Citation for published version (APA):
Bacon, G., Sweeney, A., Batchelor, R., Grant, C., Mantovani, N., Peter, S., Sin, J., & Lever Taylor, B. (Accepted/In press). At the Edge of Care: A systematic review and thematic synthesis of parent and practitioner views and experiences of support for parents with mental health needs and children's social services involvement. Health and Social Care in the Community.
At the Edge of Care
A systematic review and thematic synthesis of parent and practitioner views and experiences of support for parents with mental health needs and children’s social services involvement

Authors
1. Ms Georgia Bacon
Department of Psychiatry, University College London
Maple House
149 Tottenham Ct Rd
London W1T 7BN
georgia.bacon.21@ucl.ac.uk

2. Dr Angela Sweeney
Institute of Psychiatry, Psychology & Neuroscience, Kings College London
16 De Crespigny Park
London
SE5 8AF
angela.sweeney@kcl.ac.uk
Orcid ID: ORCID 0000-0001-6020-7490

Oxford Institute of Clinical Psychology Training and Research, University of Oxford
Isis Education Centre
Warneford Hospital
Headington
Oxford OX3 7JX
rachel.batchelor@worc.ox.ac.uk

4. Ms Claire Grant.
Institute of Epidemiology & Health, University College London
Department of Epidemiology and Public Health
University College London
1-19 Torrington Place
London WC1E 7HB
claire.grant.20@ucl.ac.uk
Orcid ID: 0000-0002-1545-6428

5. Dr Nadia Mantovani.
Population Health Research Institute, St George’s University of London
Cranmer Terrace
London SW17 0RE
and
Clinical Research Unit
South West London & St George’s Mental Health Trust
Trinity Building, Springfield University Hospital, 15 Springfield Drive, London
SW17 0YF
nmantova@sgul.ac.uk
Orcid ID: 0000-0002-0352-7444

6. Dr Sarah Peter.
Early Years Programme, Anna Freud National Centre for Children and Families.
Anna Freud Centre
4-8 Rodney Street
London N1 9JH
sarah.peter@annafreud.org

7. Professor Jacqueline Sin.
School of Health and Psychological Sciences
City, University of London
Northampton Square
London EC1V 0HB
United Kingdom
jacqueline.sin@city.ac.uk
Orcid ID: 0000-0003-0590-7165

8. Dr Billie Lever Taylor*
Faculty of Nursing, Midwifery & Palliative Care, Kings College London
James Clerk Maxwell Building
57 Waterloo Road
London, England
SE1 8WA
billie.levertaylor@kcl.ac.uk
Orcid ID: 0000-0002-6865-3425

*Corresponding author

Correspondence:
Faculty of Nursing, Midwifery & Palliative Care
King’s College London
57 Waterloo Road
London SE1 8WA.

Conflict of Interest: None
ABSTRACT

A range of professionals and services are involved in supporting parents with mental health needs where there are child protection concerns. However, they do not always meet the needs of this population who tend to experience inadequate support and mistrust of services. This review aimed to synthesise parent and practitioner experiences and views of support for parents with both mental health needs and children's social services involvement. We performed electronic searches of the following databases: PsycINFO, CINAHL, HMIC, Medline, Embase, Social Policy and Practice, Social Services Abstracts, Social Science Citation Index, OpenGrey, Social Care Online, and ProQuest. Following searching and screening, 41 studies were identified including 359 parents and 1370 practitioners. We worked with a Lived Experience Advisory Group to develop the following themes: 1) a downward spiral of service intervention; 2) working with parents, not against them; 3) support wanted versus support provided; and 4) constrained by service rigidity. We found that families were often parenting amidst trauma and adversity. However, service involvement could trigger a 'downward spiral' of stressful processes and pressure over which parents felt they lacked control. Instead of improving their situations, support sometimes added to families’ difficulties, worsening parents’ mental health and making them feel marginalised, criticised and re-traumatised. There were, however, also examples of positive practice, where practitioners and parents developed trusting, open, and mutually respectful relationships. Practitioners often felt they were limited in their ability to offer collaborative, holistic care because services were fragmented, under-funded, crisis-driven, and inflexible. Difficulties mentioned most often by parents, such as financial issues, tended not to be a focus of available interventions. We conclude that the key issues identified must be targeted to improve support.

