviews confirmed women's experiences of ongoing stigma within services and the *judgement from a society* where they often felt that they were not seen as human but as 'an addict'. Consequently, laypeople and professionals struggled to take a compassionate stance and see the complexity of women's experiences. Instead, professionals were more likely to hold on to treatment paradigms relying on reductive beliefs regarding the cause of addictions and subsequent accountability models (Bartholow & Huffman, 2021). This likely contributed to the lack of coordination and referrals to mental health and/or third-sector services, hindering comprehensive support for women's mental health and addiction issues. Kenny et al. (2015) conceptualised this cycle as re-traumatisation at the hands of state institutions.

Intersectionality of Motherhood and Addictions

Participants' motherhood identity was deeply affected by external stigma. By measuring themselves against the notion of a 'good mother' in the context of child custody loss and substance use, it was difficult to see themselves as selfless, nurturing, or compassionate. Instead, they internalised a sense of being a *mother in name only* perceiving their lack of parental qualities.

Women dealt with the loss of identity in different ways: a) learning to live with their children after regaining custody and b) acknowledging that other systemic factors contributed to the separation, and thus, the blame was to be distributed. The former strategy can be seen as a more passive way of managing stigma and learning through experience. The latter approach has been noted in the literature as a stigma-mitigating strategy linked to empowerment (Shih, 2004). By seeing one's experiences in the context of the systems that

have let them down, women regained the sense of motherhood identity, which helped them reconnect to their drive system to fight for their children.

Helpful Elements

Similarly to Bell et al. (2021), women in the current study highlighted their challenges in the social, substance misuse and mental health service systems and how devastating it was to be judged and not receive the support they had been promised. After meeting professionals willing to understand them and take their time to see them as human beings, women felt they could *reclaim the power* and a *sense of humanity* lost through the child protection process. By considering complex histories and seeing their behaviour in the context of past experiences, some professionals could put aside their biases and give these women a second chance they were asking for.

Unlike threat and drive systems, which activate people, a vital element of the soothing system was deactivation via social connectedness aided by receiving care, acceptance, kindness and encouragement (Gilbert, 2010). Once women saw that they were listened to, they felt safer and thus were more willing to cooperate. For these women, finding at least one person (or a peer group) who normalised their experiences made a difference in their recovery pathway and their ability to reconnect with their children.

Wider Clinical Implications

Due to the complexities of women's experiences of services, wider clinical implications need to be considered on at least three different levels: healthcare intervention targeting interpersonal as well as intrapersonal difficulties, service configuration and delivery focusing on the system level challenges and policy considerations.

Healthcare Intervention Considerations.

Despite having individual professionals who were open, honest and consistent, most experiences with professionals were seen as threatening. Thus, it is important to consider the

role of professionals during the separation process in the light of attachment theory. A recent systematic review by McGonagle et al., (2019) highlighted that there was some evidence of association between insecure attachment style and effective service engagement. According to attachment theory, early experiences with caregivers' impact on adulthood behaviour and relationships (Flores, 2004).

When service providers function as an attachment figure for women who feel vulnerable and dependent on the service support to help their family, these experiences were likely to trigger challenging relational difficulties (Flores, 2004). Professionals need to be willing to understand women's traumatic experiences, both historical and current, impacting on their current substance misuse and coping strategies which are often seen as aggressive and/or uncooperative. Seeing substance use in the context of suffering, can help professionals to see women's responses in the context of their experiences and access the sense of compassion crucial in facilitating co-working (Carver et al., 2020). Furthermore, being aware of professionals own coping patterns (such as withdrawing in response to aggression) and openness to explore alternative responding can result in women feeling seen. For professionals to be able to see beyond the addiction as the sole cause for the child's removal can help to reduce the re-traumatisation rates highly prevalent in current systems (Kenny et al., 2015).

Service level.

To ensure that the services are able to provide a safe base, it is important to consider the key principles of trauma-informed care (TIC). Trauma awareness, safety, choice and empowerment, and strength-based approaches have been shown to be key elements of providing a trauma-informed services (Harris & Fallot, 2001). For women in this study, these elements were often attributed to individual professionals but rarely associated with the

services, which were often seen as 'mental health' or 'social services'. To deliver a more consistent care in line with TIC principles, it is important to implement it top-down supporting professionals to be able to provide a secure base, based on awareness of trauma and empower individuals to make choices. This approach requires commitment across all levels of an organisation, in addition to logistical difficulties, philosophical challenges reported between mental health and substance misuse treatment approaches need to be considered (Moses et al., 2003).

It is also important to acknowledge that TIC requires professionals to be able to be present and willing to engage with women with highly traumatic histories as well as at times challenging maladaptive coping strategies. Growing emphasis is on staff support and training to mitigate the risks of vicarious trauma amongst professionals (Hopper, Bassuk & Olivet, 2010). There is growing evidence that team formulation (i.e., Araci & Clarke, 2017) and reflective practice (Mann, Gordon & MacLeod, 2009) promote compassion and resilience within the team. This resonates with the notion that nurturing compassion is essential not only for the recipients of care but also for those delivering it, acting as a buffer against the potential toll of vicarious trauma.

Policy level.

In addition to core TIC principles discussed above, more recent publications have included the importance of identity and context within the framework (i.e., Wilson, Fauci, & Goodman, 2015). The importance of staff being able to respond to multiple identities- including motherhood identity, has been highlighted as scarcely explored but important area for recovery. Thus, it is important to consider motherhood as well as the whole family when developing policies for this population.

Placing trauma-informed procedures at the centre of all service delivery can help to bridge the separation between services, commonly experienced by the women. TIC acknowledges that substances and many mental health symptoms may be attempts to cope with trauma (Elliott et al., 2005) and thus should be treated in an integrated way from the beginning. This approach would also align with current social and healthcare policies focusing on improving the collaborative provision of care within the Welsh communities (Social Services and Well-being Wales Act, 2014; Healthier Wales, 2021; Prudent Healthcare, 2016).

Limitations

The results of this study need to be considered in light of its limitations. Notably, all participants in this study were white and British, meaning no cultural differences were explored. Furthermore, as recruitment was based on self-selected participants, the study could capture only a small proportion of experiences from passionate people in a safe environment to speak of their journey. Such self-selection may not be representative of people's experiences overall; however, having a mix of recruitment from statutory and non-statutory services attempted to create a mix of experiences to some extent. Lastly, the scope of this study did not allow an in-depth analysis of motherhood identity nor what women would have found helpful from services. Further research must address these gaps to increase the understanding of women's experiences with the services (see Chapter 3 for additional analysis).

Conclusions

In conclusion, this study explored the complex and multi-layered themes that aimed to understand experiences of mothers navigating the challenges of child custody loss, substance misuse, and stigmatisation. The identified themes highlighted the power struggle, the labyrinthine nature of health and social care systems, societal judgement, evolving self-

perceptions, and the journey to regain a sense of humanity. These themes were found to be deeply connected to various levels of stigma, shaping women's responses and coping strategies. Women's experiences highlight the need for trauma-informed care that recognizes the multifaceted challenges faced by these women and embraces compassionate and holistic approaches to support their recovery and reconnection with their children. Despite the study's limitations, its insights contribute to a more comprehensive understanding of the experiences of these mothers and lay the groundwork for future research and interventions aimed at improving their well-being and the quality of services they receive.

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Chapter 3

Contributions to Theory and Clinical Practice

This paper will address two key areas: a) looking at the process of the research, including researcher positioning as well as reflexivity, and b) exploring the implications and future directions for this population.

Research Process

Starting to write a large-scale research project as an inexperienced researcher whilst completing clinical doctorate training was a fear-provoking task. It was challenging to pick a meaningful and doable topic in the provided timeframe. This resulted in months of meetings and reiterative changes. Finally, an issue in the back of my mind since my placement in substance misuse service emerged to the front. The unfairness, pain, rawness and vulnerability of women who have had their children removed piqued my interest in understanding the available support options. As it transpired, there was very little available for them, as services focused on the risk and safety of the children. I wanted to know more about the dynamic from the women's perspective and how they experienced the links with the services that did not seem to serve their needs.

Systematic Review Process

Conducting a systematic literature review posed challenges, especially concerning the choice of topic and ensuring a rigorous review process was carried out. Firstly, choosing a topic that had a direct link with the empirical paper felt important as it would provide background reading and a deeper understanding of the context for interpersonal and systemic challenges discussed in the second paper. Secondly, adhering to a clear and rigid review process was essential once the topic was chosen. Multiple papers seemed relevant and could have added another layer of conceptualising or understanding to the mental health experiences of women separated from their children. However, these papers could not be included in the review as they did not meet the inclusion criteria. As the aim was to create a

nuanced understanding of mental health experiences, excluding papers was a frustrating but necessary process to ensure the quality of the review.

During the write-up stages of the findings (in both papers), I had multiple moments when I had to take a break due to the emotive content. Part of me felt these breaks were frustrating as they slowed down the write-up to a strict deadline. However, a small part of me was able to be compassionate towards myself and allow for these breaks to help me process, and stay with, the content. There was an increased understanding that even as an impartial reader of the review papers, who did not interview the women in these studies, I ultimately saw why someone would need to numb these intensely emotional experiences as the systemic challenges were stacked against them.

Empirical paper process

Although the emotive experience was similar, if not stronger, during the empirical study, this paper posed very different challenges. Following a delayed ethical process, it was time to find the participants willing to engage in potentially challenging and emotive interviews. The first participants came from charitable services and consisted of women ready to share their knowledge and motivated to create change. As part of the Fellowship movement (including Alcoholics Anonymous and Narcotics Anonymous), their interviews often returned to their learnings from peer support groups and used language typical of the Fellowship (i.e., '*being powerless*'. '*I am an addict*' etc.). Thus, it was essential to explore these statements further in an attempt to unpick what those phrases meant for the individual. This language was less common in participants from the NHS population, who seemed to focus more on individual meaning-making. Despite this difference in the use of language, all women acknowledged the importance of normalising and making sense of their experiences in the context of their past.

Interestingly, one of the key learnings for many was understanding emotions and learning new ways to cope with them. This was also noted in the interview process, where initially, most women were very guarded, and as the interview progressed, they could notice (at times with surprise) what emotions came up for them. Most commonly, it was sadness for their children and lost time that they would never be able to get back. For some, it was residual anger towards what happened, despite most participants (with some exceptions) acknowledging that it was not the individual social workers' fault and that they had their children's interests at heart.

The interviews contained so much rich data that it was challenging to narrow down the write-up. This may be reflected in the fact that this research was unable to address all three aims in adequate depth, which has been acknowledged as a limitation and may need a separate write-up. Furthermore, as a new researcher passionate about this topic, there was a pull to cover too much, not allowing enough depth in the interview for the 'motherhood identity' construct. On reflection, one question, and maybe even one interview, was not enough to develop the trust to explore a concept that, for many women, was still a painful experience. Identity is a complex construct that needs a separate research paper.

Researcher Positioning Statement

To understand the research outcomes, it is important to understand the context of the research team. For instance, the first author in this research comes from a historically collectivistic culture; however, has received higher education in an Anglo-centric country. Although their clinical training was mainly rooted in an individualistic understanding of mental health, they appreciate the systemic approaches and the importance of community connection. This intrinsic value has likely influenced the write-up of both papers, where they identified stigma and systemic barriers as overarching themes impacting both mental health experiences and interactions with professionals. This perspective shed light on the

significance of cultural diversity in interpreting the findings and was negotiated by discussions within the research team, who came from different cultural backgrounds.

Additionally, it is essential to acknowledge that this research has been produced from a critical realist epistemological assumption (Madill, Jordan & Shirley, 2000). The assumption was that although women who have been separated from their children all have their narratives and experiences, to improve our current service delivery, we need to understand their perceived reality to provide better care. Thus, choosing a methodology for both papers reflecting this position was critical. Due to IPA being idiosyncratic and focusing explicitly on the double-hermeneutic nature of the phenomenological analysis (Smith, Flowers & Larkin, 2022), it was a good match with the researcher's positioning.

Similarly, narrative textual synthesis acknowledged that a purely inductive approach does not exist, and the researcher cannot separate themselves from their prior knowledge (Langley, 1999). Instead, with the help of reflexivity discussed below, this was used as a strength and individual experiences were viewed through a lens of the existing knowledge that allowed to build a narrative summarising the mothers' experience of mental health.

When considering systematic review analysis, it was also important to acknowledge that as a doctorate candidate in clinical psychology, the first author already had a strong bias in how they defined mental health and which, out of dozens of definitions of mental health, they were drawn to, settling on a definition including the emotional, psychological and social context. Interestingly, the researcher did not choose a biopsychosocial model, which would have added a layer of analysis relevant to some of the reviewed literature (i.e., Kenny et al., 2015). On reflection, this could have been a desire to pull away from the researcher's original cultural understanding of mental health, which was conceptualised as a physical illness, as they had witnessed the damage such an approach can have on people. In future research, it might be helpful to slow down the process and notice when certain aspects of past

experiences might be biasing one's research process and bring this to research team meetings for further discussion.

Reflexivity

It is important to note that the researchers did not have personal experiences of having children taken into the care system and nor did they have experience with substance misuse. The researchers' main experience with this participant group has been through clinical work in a substance misuse context. To mediate the risk of reproducing the existing inequalities and misinterpretation, an expert by experience was involved as a reflective collaborator during the empirical research set-up (Smith, Flowers & Larkin, 2022). During this collaboration, someone who had been at risk of being separated from their child provided their perspective on the sensitivity of the interview schedule, shaped the research question and discussed how to ensure the participants' comfort throughout this process.

As this research was an emotive topic for both participants and the researcher, it was important to build trust and plan a distress protocol before starting the interviews. To do so, the researcher ensured they had a chance to speak to prospective participants at least once before the interview to review any questions they may have had since reading the participant information sheet and consent form (Smith, Flowers & Larkin, 2022). This contact also allowed the researcher to introduce themselves and give each participant information about the researcher's background and motivation to undertake this research. This approach paid off as one of the participants expressed openly their distrust towards professionals and felt that they needed to know the person before they were willing to share their experiences. Considering the ongoing lack of power this population experienced, as their children were removed and the sense of stigmatisation, it was of utmost importance for the researcher to be transparent and build rapport with the participants. Despite the benefits of transparency and honesty about the researcher's positioning, this also carried a risk that participants may have

wanted to please the researcher and thus try to talk about the topics they thought the
researcher wanted to hear (Onwuegbuzie & Leech, 2007).

As the first author carried a strong sense of duty to enable women who have often
been overlooked and not heard within the system, this meant an additional emotional strain
on the work. It was sometimes challenging to step away from the 'clinician' and stay in the
'research persona' when exploring topics such as loneliness, multiple losses and the sense of
entrapment. This challenge also came up when participants were talking about the services
that the first author had worked in, as their positions and views about these services may have
differed or aligned differently to the researchers' experience of working in the service. To
minimise this bias, the first author kept a reflexive diary and practised mindful awareness in
the present moment. However, despite the best efforts, the first author's position is likely to
have influenced the data analysis and interpretation as many challenges experienced by the
participants aligned with the researcher's clinical experience.

Implications for Clinical Practice

Due to this study's scope, exploring women's perspectives on service improvements
was impossible. Although not part of the write-up in the main paper, this was a topic that
many women felt passionate about sharing and for the services to understand. Women
highlighted two key improvements that would have made the post-separation period feel
more supported: working with the family and promoting values and individual learning for
the professionals (see Table 1). Further subthemes were conceptualised in light of these key
experiential themes developed during IPA analysis.

Table 1. Improvement recommendations

Clinical practice improvement themes	Subthemes
Responding to the Whole Family	a) A Whole Family Support
	b) Coordinated Multi-Agency Approach
Promoting Values Within the Teams and Individual Learning in Professionals	a) Transparent, Consistent and Reliable
	b) Hopefulness and Persistence in Offering Support

Responding to the Whole Family

Current framework focusing on safeguarding children has been effective in ensuring children's physical safety. However, this framework has little space for systemic thinking as it focuses largely on minimising risks (Broadhurst & Mason, 2017). All but one (Ali) of the interviewed women agreed that at the time it was necessary to remove their children from their care to ensure their children's safety and wellbeing. The missing link for these women seemed to be seeing the family as a whole and ensuring that appropriate follow-up support was offered.

Despite the growing literature on the need for professional support for parents and their rehabilitation, as they had repeated appearances in the family courts (Broadhurst & Mason, 2020), no specialised parental support or care is currently available in North Wales. Nevertheless, with no specialist support available, women were expected to be '*at their best during the worst time of their life*' (Honey, Miceli & Mayes, 2021), likely setting them up for further failure. All women highlighted the sense of being left without any support following the separation from their children and felt that whole family support or even a separate social worker allocated to the mother would have been helpful at the time:

'*they need to look after mums more, especially after taking a kid, but even in that*

six weeks period, I didn't see anybody. They didn't- I didn't have support, I just…

I felt like I never had their support; I just had their judgement.' (Jen)

From the participants' perspective, they needed support when their emotions were running high rather than being left alone, when the compounding risks of poverty and homelessness were a reality for many women. A timely, coordinated, multi-agency approach could have ensured that physical safety needs such as housing and food were met (Maslow & Lewis, 1987) before further support was offered. For professionals to be able to see beyond the addiction as the sole cause for the child's removal and see removal as the solution to complex difficulties, they could aid a recovery process by addressing systemic challenges:

'*If there was a way to keep families together, it should involve housing, GPs,*

social services, substance misuse services. Um, people being directed to recovery

groups, narcotics anonymous, AA, rehabs.' (Sandra)

Juliet Young (2022) captured these ideas visually (see Figure 1.) when highlighting the multiple layers to recovery requiring a top-down systemic approach, from policy-making and organisational structures to individual teams and professionals.

Figure 1. Systemic understanding of a whole system approach to recovery (used with permission from Juliet Young)
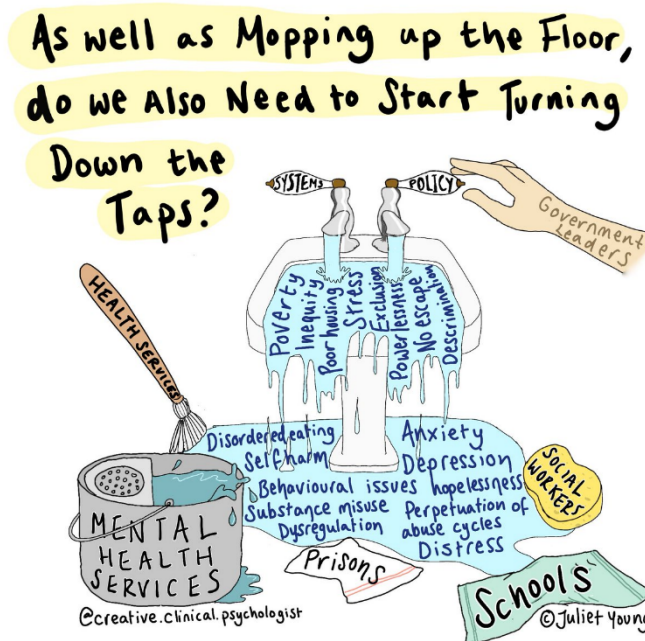
Services communicating and working together can aid professionals' understanding of the family and allow a seamless transition between the services at appropriate points. This approach would also align with current social and healthcare policies focusing on improving the collaborative provision of care within the Welsh communities (Social Services and Well-being Wales Act, 2014; Healthier Wales, 2021; Prudent Healthcare, 2016).

Effective co-working between services has also been identified as one of the key aims outlined by the 'Service Framework for the Treatment of People with a Co-occuring Mental Health and Substance Misuse Problems' (Welsh Government, 2015). This framework acknowledges the need for a preventative, holistic, multidisciplinary approach governed by effective clinical leadership. However, despite the existence of the above-named framework, none of the participants felt that there was an effective communication between the services. Challenges discussed by women in the interviews are well-known to the services but as identified in the framework, there needs to be a whole system approach for effective

implementation. This continues to be a challenge due to the pressures on individual services, despite the efforts made to meet the requirement from the service delivery framework.

Promoting Values within the Teams and Individual Learning in Professionals

Although systemic changes outlined in the Welsh Government Framework (2015) would be crucial for the top-down approach mentioned by the participants, this is not always possible. It is also possible to approach the changes bottom-up, promoting certain team values and creating a safe space for professionals to learn. Firstly, it was felt that the services did not model the expectations they set for the women, such as transparency, consistency, and reliability:

> *'people are in active addiction, it's erratic, but what they need is to be able to*
>
> *have that fixed consistent… You know, if you're gonna say you're gonna be there,*
>
> *be there. You know? Because that's what's expected of us in, in addiction.'*
>
> (Helen)

Providing consistency, transparency, and reliability feeds into trauma-informed care (TIC) discussed in the empirical paper. Hopper, Bassuk and Olivet (2010) conducted a literature review defining key elements of TIC: trauma awareness, emphasis on safety, opportunities to rebuild control and strength-based approach. These elements require professionals to get to know the families beyond the current '*tick box paperwork'* (Helen), understand their own biases and be willing to hold hope for the families. To aid the professionals in taking a position of trust and necessary vulnerability, it is important to acknowledge that, as highlighted in the two papers, current structures promote punishment-based approaches towards both women and professionals. A growing literature base highlights the link between perceived organisational threat and compassion for others, highlighting the need to consider compassion at a systemic level (Henshall et al., 2018). Individual teams and professionals can promote collaborative care by working together.

Maintaining hopefulness for people amidst chaotic lifestyles and compounding losses can be a challenging task for anyone. As human beings, it is natural to protect ourselves when faced with uncertainty, or at times even perceived threat, and retreat. However, due to the chaotic nature of this population, hopefulness was invaluable when professionals were able to do this; it allowed women to feel that there was someone who cared and who was reliable:

> *'I can just remember saying to her [a substance misuse worker], "Have you finished yet? Can I go now?" I was horrendous, that's horrible. But she kept going, and she kept pushing, and she was there, and she was on the phone and she just wouldn't stop, and that's just what I needed because I didn't have anyone else there to do that'* (Gina)

As professionals, taking the first 'no' as rejection and withdrawing due to ever-growing caseloads and demands can be an easy option. Putting support in place without considering its timing will likely be unhelpful. However, understanding the nature of addictions, the function of substances in managing mental health difficulties and considering contextual factors can help professionals hold compassion for this client group.

Clinical Psychologist's Role in Implementation

As clinical psychologists, we could initiate and support some of these changes in relevant roles. At a systemic level, there is an increasing movement towards advocacy and experts by experience involvement in policy development when applying the top-down approach. Implementing a compassionate leadership framework (West, 2021) can help model attentive listening, willingness to help and demonstrate empathy and understanding towards the families and professionals. This position can aid cross-boundary working between teams, creating more efficient multi-agency working within individual teams.

Furthermore, clinical psychologists are well placed to promote and support psychological safety within the team, starting from informal discussions to supporting more

formal spaces such as team formulation and reflective practice sessions. There is growing evidence that team formulation (i.e., Araci & Clarke, 2017) and reflective practice (Mann, Gordon & MacLeod, 2009) promote compassion and resilience within the team.

When working with families and/or individuals, it is important to implement trauma-informed practice and formulation. By providing transparency, consistency and reliability, clinical psychologists can provide a secure base amid chaos, even if the wider system is unable to do so.

Future Research and Theory Development

Missing Voices

Due to my experience working with mothers who have lost custody of their children, my initial interest was drawn towards their stories. However, it is important to note that due to the focus of this thesis, little voice has been given to differing perspectives on this issue, such as next of kin, fathers or professionals. One participant (Helen) reflected that family members in kinship care seem to get even less support than mothers. Having to navigate the tension between a grieving parent and social care demands can be challenging and draining. In Helen's example, this became too much for her family member, and the children had to be moved at short notice. As current literature suggests that kinship care can provide better placement stability, mental health and behavioural development for children (Winokur, Holtan & Batchelder, 2018), it is essential to understand the support structures necessary for kinship carers.

Current literature also pays little attention to the father's experiences in the post-separation period and their possible service involvement. Despite growing evidence of more positive outcomes for children, few child welfare agencies involve fathers in the process (Campbell et al., 2015).

Lastly, as this thesis has explored the interactions with professionals through the recipients' perspective, no insight is provided from the professionals' perspective. Working in inflexible systems set up to focus on child welfare and risk management (Meysen & Kelly, 2018) instead of hands-on engagement with the family can be challenging for the staff working within this context. Although creating distance from the chaos that this client group often experiences can be seen as protective, it is also important to note that it is the relationship with the client that is seen to contribute to a higher sense of work satisfaction (Alexander & Charles, 2009). Further research into professionals' perspectives of working with this population and exploring systemic changes may further build an understanding of more effective co-working.