KEY WORDS parental mental health, child protection, social services, mental health services, parenting support, systematic review, qualitative research
INTRODUCTION

Many people who have contact with mental health services are primary caregivers, with recent estimates reporting that up to 38% of those attending inpatient psychiatric services, and 51% attending outpatient services, are parents to children under the age of 18 (Maybery & Reupert, 2018). Having a child is a time of significant transition and change; estimates suggest that one in four women experience anxiety or depression during or after pregnancy (Parfitt & Ayers, 2014) while approximately 35% of women with a pre-existing diagnosis of psychosis or bipolar disorder experience an escalation postnatally (Wesseloo et al., 2016). Whilst research predominantly focuses on maternal mental health, nearly a third of fathers also experience psychological distress during the early parenting period (Giallo et al., 2012). Mental health difficulties can have wide-reaching impacts on parents and their families, especially as young children are heavily dependent on caregivers for their welfare. Whilst the majority of parents with mental health difficulties do not maltreat their children, parental mental health problems have been associated with increased risks for child maltreatment (Ayers et al., 2019).

Children’s social services provide a range of supports for families with vulnerable children and may instigate child protection procedures where a child is deemed at risk of harm. In the US, national data shows that parents with mental health diagnoses are eight times more likely to have children’s social services involvement and 25 times more likely to lose custody of their children compared to the general population (Kaplan et al., 2019). Research using administrative health and child protection records illustrate high levels of pre-existing mental health needs among mothers with child protection involvement in the UK (Pearson et al., 2021, Griffiths et al., 2021). Despite this, parental mental health received limited attention in the UK government’s recent plan for children’s social care reform (UK Department for Education, 2023).

Mothers with mental health diagnoses and child protection involvement have often experienced social services intervention as children, suggestive of an intergenerational cycle of trauma (Armfield et al., 2021). They are also more likely to be socially deprived, unemployed and to experience domestic violence (Ruud et al., 2019; Sheppard, 1997), indicating a complex interplay of risk factors, needs and wider inequity. Recent UK population data found that a combination of parental mental health difficulties and financial hardship was associated with poorer physical, mental and behavioural outcomes for children (Adjei et al., 2022). The impact of financial hardship on social services involvement is supported by a recent review of UK local authorities finding that children in the most deprived neighbourhoods were 13 times more likely to be on a Child Protection Plan and 11 times more likely to be looked after children than those living in the least deprived neighbourhoods (Bywaters et al., 2018).

Parents whose children have been removed by social services report feelings of shame (Siverns & Morgan, 2021), loss of hope (Diaz-Caneja & Johnson, 2004), escalating adversity and social isolation (Broadhurst & Mason, 2020). Some mothers go on to have further pregnancies in quick succession, with a high likelihood of repeated child protection interventions and custody loss (Shaw et al., 2017). Negative outcomes for
children can be exacerbated in the looked-after system, through multiple placements, bullying and, abuse (Stanley et al., 2005). Despite this, the number of looked after children in the UK is increasing and predicted to rise to 95,000 by 2025 (Newton, 2021).

There is a need for services to help support families with mental health needs and children’s social services involvement, preventing both the maltreatment of children and, where possible, the traumatic separation of children from their birth parents. What constitutes a ‘child protection intervention’ varies globally (Gilbert et al., 2011). Countries such as the US and UK take a ‘child protection orientation’, focusing on risk to children and the primary involvement of child protection services, but often overlooking the wider system, including parents’ mental health and financial stability (Karpetis, 2017). Contrasting this is the ‘family service orientation’ adopted by European countries such as Sweden and Germany, where the psychological and socioeconomic problems of parents are considered central aspects of child protection (Gilbert et al., 2011). The structure of services also impacts the nature of the support offered. For example, evidence has shown that the involvement of separate health and social services creates professional collaboration difficulties, leading to fragmented delivery of support (Darlington et al., 2004; 2005). In recent years, there has been an increasing number of initiatives to integrate services and provide specialised care to parents across a range of settings (Cassells et al., 2014).