Systematic Review

The systematic review identified two key areas for further research: widening mental health understanding (with a focus on cultural appropriation) and family-focused child protection systems. As the current study focuses on the emotional, psychological and social elements of mental health, it highlighted the areas less explored when understanding mothers' experiences during the post-separation period. Firstly, an increased understanding of the social aspect of mental health can help deepen the knowledge of how to support the client group who often withdraw and isolate during this period. Secondly, as discussed above, this review did not address the physical aspect of mental health experience, such as somatisation or even conceptualising mental health in physical health terminology. Further research on these topics can strengthen our understanding of this client group's experiences during this period and allow us to consider more targeted interventions.

This review also argued that family-focused approaches are needed to help the services keep the whole family system in mind. Exploring and comparing the impact of

family support systems already in place in the Nordic countries (i.e., Schofield et al., 2011) can inform the development of the most efficacious system in the context of the United Kingdom.

Empirical Paper

This paper highlighted the importance of tackling stigma on many different levels. Although population-level studies can be one of the possible routes, understanding interpersonal and institutional stigma in the context of relevant services will be of crucial importance. Furthering our understanding of what helps professionals to notice and work with their own stigma can aid the willingness to engage even in inflexible systems. From a top-down approach, organisational psychology can assist the changes in the way systems operate to enable the professionals to feel safe and competent in doing their job with an increased understanding that this client group will likely need more time, consistency, transparency and trust than what they are given at this time.

Lastly, deepening an understanding of an interplay between self-stigma, motherhood identity, and the impact this has on the willingness to engage with the services can help professionals to understand mothers' behaviour in the context of their experiences and beliefs and thus hold increased compassion for the client group who often is perceived as 'difficult'.

Compassion-Focused Therapy and Stigma

As can be seen, from the discussion in Chapter 2, Gilberts' (2010) framework of three systems can help to conceptualise the changes mothers experienced when working with the services during the post-separation period. These three systems are part of Gilberts Compassion Focused Therapy approach (CFT; 2010), which recognises the role of shame and self-stigma in emotional difficulties and emphasises the development of self-compassion as a key component of healing.

Currently, there is limited research exploring the efficacy of CFT in reducing self-stigma for mothers who have lost custody. Recently, Riebel et al. (2023) published a multi-centre randomised controlled trial investigating the efficacy and acceptability of group-based CFT on the decrease in self-stigma scores for people with mental health difficulties. Their findings highlighted a significant reduction in self-stigma and shame and improved social inclusion. Despite its promise, this is one of the early studies demonstrating the potential of CFT to reduce self-stigma. Further exploration of this approach and efficacy for mothers who have lost custody would be invaluable in addressing the challenges discussed in this thesis.

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Appendices

Chapter 1: Systematic Review Appendices

Appendix A. PRISMA-P Checklist (Moher et al., 2015)

Section and topic	Item No	Checklist item	Tick if completed
ADMINISTRATIVE INFORMATION			
Title:			
Identification	1a	Identify the report as a protocol of a systematic review	✓
Update	1b	If the protocol is for an update of a previous systematic review, identify as such	X
Registration	2	If registered, provide the name of the registry (such as PROSPERO) and registration number	CRD42023413234
Authors:			
Contact	3a	Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author	✓
Contributions	3b	Describe contributions of protocol authors and identify the guarantor of the review	✓
Amendments	4	If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments	n/a
Support:			
Sources	5a	Indicate sources of financial or other support for the review	n/a
Sponsor	5b	Provide name for the review funder and/or sponsor	n/a
Role of sponsor or funder	5c	Describe roles of funder(s), sponsor(s), and/or institution(s), if any, in developing the protocol	n/a
INTRODUCTION			
Rationale	6	Describe the rationale for the review in the context of what is already known	✓
Objectives	7	Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICOs) – adapted for qualitative systematic review	✓
METHODS			
Eligibility criteria	8	Specify the study characteristics (such as PICo, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review	✓
Information sources	9	Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage	✓
Search strategy	10	Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated	
Study records:			
Data management	11a	Describe the mechanism(s) that will be used to manage records and data throughout the review	✓
Selection process	11b	State the process that will be used for selecting studies (such as two independent reviewers) through each phase of the review (that is, screening, eligibility and inclusion in meta-analysis)	✓
Data collection process	11c	Describe planned method of extracting data from reports (such as piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators	✓
Data items	12	List and define all variables for which data will be sought (such as PICO items, funding sources), any pre-planned data assumptions and simplifications	✓
Outcomes and prioritization	13	List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale	✓
Risk of bias in individual studies	14	Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis	✓
Data synthesis	15a	Describe criteria under which study data will be quantitatively synthesised	n/a
	15b	If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data and methods of combining data from studies, including any planned exploration of consistency (such as I^2, Kendall's τ)	n/a
	15c	Describe any proposed additional analyses (such as sensitivity or subgroup analyses, meta-regression)	n/a
	15d	If quantitative synthesis is not appropriate, describe the type of summary planned	✓
Meta-bias(es)	16	Specify any planned assessment of meta-bias(es) (such as publication bias across studies, selective reporting within studies)	✓
Confidence in cumulative evidence	17	Describe how the strength of the body of evidence will be assessed (such as Joanna Briggs Institute Critical Appraisal Checklist for critical and interpretive research)	

Appendix B. PROSPERO Confirmation

PROSPERO Registration message [413234]

CRD-REGISTER <irss505@york.ac.uk>
Thu 13/04/2023 12:32
To: Valeria Malinen <vlm20yys@bangor.ac.uk>
Dear Ms Malinen,

Thank you for submitting details of your systematic review "The impact of court-enforced separation from child(ren) on women's mental health: a systematic review of qualitative evidence" to the PROSPERO register. We are pleased to confirm that the record will be published on our website within the next hour.

Your registration number is: CRD42023413234

You are free to update the record at any time, all submitted changes will be displayed as the latest version with previous versions available to public view. Please also give brief details of the key changes in the Revision notes facility and remember to update your record when your review is published. You can log in to PROSPERO and access your records at https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.crd.york.ac.uk%2FPROSPERO&data=05%7C01%7Cvlm20yys%40bangor.ac.uk%7C71c391b754a2411a564908db3c12c3ba%7Cc6474c55a9234d2a9bd4ece37148dbb2%7C0%7C0%7C638169823570443225%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=gncS9kB4mHE18Sf4mv2HkwkK1QD3G7S96kJjAEuQcfM%3D&reserved=0.

Comments and feedback on your experience of registering with PROSPERO are welcome at crd-register@york.ac.uk

Best wishes for the successful completion of your review.

Yours sincerely,

Connor Evans
PROSPERO Administrator
Centre for Reviews and Dissemination
University of York
York YO10 5DD
e: CRD-register@york.ac.uk
https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.york.ac.uk%2Finst%2Fcrd&data=05%7C01%7Cvlm20yys%40bangor.ac.uk%7C71c391b754a2411a564908db3c12c3ba%7Cc6474c55a9234d2a9bd4ece37148dbb2%7C0%7C0%7C638169823570443225%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=wRJU5%2FBk%2FgNd7hR2D1B7p4d5yFl8vA8JIJMmg%2BxCzf4%3D&reserved=0

PROSPERO is funded by the National Institute for Health Research and produced by CRD, which is an academic department of the University of York

Appendix C. Data Extraction Table Informed by Noyes et al., (2011)

Data extraction field	Information extracted
Context and participants	• Author(s) and a year of publication • Publishing journal and whether it includes full text or abstract • Participant demographic information: age, sex, ethnicity, any potential mental/physical health diagnosis • Aim of the study
Study design and methods used	• Where the study was conducted • Number of participants • Study design • Study analysis • Theoretical framework of the study and/or researchers' epistemological stance through which data is extracted.

Findings	• The key themes or concepts identified in primary studies:
	  a) First-order interpretations: reflecting participants understanding (including raw quotes)
	  b) Second-order interpretations: interpretations of participants' understanding made by the author (included in discussion and conclusion sections)

Quality of the study	• Using Joanna Briggs Institute's checklist for qualitative research (Porritt, Gomersall, & Lockwood, 2014) • Papers will be annotated as follows (informed by Malpass et al., 2009): KP (key paper- conceptually rich); SAT (satisfactory paper); ? (researchers being uncertain about the paper's relevance); IRR (paper is irrelevant); INS (methodology in this paper is of insufficient quality)

Appendix D. Joanna Briggs Institute's Checklist for Qualitative Research

JBI CRITICAL APPRAISAL CHECKLIST FOR QUALITATIVE RESEARCH

Reviewer_____Date_____

Author_____Year_____ Record Number_____

		Yes	No	Unclear	Not applicable
1.	Is there congruity between the stated philosophical perspective and the research methodology?	☐	☐	☐	☐
2.	Is there congruity between the research methodology and the research question or objectives?	☐	☐	☐	☐
3.	Is there congruity between the research methodology and the methods used to collect data?	☐	☐	☐	☐
4.	Is there congruity between the research methodology and the representation and analysis of data?	☐	☐	☐	☐
5.	Is there congruity between the research methodology and the interpretation of results?	☐	☐	☐	☐
6.	Is there a statement locating the researcher culturally or theoretically?	☐	☐	☐	☐
7.	Is the influence of the researcher on the research, and vice- versa, addressed?	☐	☐	☐	☐
8.	Are participants, and their voices, adequately represented?	☐	☐	☐	☐
9.	Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	☐	☐	☐	☐
10.	Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	☐	☐	☐	☐

Appendix E. Author's Interpretations and Key Themes (Broadhurst & Mason, 2020)

Authors and date	Location	Methodology	Sample size and population	Aim of research questions	Key findings relevant to systematic review	Notes
Broadhurst & Mason 2020	UK	'Analysis was informed by phenomenology's interest in collective accounts of experience and the pursuit of moderate generalisations'	**N** = 72 (from seven local authority areas) **Age:** not stated **Ethnicity:** White N = 62; Black N = 5; Other N = 5 **Population:** Women separated from their children	Analysis of the immediate and longer-term effects of child removal	**Immediate psychosocial crisis:** • Child removal heightened the vulnerability of mothers whose lives were already characterised by multiple and long-standing disadvantages (i.e., substance misuse relapse, homelessness, interpersonal risks) • Self-harm and suicidal ideations • Feeling alone and vulnerable • Overwhelm with loss (including panic attacks) leading to numbing. • Absence of formal support **Cumulative and enduring consequences** • **Role loss** – In the context of fragile and restricted social statuses • emptiness that pervades the everyday living • Motherhood as a basis for a few positive experiences • **Loss of the only family they had** • Restrictions on intimate partner relationships and distorted family roles • Being seen as a 'risky profile' due to mental health difficulties and former care leaver	• Diverse experiences from different regions. One of largest qualitative studies of birth mothers in care proceedings • destroying personal and intimate relationships and the risk of homelessness. • in the absence of formal or informal help, lives spin out of control, grief prompts self-harming behaviours and undermines women's rehabilitation. • Loss of the routine and purpose • Loss of value and meaning • Having to sacrifice one's own relationship for a child to have a kinship care

Appendix F. Raw Quotes Analysis Example for One of the Key Papers (Broadhurst &

Mason, 2020)
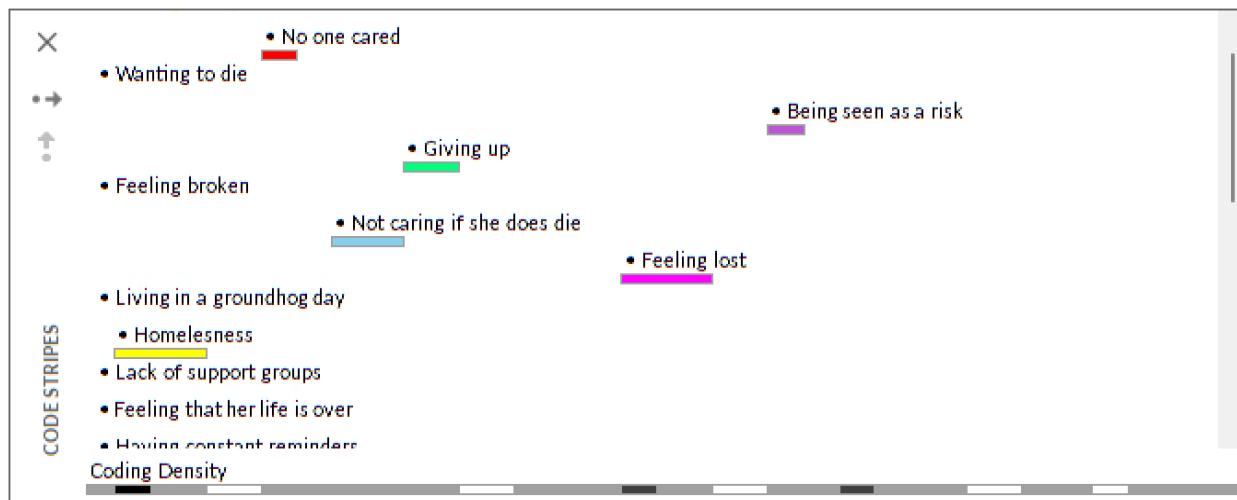
...I drank, took drugs ...was going out. Just making things worse for myself, basically ...trying to forget about everything. I couldn't afford to stay at the flat. I gave it to him – said to him, he can have it. We got it swapped over into his name (ex-partner) and that. (Kim)

Basically, once they took my kids, they left me to rot. I couldn't even go back into my house after that, I'd have panic attacks. So I made myself homeless. I turned to alcohol. I ended up drinking from half past seven in the morning until half past three in the morning. I didn't care where I were ...it killed me. I couldn't even go into my own house. I couldn't. Physically, every time I'd go in, I'd just drop, so I had to go outside ...I'm like, just do what you want to me ...(Hannah)

I think six months after I lost the children I started using heroin ...to block out how I was feeling, not having them ...having the children for eight years and then having nothing. You're not in a routine, you haven't got the dinner to cook, you haven't got to get them up for school; you haven't got the uniforms to sort out. It's just going from being busy to doing absolutely nothing. Sitting around and wondering what was happening. (Olivia)

Because they [children's services] were trying to say I was a risk to be around the baby and they were assessing Steve [baby's father] to have the baby home, so obviously me and Steve couldn't be together because he was getting the baby home. Our relationship was amazing. We did everything together. We went everywhere. It was happy, and then it just went from that to nothing ...because they thought I was a risk [to the baby]. (Gemma)

I thought well...because he's with family, he'll be fine with family, he'll flourish with them. I'm going to get really good contact, because he's with family, it'll be lovely. But the trouble was our brother and sister-in-law listened to everything, social services had gone and said. Well 'we don't believe you're very good parents and you should have baby Freddy' ...they said they were going to adopt him. So we were like 'you're family, you don't adopt family, that's sick'. 'He's already family anyway

Appendix G. Example from Raw Quotes Analysis Aable including 1ˢᵗ, 2ⁿᵈ and 3ʳᵈ Order

1ˢᵗ order	2ⁿᵈ order	3ʳᵈ order	Quotes

Themes

Psychological wellbeing	Lack of anchors in one's life	a) Family home feeling unsafe b) Loss of part of the identity (spirituality)	a) 'made her unable to return to her apartment following the apprehension or to even be in the presence of her daughters' (Kenny et al., 2015) b) 'so spiritually, I don't think even think I had a spirit to be honest, you know, I totally lost it. Everything.' (Kenny et al., 2021)
	Motherhood identity	a) Loss of motherhood identity (internalising failure as a mother) b) Confusion in motherhood role (not knowing her children 2 quotes; not knowing who she is 4 quotes; part-time mum 1 quote)	a) 'I don't feel like a mum at all.' (Baum & Burns, 2007) 'I was a risk to be around the baby' (Broadhurst & Mason, 2020) ' just felt that I wasn't good enough' (Janzen & Melrose, 2017) 'they're not really my children. I just brought them into the world.' (Janzen & Melrose, 2017) 'I had failed. To a certain extent I had failed. If anything I felt sorry for myself for you know, being allowed to bring children into the world that I couldn't keep' (Janzen & Melrose, 2017) 'Cos I suppose when you have your baby took off you, you feel like it's you, yeah? But it's not all you.-' (Morgan et al., 2019) 'I did see myself as not worthy to be a mum, when they first got taken, because I blamed myself and I wasn't worthy. I weren't, you know, good enough to be a mum.' (Schofield, 2011) b) 'I can't wait to see her but I'm dreading it. I don't know how she's going to be, how she's going to be towards me. I don't know if she's going to be angry, happy or sad; I don't know what's going to happen . . . I don't know the children. I don't know what they like, what they don't like.' (Memarnia et al., 2015) 'What's he look like now? How's he getting on at school and . . . ? You know? I don't want to like . . . I know he's with like, adoption people now, yeah, and I don't want to wreck that. But I just want . . . how, how's he getting on? And how's school? You know like a mother? It's not like I'm, you know, looking for him or whatever. I just want a nice photo of him, you know? . . . I've still got his blanket, the smell of him . . .' (Memarnia et al., 2015)

Social wellbeing	Breakdown in personal relationships	a) Due to judgement	a) *'felt like I lost all my siblings you know…They didn't know anything about the situation but they [thought], well if [child protection] had taken the kids it must've been really bad…they don't' understand anything, nor are they trying to understand anything'* (Honey, Miceli & Mayes, 2021) *'I thought they understood. They didn't understand. I felt so alone at those times. Although my family was there for me, I still felt so alone.'* (Janzen & Melrose, 2017) *'Kayla speaks about the emotional fall-out from losing her children and absence of support very bluntly, saying it was "really, really hard" and that "I had no support for what I was experiencing'* (Kenny & Barrington, 2018)
		b) Due to kinship care (familial and intimate relationships)	b) *'I thought well...because he's with family, he'll be fine with family, he'll flourish with them. I'm going to get really good contact, because he's with family, it'll be lovely […] they said they were going to adopt him. So we were like 'you're family, you don't adopt family, that's sick'. 'He's already family anyway so what are you going to adopt your family for?' So that caused a huge rift within the family'* (Broadhurst & Mason, 2020) *'aunt caring for her younger daughter would regularly threaten to return her daughter to foster care: "My aunt was really abusive and she would tell me that I had to do everything she says or that kid's going to the [foster care]'* (Kenny & Barrington, 2018) *'Our relationship was amazing. We did everything together. We went everywhere. It was happy, and then it just went from that to nothing ...because they thought I was a risk [to the baby].'* (Broadhurst & Mason, 2020)
		c) DV and SUD due to increased stress and isolation	c) *'it's like you have no support other than each other and you're both broken'* (Kenny & Barrington, 2018) *'we're drinking and broken, and don't know where to turn under all the stress. And so we started having physical altercations, which started from verbal.'* (Kenny & Barrington, 2018) *'Reflecting on this time period, she explained how increased volatility with her boyfriend (the child's father) emerged alongside the couple's increased*

Appendix H. Strength and Limitations Table

Authors	Key paper vs supplementary paper	Strength	Limitations
Baum & Burns, 2007	Supplementary paper	• Giving voice to women with learning disabilities • Interview number in line with IPA recommendations (N = 8; Smith et al., 2009)	• Quality issues regarding researchers' position and acknowledgement of how this may have impacted the research • The only study not explicitly stating ethics approval • Lack of clarity around the ages when children were removed • No clear annotation of gender or another context
Broadhurst & Mason 2020	Key paper	• Fulfilled all quality checks • Directly addressed the systematic review topic • Extensive interviews (N = 72) with women coming from different backgrounds/geographical areas.	• Lack of clarity around the ages when children were removed and the ages of women • Clearly driven by the author's previous theoretical work potentially biasing the findings
Honey, Miceli & Mayes, 2021	Supplementary paper	• Met majority of quality checks • Explicitly focusing on women with previous mental health diagnosis • Interview number in line with IPA recommendations (N = 8)	• Lack of clarity around the ages when children were removed and the ages of women • The analysis at times felt more thematically focused than IPA layering of interpretations.
Janzen & Melrose, 2017	Supplementary paper	• Explicitly focusing on the grief process adding additional emotional processing information for the review.	• Methodological issues: smaller participant number than recommended for IPA (N = 4) and lack of transparency for the hermeneutic process • Conclusions are drawn into a framework, which was beyond the experiences gathered from the data
Kenny & Barrington, 2018	Key paper	• High methodological rigour • High participant numbers (N = 19) from different backgrounds • Directly addressed the systematic review topic with an additional focus on substance misuse	• No explicit statement around philosophical stance as the main identified drawback
Kenny et al., 2015	Key paper	• High methodological rigour with additional information about philosophical stance • High participant numbers (N = 19) from different backgrounds • Directly addressed the systematic review topic with an additional focus on substance misuse	• Shares the same sample of participants as Kenny and Barrington's (2018) paper
Kenny et al., 2021	Key paper	• High methodological rigour • High participant numbers (N = 31) from different backgrounds • Directly addressed the systematic review topic with an additional focus on sex workers' experience	• Little detail was given about participant characteristics and thus lacking contextual information necessary for this research

Memarnia et al., 2015	Supplementary paper	• Directly addressed the systematic review topic with the recommended number of participants for the chosen methodology (N = 7)	• Lacked researcher statements, epistemological stance and reflections on what the researchers are bringing to the analysis
Morgan et al., 2019	Supplementary paper	• Active service-user involvement in the research process	• The study focused heavily on the treatment outcomes and thus only had small sections relating to mental health experiences.
Schofield et al.,, 2011	Supplementary paper	• Cross-cultural research with a high number of participants (N= 68) • Additional value of the focus group involvement	• Authors' theoretical/cultural positioning unclear • Lack of participant context and annotation
Siverns & Morgan, 2021	Key paper	• High-quality study meeting all quality checks • Directly answered the research question with an additional focus on voluntary placement into care.	• Includes only 3 participants, however, negated by completing two interviews with each participant to develop depth.

Chapter 2: Ethics Appendices

Appendix A. School Ethics Approval

Ethical approval granted for 2022-17161 Mother's experiences of services (Substance Misuse Services, Community Mental Health Services and/or Social Services) following a court-enforced separation from a child due to alcohol or drug use.

ethics@bangor.ac.uk <ethics@bangor.ac.uk>
Sun 14/08/2022 14:43
To: Valeria Malinen <vlm20yys@bangor.ac.uk>

Dear Valeria,

2022-17161 Mother's experiences of services (Substance Misuse Services, Community Mental Health Services and/or Social Services) following a court-enforced separation from a child due to alcohol or drug use.

Your research proposal number 2022-17161
has been reviewed by the [Pre-Aug 2021] School of Psychology Ethics and Research Committee and the committee are now able to confirm ethical and governance approval for the above research on the basis described in the application form, protocol and supporting documentation. This approval lasts for a maximum of three years from this date.

Ethical approval is granted for the study as it was explicitly described in the application

If you wish to make any non-trivial modifications to the research project, please submit an amendment form to the committee, and copies of any of the original documents reviewed which have been altered as a result of the amendment. Please also inform the committee immediately if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

Appendix B. Health Research Authority Approval

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Dr Lee Hogan
School of Psychology
Brigantia Building, Bangor University
Bangor, Gwynedd
LL57 2DG

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

31 October 2022

Dear Dr Hogan

**HRA and Health and Care
Research Wales (HCRW)
Approval Letter**

Study title: Mothers' experiences of services (i.e., Social Services, Substance Misuse Services and/or Community Mental Health Services) following a court-enforced separation from a child due to alcohol or drug use.
IRAS project ID: 316303
Protocol number: n/a
REC reference: 22/NI/0149
Sponsor Bangor University

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:
- Registration of research
- Notifying amendments
- Notifying the end of the study
The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **316303**. Please quote this on all correspondence.