Reviews of interventions for parents with mental health diagnoses show that psychological therapy (Overbeek et al., 2022), practical support (Wahl et al., 2017) and whole-family interventions (Siegenthaler et al., 2012) can have a positive impact on family wellbeing and reduce risks of child maltreatment. However, effect sizes are small and research uses a broad range of outcomes to measure effectiveness, making comparisons difficult (Van Der Put et al., 2018). Furthermore, there are a range of psychological, practical and cultural barriers to engaging parents of at-risk children (Kemp et al., 2009), and social workers cite parental non-engagement as a major contributing factor in social services decisions to issue care proceedings (Broadhurst et al., 2017).

Qualitative evidence of parents’ and practitioners’ views offers additional insights into how engagement, implementation and outcomes for parents might be improved. As well as struggling with the demands of parenting, parents with mental health needs can report their parenting role as a source of strength, resilience and hope (Perera et al., 2014; Venkataraman & Ackerson, 2008). Many parents fear custody loss and consequently are resistant to social services intervention (Ackerson, 2003). Concerns have been raised over the heavy use of diagnostic labels such as ‘personality disorder’ in this population, resulting in negative assumptions and service exclusion (Bartsch et al., 2016). Given the possibilities of intergenerational trauma, it has also been argued that a lack of trauma-informed care may make support difficult for parents to engage with (Mason et al., 2020). Overall, parents value flexible and holistic care, for example, 24-hour crisis services and family case management (Hinden et al., 2005). Recent research has suggested a ‘recovery
approach’ to child protection may be more able to incorporate service-users’ personal goals for parenting and mental wellbeing (Duffy et al., 2016).

Research examining practitioners’ views of service models has emphasised the need for greater collaboration between mental health and social work practitioners (Coates, 2017; Stanley et al., 2003). High staff turnover among both mental health and social work professionals is common (Healy et al., 2009) as well as a lack of appropriate resources, supervision and high caseloads (Afzelius et al., 2017; Paris & Hoge, 2010). There is a need to understand the impact of these system constraints on both professionals and the families they support.

Whilst existing research offers insight into different aspects of support, synthesising the evidence systematically allows us to gain a more comprehensive understanding of experiences and views of support for parents with mental health needs and children’s social services involvement. Despite methodological challenges involved in synthesising qualitative research (Popay, 1998), there is growing recognition of the value of synthesising people’s experiences and views of treatment or services to inform recommendation for policy and practice changes (Harden, 2004). Furthermore, existing literature outlines steps authors can take to ensure qualitative evidence is synthesised with sufficient rigour, whilst maintaining the context and meaning present in individual studies e.g. Thomas and Harden, 2008). Whilst existing reviews focus on parents with mental health needs (Radley et al., 2022) or those with child protection concerns (Van Der Put et al., 2018), families with both mental health and children’s social services involvement have a distinct set of needs which single-focus interventions often neglect (McPherson et al., 2018). The nature, structure and names of these services differ between contexts, but for the purpose of this review we will use 'children's social services' to mean services designed to support and protect vulnerable children.

We aimed to carry out a systematic review and thematic synthesis of parents' and practitioners' experiences of support and interventions for parents with mental health needs and children’s social services involvement. The objective was to explore parents’ and practitioners’ views of support, including understanding the facilitators and barriers to meeting the needs of families and the impact of social and demographic factors on how support is received.

What is known about this topic

- The effects of child abuse and child protection involvement are profound and enduring for both parent and child.
- A range of services and professionals are involved in supporting parents with mental health needs and children’s social services involvement.
- These parents have diverse and complex needs and find it difficult to access and engage with support.
What this paper adds

• Children’s social services involvement places parents under pressure, creating stress and sparking a cascade of stressful professional involvement which parents feel they lack control of.
• Trauma-informed, transparent and collaborative support is crucial to parental engagement with services.
• Organisational factors including resources, timing of care, service structure and high caseloads limit the quality of support professionals can offer.