Yours sincerely,

Anna Martin

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: Ms Valeria Malinen

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	Version	Date
Contract/Study Agreement template [PIC agreement]		20 September 2022
Copies of materials calling attention of potential participants to the research [Initial Contact Form]	1	26 June 2022
IRAS Application Form [IRAS_Form_24082022]		24 August 2022
Participant consent form		26 June 2022
Participant information sheet (PIS)	2.0	10 October 2022
Research protocol or project proposal	1.0	15 August 2022

IRAS project ID	316303

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
The NHS involvement in this study is to identify participants and provide recruitment materials, therefore this is PIC activity only.	Organisations will be required to formally confirm capacity and capability, by provision of a signed PIC agreement to the relevant Trial Site. This is expected within 35 days after provision of the PIC agreement.	The sponsor has provided the appropriate model PIC agreement that it intends to use as a subcontract between participating organisations and NHS organisations acting as their Participant Identification Centres (PICs).	Financial arrangements regarding PICs will be detailed in the model PIC agreement.	In line with HRA/HCRW expectations the Chief Investigator may be responsible for all research activities performed at participating NHS organisations of this type.	Only members of the direct care team should undertake identification and initial approach of patients.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.

n/a

Appendix C. Integrated Research Application System Approval

HSC Business Services Organisation

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Health and Social Care Research Ethics Committee A (HSC REC A)

20 October 2022

Dr Lee Hogan
School of Psychology
Brigantia Building, Bangor University
Bangor, Gwynedd
LL57 2DG

Dear Dr Hogan

Study title:	Mothers' experiences of services (i.e., Social Services, Substance Misuse Services and/or Community Mental Health Services) following a court-enforced separation from a child due to alcohol or drug use.
REC reference:	22/NI/0149
Protocol number:	n/a
IRAS project ID:	316303

Thank you for your letter of 17 October 2022, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

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.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the

Office for Research Ethics Committees Northern Ireland (ORECNI)
Lissue Industrial Estate West, 5 Rathdown Walk, LISBURN, BT28 2RF
Tel: (028) 95 361400 **General Email:** info.orecni@hscni.net

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, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [School of Psychology Ethics and Research Committee Approval]		14 August 2022
Copies of materials calling attention of potential participants to the research [Initial Contact Form]	1	26 June 2022
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		01 August 2022
Interview schedules or topic guides for participants	1	26 June 2022
IRAS Application Form [IRAS_Form_17102022]		17 October 2022
Other [Debriefing Form for Participation in a Research Study]	1	26 June 2022
Other [Distress protocol]	1.0	10 October 2022
Other [Incidental Disclosure Protocol]	1.0	10 October 2022
Other Provisional Opinion Response	1.0	17 October 2022
Participant consent form [n/a]	2.0	10 October 2022
Participant information sheet (PIS) [n/a]	2.0	10 October 2022
Research protocol or project proposal	1.0	15 August 2022
Summary CV for Chief Investigator (CI)		25 July 2022
Summary CV for student		12 August 2022

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 research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at: https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

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).

After ethical review: Reporting requirements

Summary CV for supervisor (student research)	22 July 2022

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.

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 Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS project ID: 316303   Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Denise Nesbitt

p.p
Dr Alastair Walker
Chair

Email:RECA@hscni.net

Enclosures:	"After ethical review – guidance for researchers"
Copy to:	Ms Valeria Malinen

Appendix D. Betsi Cadwaladr University Health Board (BCUHB) Research &

Development

IRAS 316303 | Mothers' experiences of services | BCUHB R&D Confirmation that research can proceed

Lewis Waggett (BCUHB - Research & Development) <Lewis.Waggett@wales.nhs.uk>
Wed 11/01/2023 14:00
To: Lee Hogan (Staff) <lee.hogan@bangor.ac.uk>
Cc: Valeria Malinen <vlm20yys@bangor.ac.uk>

📎 1 attachments (848 KB)
mNC_PIC_Agreement(Sponsor-PIC).pdf;

Dear Dr Lee Hogan

Re: IRAS 316303. Confirmation that the research can proceed at BCUHB

Full Study Title: Mothers' experiences of services (i.e., Social Services, Substance Misuse Services and/or Community Mental Health Services) following a court-enforced separation from a child due to alcohol or drug use.

As per the IRAS Help section guidance for NHS, organisations will not be required to formally confirm capacity and capability for this study and research procedures may commence providing:
- NHS organisation has been contacted
- HRA and HCRW approval has been issued
- NHS organisation has not provided a reason as to why it cannot participate or requested additional time to confirm.

This email confirms that Betsi Cadwaladr University Health Board (BCUHB) positively confirms that the research may proceed.

The documents reviewed are those as listed in the HRA approval letter.

Please find attached the fully signed PIC agreement.

We agree to start this study when you as Sponsor issue the greenlight.

If you wish to discuss further, please do not hesitate to contact us.

N.B. Future submission of amendments, should be sent to our R&D generic inbox:
BCU.ResearchApplications@wales.nhs.uk

We wish you all the best with your research project.

Many thanks
Lewis

Lewis Waggett
Hwylusydd Ymchwil • Research Facilitator

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Research & Development Office
Holywell Community Hospital
Halkyn Road
Holywell

Chapter 2: Empirical Paper Appendices

Appendix A. Copy of Research Protocol submitted to IRAS (v 1.0)

STUDY PROTOCOL

Mothers' experiences of services (i.e., Social Services, Substance Misuse Services and/or Community Mental Health Services) following a court-enforced separation from a child due to alcohol or drug use.

1   BACKGROUND

It is estimated that between 50% and 80% of children in foster care are from households with at least one substance-using parent (Fernandez & Lee, 2013). Almost half of the mothers receiving treatment for substance use experienced separation from at least one of their children (Porowski, Burgdorf, & Herrell, 2004).

There is growing evidence identifying the factors contributing to the separation from a child for mothers who were misusing substances. One of the most prominent factors identified has been low socioeconomic status and other risk factors often linked to this, such as the younger age of a first child and criminal justice involvement (Canfield et al., 2017). Furthermore, the presence of mental health difficulties, adverse childhood events and the absence of informal support have been identified as additional determinants for heightened risk (Canfield et al., 2017).

Service's stigma toward substance misusing new mothers has also been well evidenced. A recent scoping review (Wolfson et al., 2021) identified four levels of stigma experienced by (mostly new) mothers at the:

1.   Individual-level (i.e., fear and mistrust of social services; Falletta et al., 2018)

2.   Interpersonal level (i.e., familial and relational influence on accessing services)

3.   Institutional level (i.e., the expectation of multiple documentation, attending appointments etc.)

4.   Population-level (i.e., the negative stereotype of mothers with substance misuse difficulties)

Having to cope with predisposing risk factors as well as a wide range of stigma, can make it more challenging to engage with the services in the first place and thus, due to lack of support, makes it more likely for mothers to be separated from their child (Stone, 2015). Further evidence suggests that losing custody can increase substance misuse (Kenny, Barrington, & Green, 2015). This study aims to give a voice to women who have found themselves in this predicament. Learning from women's experiences could offer helpful insights for relevant service development.

A discourse analysis study explored the experiences of thirteen mothers with drug use histories and the use of social services (Virokannas, 2011) and identified four motherhood identity categories:

•   Responsible motherhood – asking for help,

•   Giving up motherhood – submitting to outside forces,

•   Strategic motherhood – learning to cope,

•   Stigmatized motherhood – fighting back.

From this study, it was concluded that a mutually trusting relationship was the key to cooperative partnership. However, it also raised questions about whether current service processes might be excessively threatening to mothers in this predicament. This initial

limited evidence can provide a framework when considering parental identity in relation to engagement with the services following separation from a child.

Despite the existing research calling for trauma-informed (Barthaolow & Huffman, 2021), unified care with further substance misuse training there is little available evidence from the mothers themselves identifying how people made sense of their engagement with the services. Adams and colleagues (2021) are among the few researchers who have explored the impact of motherhood identity on women's substance use and their engagement with substance misuse-specific treatment. The study took place in America where twenty women were involved in focus groups exploring 'women's identities as mothers and motherhood as a potential barrier or facilitator to substance misuse treatment'. Their research highlighted specific barriers to treatment engagement from interpersonal and structural factors. One of the main structural factors was fear of having their child(ren) taken into care. The authors focused on women in treatment and did not include participants who were separated from their child.

2   RATIONALE

By exploring people's experiences of the services, we are giving mothers a voice. Service's stigma toward substance misusing new mothers has been well evidenced (Wolfson et al., 2021) with identified interpersonal and structural factors (Adams et al., 2021). Thus, it would be important to build on the existing research by giving a voice to women who have lost custody and exploring how this has impacted their interaction and engagement with the services in general. The proposed research, therefore, aims to explore similarities and differences in perception of mental health, substance misuse and social services.

3   THEORETICAL FRAMEWORK

As it can be seen from the background section, so far, the literature has looked at following factors in relation to mother's separation from a child due to substance use:

Substance misuse often comes at a high cost to the families where almost half of the women receiving treatment for substance misuse have lost at least one of their children (Porowski, Burgdorf, & Herrell, 2004)

There is growing evidence identifying the factors contributing to the separation from a child for mothers who were misusing substances but very little evidence looking at service engagement from mother's perspective.

Service's stigma toward substance misusing new mothers has also been well evidenced (i.e., Wolfson et al., 2021).

Public and systemic stigma accompanying the separation from a child is often internalized (Luoma et al., 2007) and impacts on one's motherhood identity (Virokannas, 2011).

From our perspective, a question that remain unanswered is: 'How do mothers make sense of their engagement with different services?' Within this question we are interested in exploring how those interactions may have impacted on their motherhood identity in the context of British/Welsh culture.

4   RESEARCH QUESTION/AIM(S)

The principal research question includes an exploration into women's experiences of service(s) engagement following separation from a child. The following services will be included:

• Involvement with social services as all women would have had this experience.

• Substance misuse services, as due to recruitment strategy, all of the interviewed women would have had contact with these services.

- Mental health services, as mental health is one of the high-risk factors for a separation from a child and thus there is a presumption that at least some of the interviewees would have had experience with mental health-specific services.

4.1 Objectives

1. How did they make sense of these interactions and what was the impact of this on their maternal identity?

2. How did separation from the child via court proceedings impact on their relationship with themselves, others (including social networks), and the wider community (services, neighbourhood etc.)?

4.2 Outcome

We believe that this study raises an important question. By exploring people's experiences of the services, we are giving mothers a voice. Service's stigma toward substance misusing new mothers has been well evidenced (Wolfson et al., 2021) with identified interpersonal and structural factors (Adams et al., 2021). Thus, it would be important to build on the existing research by giving a voice to women who have lost custody and exploring how this has impacted their interaction and engagement with the services in general. The proposed research, therefore, aims to explore similarities and differences in perception of mental health, substance misuse and social services.

This study has also been discussed with two Experts By Experience (EBE). EBE are people who either would have gone through the process of separation from a child or had faced this risk in the past. Both EBEs felt that despite the emotional aspect of this study, there will be many mothers who would want to share their stories in hopes of helping other people in this predicament.

5 STUDY DESIGN and METHODS of DATA COLLECTION AND DATA ANALYIS

This study will use an Interpretative Phenomenological Analysis (IPA) design. As, to our knowledge, there are no previous studies exploring these questions, IPA would allow the researchers to explore participants' experiences without having any predetermined theories in mind. This will be done with semi-structured interviews of approximately 60-minute interviews, depending on how much participants are able to talk about their experiences. Each participant will attend one interview. Due to ongoing potential changes in Covid-19 restrictions, the interviews will take place via an online platform (such as Teams on the encrypted computer) or telephone calls recorded on an encrypted device.

The semi-structured interview schedule (see attached documents) would help participants explore their experiences of service(s) involvement following separation from a child. Follow-up questions will aim to explore the participant's cognitions and beliefs about how the services perceived them and the impact this had on their further engagement and support-seeking (see attached documents for the proposed interview schedule). This interview schedule has been discussed and refined with an expert by experience. The Main suggested changes were in relation to the wording (i.e., Q7 and Q8). It was felt that the questions were sensitive and would allow participants to share their thoughts in as much or as little details as they would feel comfortable.

The following theme analysis procedure will be adopted (as proposed by Smith, Flowers & Larkin, 2022):

- Focusing on individual lived experience on a case-by-case basis
- Focus on personal meaning and sense-making of individual's interactions with services
- Examining similarities and differences to account for both shared themes as well as distinctive variations in those themes.
- The questions aim to elicit the interplay between relational experience with services and the potential threat posed to self (/motherhood) – identity.

Due to ongoing potential changes in Covid-19 restrictions, the interviews will take place via an online platform (such as Teams on the encrypted computer) or telephone calls recorded on an encrypted device. Student researcher will be responsible for recruitment, data collection, transcription and data analysis. For more data security information please see section 8.6.

Measures

As this will be qualitative research, no measures will be applied.

Demographic information will be recorded. This would be in line with the IPA inclusion criteria for homogeneity and informed by Söderström and colleagues' study (2012). This study was chosen due to having parallels with the current study; exploring the interplay between substance use and motherhood identity with an IPA design.

6   STUDY SETTING

The data will be collected via Teams interviews. No sites will be used for data collection.

7   SAMPLE AND RECRUITMENT

7.1 Eligibility Criteria

7.1.1   Inclusion criteria

- Female, age between 18-99

- Have been involved in court proceedings within the jurisdiction of the United Kingdom.

- Accessed services within North Wales.

- Mothers who have had their child(ren) removed through court proceedings.

- Mothers who have been in contact with at least one of the following services: substance misuse service, mental health services and/or social services.

- Mothers who have (re)gained access to their child(ren).

- At least 12 months in recovery from substance misuse as identified by individuals' primary keyworker/third sector worker.

7.1.2   Exclusion criteria

- Ongoing substance misuse and/or unmanaged mental health difficulties requiring active intervention.

- Current ongoing custody queries and/or active involvement with a legal dispute in relation to child welfare.

7.2 Sampling

7.2.1   Size of sample

Due to the multi-layered nature of the interpretation process in IPA, the data saturation proposed in many other qualitative approaches is no longer relevant. The focus of this research will be on individuals' interaction with different services following what is considered a highly stigmatised event in their life. This approach would capture both what is told as well as how it is told (Smith & Nizza, 2021), meaning that individuals' accounts are what matters rather than number saturation. Thus, this project will aim to recruit between 6-10 participants and conducting approximately 60 minutes long interviews will be sufficient to provide the researcher with enough material.

Sampling technique

Snowball sampling will be implemented through keyworkers and relevant organisations. Due to the small sample required for this study (e.g., no more than 10 participants), a broader sampling method might be inappropriate and potentially triggering.

7.3   Recruitment

The researcher will approach professionals in substance misuse services and third sector (i.e., Adferiad Recovery and North Wales Recovery Community) explaining the study, inclusion/exclusion criteria and asking them to identify potential participants. They will be given an initial information sheet and an initial contact form (see attached documents) to be given to people who match the inclusion and exclusion criteria. From there on, potential participants can reach out to the researcher directly to ensure that third-party recruiters will not know who decided to take part in the study. These measures are put in place to ensure that whoever has been identified as a participant will receive the same level of care regardless of their decision to participate in the study. Written consent will be obtained.

This study has been discussed with the senior leadership at a local substance misuse service and both third sector services. Senior leadership as well as the third sector leads were supportive of this research as long as there is ethical approval from the right research body.

7.3.1 Sample identification

Participant identification will be done by relevant professionals who are already working with potential participants. Researchers will not have access to any personal information beyond what is shared directly with them by the participants.

Principal investigator will approach identified organisations (Substance Misuse Service, Adferiad Recovery and North Wales Recovery Community) initially, discussing the project with the staff and asking them to consider any potential participants. Information will be given initially verbally and followed up by information sheets and initial contact forms. Due to the small sample required for this study, a broader sampling method might be inappropriate and potentially triggering.

Relevant professionals will be given an initial information sheet and an initial contact form (see attached documents) to be given to people who match the inclusion and exclusion criteria. From there on, potential participants can reach out to the researcher directly to ensure that third-party recruiters will not know who decided to take part in the study. These measures are put in place to ensure that whoever has been identified as a participant will receive the same level of care regardless of their decision to participate in the study.

No posters, leaflets, adverts or websites will be used.

Written consent will be sought.

Participants will be reimbursed £20 for their participation in the interview. HRA Ethics Guidance has been reviewed.

7.3.2 Consent

From the start, it is important that participant have time to consider the implications of taking part in this study. To ensure that we are able to gain an informed consent, we have planned a two stage opt in system. Firstly, identified participants will receive the information sheet along with initial contact form (see the attached documents). The initial contact form asks the potential participants to contact the researcher(s) should they wish to (potentially) take part in the study. Once the initial contact form has been received by the researcher(s), they would contact the participants to discuss the study. Following this conversation, participants will be given an informed consent form. Participants will be given at least 48h before being contacted by a researcher. We believe that by giving time and reducing the pressure to participate, we will gain informed consent.

8   ETHICAL AND REGULATORY CONSIDERATIONS

8.1 Assessment and management of risk

Participants

From the start, it is important that participants have time to consider the implications of taking part in this study. To ensure that we are able to gain informed consent, we have planned a two-stage opt-in system. Firstly, identified participants will receive the information sheet along with the initial contact form (see the attached documents). The initial contact form asks the potential participants to contact the researcher(s) should they wish to (potentially) take part in the study. Once the initial contact form has been received by the researcher(s), they would contact the participants to discuss the study. Following this conversation, participants will be given informed consent and 48 hours to consider participation in the study. They will then be contacted by a researcher to gain informed consent. We believe that by giving time and reducing the pressure to participate, we will gain informed consent.

As the research topic can be potentially highly emotive, further support might need to be considered. Should any of the participants experience high levels of distress, the interview will be stopped, and the focus will be shifted toward the person's needs at that moment. There are two layers of support that might be considered in this case. Firstly, the researcher will be a third-year doctoral candidate in clinical psychology who has been trained to deal with high levels of distress and would be able to conduct a risk assessment and offer support at the moment. Secondly, participants will be provided with debriefing information including available support organisations such as Samaritans, MIND etc.

The consent form also outlines that should we have any concerns about a participant's wellbeing, we will contact their GP. This will be discussed and highlighted prior to commencing an interview.

Researchers

As the interviews will be conducted over phone/video there are no physical risks posed to the researcher. However, due to the sensitive nature of the topic, it would be important for

the researcher to have a debriefing opportunity in the form of reflective practice. This will be facilitated by a qualified clinical psychologist upon request.

8.2   Research Ethics Committee (REC) and other Regulatory review & reports

Before the start of the study, a favourable opinion will be sought from a REC (Wales REC 5) for the study protocol, informed consent forms and other relevant documents e.g. advertisements.

Regulatory Review & Compliance

Before any site can enrol patients into the study, the Chief Investigator/Principal Investigator or designee will ensure that appropriate approvals from participating organisations are in place. Specific arrangements on how to gain approval from participating organisations are in place and comply with the relevant guidance. Different arrangements for NHS and non NHS sites are described as <u>relevant</u>.

For any amendment to the study, the Chief Investigator or designee, in agreement with the sponsor will submit information to the appropriate body in order for them to issue approval for the amendment. The Chief Investigator or designee will work with sites (R&D departments at NHS sites as well as the study delivery team) so they can put the necessary arrangements in place to implement the amendment to confirm their support for the study as <u>amended</u>.

Amendments

If the sponsor wishes to make a substantial amendment to the REC application or the supporting documents, the sponsor must submit a valid notice of amendment to the REC for consideration. The REC will provide a response regarding the amendment within 35 days of receipt of the notice. It is the sponsor's responsibility to decide whether an amendment is substantial or non-substantial for the purposes of submission to the REC.

Any amendments will be initially discussed and agreed upon within the research team. Once any amendments are agreed upon Amendment Categorisation Tool (https://www.myresearchproject.org.uk/help/hlpamendmentsresearch.aspx) will be used to categorise the changes.

The outcome of this will be communicated with the sponsor whose responsibility it will be to communicate the amendments to relevant stakeholders (e.g., REC, R&D, regulatory agencies).

The amendment history will be tracked in the protocol.

8.3 Peer review

The study protocol has been reviewed by Bangor University NWCPP research team, chief investigator and academic supervisor. This project will be closely supervised throughout as part of the doctorate in clinical psychology training. In 2023 viva voce exam will offer a final evaluation for the conduct of the research.

8.4 Patient & Public Involvement

Experts by Experience (EBE)

This study involves people who have either been in a position where they were separated from their children due to alcohol or drug use or were at risk of going through this process. For the purpose of this study they will be called Experts by Experience (EBE). EBE will be involved in the following stage:

Forming and refining the study idea as being pertinent to their experience.

Helping to refining the study title, including considerations regarding study's acceptability to potential participants.

Reviewing and advising on interview schedule.

Ongoing involvement in the study aiming to reduce researcher's bias and reviewing study findings.

8.5 Protocol compliance

In case of an accidental deviation from the protocol, the following steps will be taken:

This will be documented in the updated version of the protocol.

Relevant forms will be completed and reported to the Chief Investigator and the Sponsor in a timely manner.

Deviations from the protocol which are found to frequently recur are not acceptable, will require immediate action and could potentially be classified as a serious breach.

8.6 Data protection and patient confidentiality

All researchers and study site staff will comply with the requirements of the Data Protection Act 1998 with regards to the collection, storage, processing and disclosure of personal information and will uphold the Act's core principles.

Identifiable data, such as consent forms, will be stored in the locked cabinets in the clinical supervisor's office at North Wales Clinical Psychology Programme.

Nonidentifiable electronic data will be stored on organisationally encrypted machines. Recordings with nonidentifiable information will be held until the end of the project and destroyed thereafter. No video recordings will be kept. All of the recordings will be audio. Recordings of interviews will be destroyed after they have been transcribed.

Anonymised transcriptions will be password protected and stored on organisationally encrypted machines for up to two years post-publication or up until December 2025, whichever date comes first.

To be able to use direct quotes in any potential publications, all data will be anonymised, and the publication will include pseudonyms and age gap in increments of ten (i.e., Mary, 20-30).

The creation of coded, depersonalised data where the participant's identifying information is replaced by an unrelated sequence of characters.

Only the researcher (student) and chief investigator will have access to the confidential data as it would be their responsibility to collect, anonymise and transcribe the data.

Chief investigator (Dr Lee Hogan) will act as custodian for the data generated by the study. The research data will be stored in the locked cupboard at Brigantia Building, Bangor University.

8.7 Indemnity

Bangor University research insurance has been put in place to meet the potential legal liability of the sponsor's harm.

8.8 Access to the final study dataset

Once the study has been completed (By September 2023), the participants will be notified and sent a link directing them to the finished paper. This will be completed as an individual email from a university encrypted email to ensure individuals' data protection.

9 DISSEMINIATION POLICY

9.1 Dissemination policy

The NWCPP will hold the data after completion of the study on a password protected pen drive. Thesis will be prepared with a journal submission in mind. This thesis will also be available in the form of an E-Thesis via PURE.

9.2 Authorship eligibility guidelines and any intended use of professional writers

Authors of the final study report are as follows: Dr Lee Hogan, Valeria Malinen and Dr Jaci
Huws.

Appendix B. Participant Information Sheet (PIS; v 2.0)

North Wales Clinical Psychology Programme/Rhaglen
Seicoleg
Clinigol Gogledd Cymru
Room 246, Brigantia Building
School of Psychology/Ysgol Seicoleg
Bangor University/Prifysgol Bangor
Bangor
Gwynedd
LL57 2AS
Telephone: 01248 382205

Information Sheet

Title of the study
Mothers' experiences of services (i.e., Social, Substance Misuse and/or Community Mental Health) following a court-enforced separation from a child due to alcohol or drug use.

Summary of Participant Information Sheet
This research study will use anonymised information from your interview. We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really needed for this study.

Everyone involved in this study will keep your data safe and secure. We will follow all privacy rules. At the end of the study, we will save some of the anonymised data in case we need to check it. We will make sure no-one can work out who you are from the reports we write.

This information pack tells you more about this.

Why have I been asked to part?
If you have been given this information sheet, you will have been identified by your allocated keyworker or a third sector worker as a potential participant.

To take part, you must previously have had a drug or alcohol dependency and have been abstinent from substances for at least twelve months. You must also have had an experience of having a court-enforced separation from your child due to a substance use issue. We can only speak to people who have no ongoing court proceedings in relation to their separation from their child.

What does the study involve?
In the study you will be asked to take part in a semi-structured interview, where you will be asked questions about your experiences of services (i.e., social services, substance misuse services, and/or community mental health services) following a court-enforced separation from your child. The interview will last anywhere between 60 -90 minutes and will be recorded for later analysis.

Are there any benefits or risks?
You will receive a £20 Amazon voucher for your time. Your participation might benefit other mothers who are at risk of separation from their child. We hope that your insight will help us understand people's experiences when engaging with appropriate services. In the event of publication, we also hope that this understanding can reach relevant services and start a conversation about the best way to support not only children but also their mothers.

There are no foreseen risks to participating, but if you feel distressed at any point then you are free to not answer a question or withdraw, without penalty to your care. You will still be provided the voucher for your time and you can ask for your data to be removed from the audio recorder at any point.

North Wales Clinical Psychology Programme/Rhaglen Seicoleg Clinigol Gogledd Cymru Room 246, Brigantia Building School of Psychology/Ysgol Seicoleg Bangor University/Prifysgol Bangor Bangor Gwynedd LL57 2AS **Telephone:** 01248 382205

How will we use information about you?

We will need to use information from you for this research project. This information will include your:
- initials
- name
- contact details

We will use this information to do the research and to check our records to make sure that the research is being done properly. From the information that we store, people will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way so that no-one can work out that you took part in the study.