2. METHODS

2.1 Search Strategy

We followed PRISMA reporting guidelines throughout (Page et al., 2021) and prospectively registered the study protocol on PROSPERO (CRD42022310600). The protocol was developed collaboratively by our multidisciplinary review team which included survivor, clinical and social science researchers and clinicians working in this field. We identified eligible studies for the review by searching eight electronic databases: PsycINFO, CINAHL, HMIC, Medline, Embase, Social Policy and Practice, Social Services Abstracts and Social Science Citation Index. We searched grey literature on OpenGrey, Social Care Online and ProQuest. We completed forward citation searching of included studies in Google Scholar. Studies were also identified through expert recommendations from the review team and their networks.

Our search strategy included MeSH headings and free-text terms based on the following key concepts centred around the SPICE framework (Booth, 2006): child protection/child abuse (setting), parents and health and social care professionals (perspective), support/interventions (phenomenon of Interest), Mental health (context) and qualitative/experiences (evaluation). We limited searches to studies published since the year 2000 to balance the breadth of studies returned with relevance to current service provision. Our search strategy can be found in the supplementary material (S1).

2.2 Screening and Selection Criteria

We imported all studies returned by searches into EPPI-reviewer and removed duplicates. The eligibility criteria found in Table 1 were used to screen the titles and abstracts of papers as well as for subsequent full-text screening. Two reviewers independently completed double-screening of 10% of studies from both the title and abstract and full-text pools. One study (Storhaug & Oien, 2012), including the experiences of fathers whose partners had mental health diagnoses, was taken to the wider review team for further discussion before being excluded from the final pool. Lastly, forward-citation searching was completed for included papers, and any identified studies were double-screened.
2.3 Quality Appraisal

We used the Critical Appraisal Skills Programme (CASP) qualitative checklist (2018) to assess the quality of included papers, as recommended in Long et al. (2020). Discussion with the review team identified the importance of additional areas of assessment relevant to the review: positionality, service-user involvement and intersectionality, which were added as key questions 11-13. A full version of the adapted CASP and further information about scoring used in this review can be found in S2. We rated included studies 'Yes' 'No' or 'Can't tell' for each CASP criteria, with 10% of studies doubly rated and discrepancies resolved through further discussion. In cases of uncertainty or insufficient information required for scoring, we allocated studies 'Can't tell' for that criterion. The quality assessment of two studies (Perera et al., 2014; Stephens, 2019) required the acquisition of additional details of the study methodologies. We chose not to exclude studies from the review based on quality as we recognised that low-quality studies may still offer useful perspectives important to the review. Instead, we aimed to gain insight into the strength of evidence and methods used.

2.4. Lived Experience Involvement

We sought input from a Lived Experience Advisory Group (LEAG) consisting of four mothers from diverse cultural and socioeconomic backgrounds with lived experience relevant to our topic. During the data synthesis stage, we held two data workshops with the group who used their experience of mental health difficulties and children's social services involvement to help us make sense of the findings and their implications. Data workshops were informed by Shimmin et al. (2017) principles for trauma-informed intersectional Patient and Public involvement in research. Given the sensitive nature of this review, one-to-one debrief meetings were offered to each LEAG member after meetings.

2.5. Thematic synthesis

We analysed the findings using thematic synthesis in line with Thomas and Harden's approach (2008) including i) coding text, ii) developing descriptive themes and iii) generating analytic themes.