Should the research team become concerned about your emotional wellbeing or safety during your involvement in the study, they will have a duty of care to inform your GP and the clinicians involved in your care. Before taking any actions, your researcher will do their best to discuss this with you, including explicitly stating what information will be shared with your GP and/or clinician involved in your care.

Confidentiality will not be maintained if there is a risk of significant harm to someone else, or there is disclosure of a serious crime. These instances will be managed on a case-by-case basis, and this would be discussed with you before disclosure to the relevant services.

What if I don't want to take part?
Taking part in this study is completely voluntary. If you do take part, then you can withdraw at any point without penalty or explanation. Your participation will not affect your usual care in any way.

What are my choices about how your information is used?
You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

We need to manage your records in specific ways for the research to be reliable. This means that we will not be able to let you see or change the data we hold about you.

Where can I find out more about how my information is used?
You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- leaflet available from www.hra.nhs.uk/patientdataandresearch

North Wales Clinical Psychology Programme/Rhaglen Seicoleg Clinigol Gogledd Cymru
Room 246, Brigantia Building
School of Psychology/Ysgol Seicoleg
Bangor University/Prifysgol Bangor
Bangor
Gwynedd
LL57 2AS
Telephone: 01248 382205

- by asking one of the research team (either Valeria Malinen; vlm20yys@bangor.ac.uk or Dr Lee Hogan; lee.hogan@bangor.ac.uk)
- or by contacting Gwenan Hine who is a head of governance services in Bangor University. Email: gwenan.hine@bangor.ac.uk or phone 01248 382413

Who do I contact with any complaints about this study?

If you have any concerns or complaints about this study please consider one of the following options.

To proceed with the complaint within the University please contact Dr Huw Roberts, College Manager, College of Human Sciences, Bangor University, Gwynedd, LL57 2AS or email huw.roberts@bangor.ac.uk.

Alternatively, you can contact an independent Patient Advisory Liaison Service (PALS) within Betsi Cadwaladr University Health Board by either emailing them on BCU.PALS@wales.nhs.uk or phoning 03000 851234.

Appendix C. Consent Forms: Initial Contact Form (v 1.0) and Informed Consent Form (v 2.0)

North Wales Clinical Psychology Programme/Rhaglen
Seicoleg
Clinigol Gogledd Cymru
Room 246, Brigantia Building
School of Psychology/Ysgol Seicoleg
Bangor University/Prifysgol Bangor
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LL57 2AS
Telephone: 01248 382205

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

PRIFYSGOL BANGOR UNIVERSITY

Initial Contact Form

Study Title:

Mothers' experiences of services (i.e., Social Services, Substance Misuse Services and/or Community Mental Health Services) following a court-enforced separation from a child due to alcohol or drug use.

Researcher: Valeria Malinen (vlm20yys@bangor.ac.uk)
Supervised by: Dr Lee Hogan (lee.hogan@bangor.ac.uk) and Dr Jaci Huws (j.huws@bangor.ac.uk)

If you are interested in taking part in this study, please complete this form and return to Valeria Malinen in one of the following ways:
   I.   You can email the completed form to vlm20yys@bangor.ac.uk
   II. You can post it to Dr Lee Hogan on the following address: School of Psychology, Adeilad Brigantia, Penrallt Rd, Bangor, LL57 2AS, UK

Following your expression of interest, you will be contacted by a researcher who will discuss this study with you. You will also have a chance to ask any questions you may have.

Please click/cross the box

I agree to be contacted to discuss the research study   ☐

The best number to contact me _____

The best email address to use_____

Please note that this email address will be used to send you the £20 Amazon voucher as a thank you for you participation. For this reason, please ensure that you are able to access this email address. This email will also be used to send you a link to the final copy of this study.

X

_____   _____
Name of participant   Date   Signature

IRAS number: 316303   Version 1 26.06.22

GIG
CYMRU
NHS
WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

North Wales Clinical Psychology Programme/Rhaglen
Seicoleg
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Room 246, Brigantia Building
School of Psychology/Ysgol Seicoleg
Bangor University/Prifysgol Bangor
Bangor
Gwynedd
LL57 2AS
Telephone: 01248 382205

PRIFYSGOL
BANGOR
UNIVERSITY

Informed consent form

Study Title: Mothers' experiences of services (i.e., Social Services, Substance Misuse Services and/or Community Mental Health Services) following a court-enforced separation from a child due to alcohol or drug use.

Participant ID number: _____
(Please **click/cross** each statement if you agree)

1. I confirm that I have read and understood the information sheet provided for this study. I have had some time to consider this information, ask any of the arising questions and have received satisfactory answers to any questions I have had. ☐

2. I agree for this interview to be recorded and understand that my identity will be anonymised before the study will be submitted and/or included in any publications. ☐

3. I give permission to use anonymised direct quotes from the interview in any future research reports. ☐

4. I understand that my participation is voluntary, and I am free to withdraw at any time. This will not affect my care in any way. ☐

5. I understand that should the research team become concerned about my emotional wellbeing during my involvement in the study, they will have a duty of care to inform my GP and the clinicians involved in my care. ☐

6. I agree to take part in this study. ☐

X

_____   _____
Name of participant   Date   Signature

_____   _____
Researcher   Date   Signature

1 copy for participant's records; 1 copy for researcher

IRAS number: 316303   Version 2. 10.10.22

Appendix D. Interview Schedule (v 1.0)

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Telephone: 01248 382205

Interview Schedule

Study Title:

Mothers' experiences of services (i.e., Social Services, Substance Misuse Services and/or Community Mental Health Services) following a court-enforced separation from a child due to alcohol or drug use.

Introduction

- Introduce myself, my position and the research study.

- Gauge participants understanding for the purpose of the study, fill any blanks and provide a space to ask any additional questions. Check if participant is willing to proceed.

- Review that participant has a) read and understood the information sheet and b) completed and returned written consent form before proceeding with the interview.

- Verbally reiterate confidentiality of the interviews and explain the procedures around recording, anonymization process and storage of the data for up to two years post publication or by December 2025, whichever comes first.

- Demographics

- Allow further space for any questions.

Recording

- State participant number and gain verbal consent for recording.

Questions

1. **Q1 (Narrative): Can you tell me about your child(ren)?**

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PRIFYSGOL BANGOR UNIVERSITY

Prompts: (1) How old are your children now? (2) Where do they live? (2) How often do you see them? (3) What is your relationship like with them at the moment? (4) How has your relationship evolved over time?

2. **Q2 (Narrative): Can you tell me about how the custody case impacted you?**

    Prompts: (1) Who was involved? (2) How did you feel? (3) Any fears or hopes?

3. **Q3: Who did you talk to about what happened?**

    Prompts: (1) Immediate social network vs professionals. How did they respond?

4. **Q4 (Comparative): a) Which services did you attempt to access and b) were the differences between the way services responded to your request for help?**

    Prompts: (1) Could you give me an example? (2) What was helpful? (3) What was unhelpful? NB! How did it make you feel?

5. **Q5 (Circular): How do you think the professionals involved perceived you?**

    Prompts: (1) What made you come to this conclusion? (2) Did it change after the decision to remove your child was made? Tell me more about that.

6. **Q6 (Comparative): Do you feel safeguarding procedures are different for people who use substances compared to safeguarding to other queries?**

    Prompt: (1) How? (2) Could you provide an example?

7. **Q7 (Evaluative): Do you feel that you interaction with the services changed how you viewed yourself as a mother? If so, how?**

    Prompts: (1) How? (2) What did you do in response to this?

8. **Q8: How did you feel about the services?**

    Prompts: Did you want to engage or withdraw from the services? What was the impact of that?

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9. **Q9: What did you find most helpful at the time?**

   Prompt: Social networks? Community? Self-efficacy? Anything else?

10. **Q10: What could the services have done differently that might have helped you and your child?**

    Prompt: What would have helped you to engage with the services?

Closing

- Let the participant know that we have covered all of the questions researcher has planned for this interview.

- Provide an opportunity for the participant to add any further comments: '*Do you feel that there is anything else that we have not covered today but would help us to make sense of your experience?*'

- Thank the participant for their time and ask if there might be any questions participant might have to the researcher at this stage.

Stop the recording and debrief

- Provide short debriefing document including;

    a) researchers contact details

    b) purpose of the study

    c) information on how to asks any further questions

    d) and complaint procedure.

- Explain that full verbal and/or written debrief will be provided at the end of the study.

- Amazon voucher and debriefing document

Appendix E. Study Debrief (v 2.0)

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Debriefing Form for Participation in a Research Study

Title of the study

Mothers' experiences of services (i.e., Social, Substance Misuse and/or Community Mental Health) following a court-enforced separation from a child due to alcohol or drug use.

Researcher: Valeria Malinen (vlm20yys@bangor.ac.uk)
Supervisors: Dr Lee Hogan (lee.hogan@bangor.ac.uk)
Dr Jaci Huws (j.huws@bangor.ac.uk)

Purpose of the study

The purpose of this study was to explore the mother's experiences with different services following a court-enforced separation from a child due to substance use. To this date it is an under-researched topic as the majority of the research focuses on the impact separation has on people and the reasons this has occurred. By giving people an opportunity to reflect on their experiences with the services involved, we hope to understand how we can improve the support available for people who might be in this situation in the future.

Confidentiality

You may decide that you do not want your data used in this research. If you would like your data removed and permanently deleted, then please contact the researcher Valeria Malinen (vlm20yys@bangor.ac.uk) or either of the nominated supervisors within 20 days of your interview. After the 20-day period, your data will be transcribed and anonymised.

Whether you agree or do not agree to have your data used for this study, you will still receive £20 Amazon voucher for your participation. This will be sent to you on the email address you have provided on the initial contact form. Please note that it can take up to 10 working days to complete this following the completion of your interview.

Your wellbeing

If you feel that your mental health has deteriorated and you wish to access further support, please consider one of the following options:

Mind Cymru

A local mental health charity that can offer online support, provide advice for available local support options and operates an Infoline for information on types of mental health difficulties, where to ger help and advocacy

For further information see: https://www.mind.org.uk/about-us/mind-cymru/
Call: 0300-1233-393
Or email info@mind.org.uk

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Adferiad Recovery
Provides services for people with co-occurring mental health and substance misuse conditions and related issues.

For further information see: www.adferiad.org.uk
Email: info@adferiad.org.uk
Tel: 02920 407 407

For 24/7 confidential mental health support you might want to consider **Samaritans**
Call: 116 123

Final report
You will be sent a link to the final copy (or a summary of the findings) once the study is completed. This will be done via the email you provided to us in the initial contact form. If you do not want to receive this copy, please feel free to contact us via the emails provided above. Alternatively, you can telephone (01248 388276) or write to us at the School of Psychology, Adeilad Brigantia, Penrallt Rd, Bangor, LL57 2AS, UK.

Useful contact information
If you have any concerns or complaints about this study, then please contact Dr Huw Roberts, College Manager, College of Human Sciences, Bangor University, Gwynedd, LL57 2AS or email huw.roberts@bangor.ac.uk.

Alternatively, you can contact an independent Patient Advisory Liaison Service (PALS) within Betsi Cadwaladr University Health Board by either emailing them on BCU.PALS@wales.nhs.uk or phoning 03000 851234.

Thank you for taking part in this study! Your contribution is greatly appreciated.

Appendix F. Distress Protocol (v 1.0)

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Distress Protocol

Adapted from Draucker, C. B., Martsolf, D. S., & Poole, C. (2009). Developing distress protocols for research on sensitive topics. *Archives of psychiatric nursing, 23*(5), 343-350.

Stages during the interview	
Identifying distress	A participant reports that they are experiencing high level of distress (i.e., Says that '*I am finding this difficult to answer.*'). OR A participant's behaviour communicates distress (i.e., tearfulness, shaking, change in ability to engage with the interview).

Stage 1 response	➢ Immediately stop the interview.
	 ➢ Offer immediate support with validation and offering to take a comfort break to grab a glass of water.
	 ➢ Conduct a mini mental health assessment:
	     Tell me what is going through your mind?
	     What feelings are coming up?
	     How do you usually manage these feelings?
	     Do you feel safe?

Review	Check if participant wishes to carry on with the interview ⟶ Resume with the interview with more frequent check-ins on how they are finding the process. OR If participant wishes to stop the interview ⟶ Proceed to Stage 2 response
Stage 2 response	Query if there is anyone in their home, who can support them in the moment. AND/OR Support the participant to gain further support from GP and/or their current mental health provider (i.e., '*Do you feel able to reach out to your GP/mental health provider now?*' or '*As we discussed earlier, my priority is your wellbeing. I can see that you are feeling very upset at the moment and I wonder if having an additional support might be helpful. Would you be happy for me to contact your GP in light of what we have been talking about?).*' OR

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If there are concerns about safety and participant has not given consent to contact their GP, restate duty of care statement on PIS and follow the necessary steps of contacting the GP.

Note. If the researcher has to implement the Stage 2 response, further supervision will be provided by the chief investigator.

Appendix G. An Axtract from Analysis. P04: Sandra, pg. 7

Transcript P04: Sandra's experience I: interviewer, P: Participant	Exploratory phenomenological noting	Linguistic noting	Conceptual and reflective noting
ended up getting evicted as well. And I... I just basically... **I mean things were bad then, but then when the kids went and I was, you know, there were court dates in that coming up. Um, I had no way of getting clean or getting better. And I, I didn't know what to do, so I just used more. I just. I just got worse.** I: I can imagine. And it sounds to me that there was almost kind of hope that it if I put myself on a line, and I am really honest, and explain the situation, surely the professional should, kind of, step in and help out. But it almost feels like it went the opposite way. It was, as you say, an emergency [situation] it happened out of the blue almost. And then you're left without anything. Is that correct? P: **There was a big meeting on and, and, I, I, I wasn't prepared for it. I there were probably about 15 people, all different professionals...** And, and, and me and yeah. And I, you know they... **Some family came to get the kids' stuff after the meeting, and they said that this will be temporary.** And we'll have court cases in that and you know. But **by the time the court cases came round things have taken a real spiral. I had nowhere to live. I was staying with somebody that was quite violent. I've moved in with the man that was quite violent** and had history for that. And they were telling me to, to leave that place. But I have nowhere to go. And, yeah. It was very difficult.	The impact this had on housing, mental health and further declining ability/motivation to engage with the services. Being in a big meeting, where decision of taking her kids were made for her with the clause that this is temporary. Being separated from the children was enough to start a worsening spiral and she was no longer in the place to take care of them.	Ix3 a sense of nervousness or insecurity? attempt to assert control over the situation?? Vulnerable? "professionals": positioning herself as less powerful or knowledgeable. Professionals =expertise or authority	Powerlessness and worsening spiral once the children were removed. Being in a room where she was outnumbered and professionals were holding authority and decision making power.

Appendix H. Developing Personal Experiential Themes. Example from P04: Sandra p. 3

2. Weaknesses of statutory services		
Intimidating court processes where Sandra felt outnumbered	7	'There was a big meeting on and, and, I, I, I wasn't prepared for it. I there were probably about 15 people, all different professionals...'
Power imbalance in the meetings where things were not discussed with Sandra and being openly judged for her decisions	17	'They [social workers] openly discussed it [the abortion] in one of the big meetings and I didn't know that they knew about it. I think I told my mother and I think my mother told the social worker. And they openly discussed it with me sat there in a meeting. And it basically felt like, you know the... That everybody was kind of thinking that I didn't want any kids in my life and it, and it wasn't that at all.'
Long waiting time meant that Sandra stopped taking drugs abruptly	10	'My mom and dad took me home and I couldn't get an assessment with substance misuse service for three months. So, um, I went cold turkey in the end.'
Lack of understanding about addictions (social services) and acknowledging that this knowledge is unlikely to be provided by the person at the time	14	'I don't think professionals understand the nature of addiction. Umm. I think they are just there for the children'.
	28	'I think they just don't know; I think. I think that they (pause) They just have no idea about addiction and what it is that people suffer with. And therefore, they don't know what it is that people actually need to get well and what support they need in place'
	29	'I can't blame them because I didn't really understand it myself until I came into recovery.'
Lack of support for mothers or helping a family to stay together, instead the focus seems to be exclusively on safeguarding children	14	'There isn't the support for the mothers. They talk about wanting to keep families together. But really, there isn't any kind of plan in place for that. Not anything that works anyway.'
	15	'It was just kind of safeguarding of children. Which is, you know what needs to happen straight away and (pause)... But I feel it's not geared towards helping families stay together or helping mothers to get better.'
Being left without support (both professional and family), signposting and alone after being honest.	6	'I thought by being honest that I might receive some more, some more help and support. Um, but that wasn't what happened. I was just kind of left in an empty house with...Without the children there. Without any support and without any way to get better.'
	8	'the support options that were available previously, were no longer available due to her daughter being placed with the family.'
	13	'Nobody, nobody told me about any services that you can access. I was just kind of um. I was just kind of left on my own.'
	9	

Appendix I. Experiential Statement Grouping Example

Appendix J. Mapping and Generating Group Experiential Themes (GETs) using Padlet

Helen
Power hierarchy when working with professionals: do as you are told

Ali
Inflexibility in statutory services beliefs of what is 'the right thing to do'. Discounting Ali's and non-statutory service experience

Helen
Lack of agency when seeing children. Every aspect controlled by the system.

Services
Unhelpful

Ali
One size fits all approach: losing the sight of the person and their preferences

Ffion
Being a mother in name only: not feeling like her daughter was hers anymore. Lack of agency, alienation and no way to protect her

Court process

Sandra
Intimidating court processes where Sandra felt outnumbered

Individual communication experiences

Helen
Being... by Gina ...ss

Jen
A ghost in the courtroom: Sense of being talked about, helpless and disregarded

Sandra
Lack of understanding about addictions (social services)

Gina
Lack of collaboration: One set of rules for one side and not the other.

Helen
Pressure... resulted in... was seen... within ser... drinking, ... giving ex...

Helen
Lack of transparency and collaboration

Jen
Lack of transparency [social services] and sense of being surveyed leading to lack of trust from Jen

Inflexibilit... services l... educed e...

Helen
eciproca... nd transp... Helen and...

Punishment based processes

Helen
Punishment based

Gina
Inflexible, non-compassionate and punishment-based procedures to make people comply.

Ali
Honesty being punished by the services leading to secrecy and disengagement from potential support sources.

Sandra
Being left without support (both professional and family), signposting and alone after being honest.

Helen
Quality of care is dependable on individual worker's ability to keep an open mind and maintain compassion

Gina

...to meet ...sionals demands at ...st of honesty ...ngful recovery

Lack of open-mindedness from professionals

Helen
Lack of clarity and persistency in communicating a message

Jen
Lack of gradual approa... setting people up for failure

Gina
Do as you... emotiona... Gina ha...

Helen
Whose opinion gets listened to: Seen as not having a 'bad enough' problem and thus not taking action earlier

Who gets listened to

Ali
Lack of choice in terms of ...ript. Professionals ...itioning that their ...nion is more valuable

Power imbalance in the meetings where things were not discussed with Sandra and being openly judged for her decisions

Anna
Power held by the services over service users' voices

Broken promises and feeling abandoned

Anna
No follow-up support offered for substance misuse or post adoption despite the promise

Ali
Lack of continuing support/signposting once children are removed

Ffion
Services failing to mediate contact post rehab

Jen
Rapid... health... unit a... disch... OD

Jen
Feeling vulnerable and powerless with no say over her children's future

Ffion
Having to advocate for herself and find her way through legal pathways and being listened to

Sandra
Lack of support for mothers or helping a family to stay together, instead the focus seems to be exclusively on safeguarding children

Gina
Broken promises: Feeling disappointed and angry that after all the pain and effort she has gone through in rehab there was no plan in place

Struggling to take into account complexity

Helen
Focus o... rather th...

Child focus

Jen
Social services focusing on the child and not the family

Struggling to see vulnerability

Difficulties to see emotion in the context: When emotions got too high, aggression was the only way she knew how to handle.

Helen
Services struggled to see vulnerability behind Helen's actions

Ali
Being combative towards the services as it was the only way she knew to get her needs met

Sense that her needs do not matter to professionals following separation from children

Gina
This is just a job attitude and not caring about the people

Having to 'play the system'

Jer...
Pray...
An easy target who did not know how to work the system

Ffion
People getting away from...

Helen

Chapter 3: Contributions to Theory and Clinical Practice Appendix

Appendix A. An Extract from Reflective Diary

Running thoughts across the interviews

- Difficulty to ensure that I was just **checking my understanding and not analysing during the interview** (Smith, 2022). As clinical psychologists, we are used to checking understanding but also making meaning is a big part of our job (hypothesising and meaning-making). It was challenging to ensure that I am not adding my own analysis on top of people's experiences during the interviews.

- It was challenging to listen to people's experiences from **a neutral position**. As someone who values NHS and social care, it was upsetting to hear people's experiences of when things went wrong. I had to remind myself that this is a way people had made sense of one of the most difficult things that have happened in their lives. It might be that allocating blame and holding on to anger has helped them make sense of the pain they and their children had to endure.

- Frustration and upset how **mental health** and substance misuse is separated in our current systems. For example, none of the participants were offered MH support despite several of them asking for it. The only interaction people had with mental health services was being rejected or being admitted involuntarily.

  Reflection: As a mental health professional, I felt angry about the injustice of the system and the lack of preventative approaches we as a system are able to take.

  It does seem that substance misuse is viewed separately to MH, despite every participant saying that substances were the only way they knew how to deal with their pain.

- **Role of stigma**?? Being promised a 'recovery route' that often wasn't even planned due to professionals not believing that they can do it. Asking for help and clarity of the next steps after the loss of children with no avail.

  Review of drugs: phase two report - GOV.UK https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery#executive-summary: is imperative for people with dependent substance use to be given access to mental health treatment. Not to be turned away and told to address their substance use first.

- Lack of **timely involvement** and ignoring the pleas for help (P03, P04, P05). Sense of entrapment.

- Conceptualizing similar themes in a different way between participants. With some participants, I have conceptualised 'dealing with uncertainty' as part of the complexity and with others, I have conceptualised it as part of recovery (P05).

  On reflection: the role language plays in my interpretation of similar phenomena.

- Use of language: people who were recruited from the third sector seemed to have similarities in the language used due to the AA programme. There is a query of how much their reflections show their own story and how much of it is about learned

language that is repeated enough. And in either of these cases, how much does it matter?

> *i.e.,* P01: 'being in denial' (p. 10), 'being brought to my knees'(p. 40), 'surrender' (p.32), 'gratefulness for being an addict' (p.40)

- Noticing being drawn to some stories and pushed away from others. More energetic speakers who focused on self-efficacy were easier to analyse and look at a depth of their experiences (i.e., P05). In contrast, speakers who used a language representing fellowship were harder to keep in mind (i.e., P02).

  > *Reflection*: Risk of potential bias of whose stories will be represented in the findings and discussions. Different recovery pathways are valid, and my job is to stay close to people's experiences and notice when there is an urge to pull away from someone's story and reflect on why this might be.

P01 reflections

- The theme of distrust: asking the researcher, 'Why are you doing this' and at a later stage, reflecting that only people who have had this experience were really able to be there.
- The sense of participant feeling alone and scared
- Struggling to keep the participant on track. As a result, there are moments where I found myself frustrated as a participant was talking around the context and did not follow the participant as much as the approach would prescribe.
  Reflection: in future interviews, I need to be aware of this and notice when my emotions may interfere with the process.
- Emotive: crying when thinking about the impact this has had on one's children
- My own tearfulness in response and feeling unable to do anything as I was there in a research capacity.
- The pull between knowing that this was for the best and the impact this is having on people's lives. Old coping strategies are the only things to rely on.
- The importance of being human.
- Noticing my own sense of discomfort to sit with the sadness as 'this is research and not a therapy'
- Noticing my anger, 'Why are procedures more important than human beings?'

P01 analysis reflections

- I noticed my own judgements when P talked about being glad that her children were removed. This is not something that I noticed during the interview, probably due to the focus being on the conduction of the interview.
  To ensure that my analysis was not biased, I stepped away from analysis and acknowledged that it is a human reaction. I let myself experience a brief disgust and returned once it had subsided.

  > On reflection: This was a very human reaction, especially considering the high emotiveness of the interview. Considering the context and participants' progress, I can see how human her reaction must have been when she was really struggling and taking away the kids must have felt like responsibility lifted.

Word Count

Thesis section	Excluding references, tables, appendices etc	Inclusive
Thesis summary	286	286
Systematic review abstract	186	186
Systematic review body	6,744	9.877
Empirical study abstract	199	199
Empirical study body	8,202	9,741
Contributions chapter with reflective commentary	3,985	4,721
Title pages, acknowledgements, contents, ethics appendices, wordcount	N/A	6,401
Total word count	19,602	31,411