2.5.1 Data extraction

We imported included studies into NVivo fusing separate NVivo files for parents and practitioner views to allow for separate coding and subsequent comparison of their viewpoints. Since the review focused on support, we restricted coding to aspects of the results section that discussed parents' or practitioners’ perspectives and experiences of receiving/providing support. We adopted a broad definition of support, including a range of health and social care interventions/support, such as mental health, social work, parenting/caregiving, or practical support aimed at parents and provided by professionals from different backgrounds and services.
2.5.2 Data analysis

First, the lead author coded findings inductively into descriptive codes, and a second author (initials) independently coded 10% of studies. The two authors then met to compare coding frames and develop a shared understanding of the data. The early codes and ideas for descriptive themes were presented in separate online meetings of the LEAG and wider review team, who offered their understanding and interpretations of the early themes. We documented insights from these meetings with the group’s permission, and these informed our later analytical processes. In the final stage of analysis, we developed analytical themes in an iterative process involving discussions with the review team and a second data workshop with the LEAG. The involvement of lived experience advisors, clinicians and multidisciplinary researchers helped us ground findings in experiential knowledge. This allowed the interpretation of data from multiple cultural and social perspectives as well as discussion of issues felt to be missing from the literature.

3. RESULTS

3.1. Description of Included Papers

We managed database searching and screening in EPPI-reviewer. A full description of the screening process can be found in Figure 1. Our review included 41 eligible papers, including 39 peer-reviewed studies and two reports published by charities (Table 2). Ten studies included both parents and professionals, 15 studies focused on parents only and 16 on professionals. This review includes the experiences of 337 parents receiving support, mostly mothers. Parents had a wide range of mental health diagnoses including depression, anxiety, psychosis and personality disorders. Many had a history of psychological trauma, mostly child abuse or domestic violence. Most studies discussed children’s social services interventions in the context of child protection procedures for children under the age of 18 with only three studies focusing on parents with young children (<4 years old). The views of 1,370 professionals including social workers, family support workers, case managers, child protection workers, psychologists, psychiatrists, nurses, housing shelter workers, general practitioners and solicitors are reported. The large professional participant pool reflects the methods of data collection which included focus groups and online surveys, whereas parents’ views tended to be acquired through individual interviews.

In terms of settings, most participants were recruited from community mental health and social care services or local authorities. Two studies were set in services supporting the homeless (Barrow et al., 2014; Caplan et al., 2020). Studies were carried out in the UK (n=13), US (n=10), Australia (n=10), Canada (n=3), Sweden (n=2), New Zealand (n=2) and Japan (n=1)
3.2. Quality Assessment

There was a wide variation in the quality of studies, as seen in Table 3. All studies but one reported clear and relevant research goals, investigated with an appropriate design and methodology. Studies tended to score well on recruitment and data collection methods, but many lacked exploration of researcher reflexivity and adequate consideration of ethical issues despite, conducting interviews with a vulnerable participant group. Whilst several studies referenced a valid method of qualitative analysis, others did not provide sufficient detail required by the CASP criteria such as how analytical themes were derived from the data and were subsequently scored as 'can’t tell'. Most studies stated their findings and their implications clearly. Discussions of intersectionality, user involvement and positionality were rare, meaning most studies scored low on the additional quality assessment criteria. 26 studies did not report basic demographic information about participants limiting our understanding of how participant sociodemographic and researcher identity impacted findings and conclusions.

3.3. Thematic Synthesis

We developed four overarching themes encompassing both parents’ and practitioners’ views and experiences of support: 1) A downward spiral of service intervention; 2) working with parents, not against them; 3) support wanted vs support provided; and 4) constrained by service rigidity. We use 'parents' throughout to acknowledge the mixed participant pools, but most perspectives in the literature were those of mothers. An overview of themes, sub-themes and quotes is reported in Table 4.

3.3.1. A downward spiral of service intervention

Parents wanted support from services, but often found that service intervention triggered a stressful and intrusive process over which parents lacked control. Instead of improving their situations, intervention contributed to further difficulties and, when it culminated in parents being separated from their children, practitioners sometimes described this as almost inevitable.

**Needing support but fearing the consequences.** Parents identified negative consequences both of seeking and not seeking service support, meaning they felt as if there was no way out of their situation. When parents sought help, they expressed concerns that they would be viewed as unfit parents and lose custody of their children, fears they felt were often later confirmed. Consequently, some parents reported concealing information about their difficulties, but this sometimes resulted in them being judged as uncooperative or avoidant by professionals:

“Social services still say to this day if I end up in hospital… I’d lose the kids. So that hangs over your head – it makes you stay quiet rather than say anything at all... It’s been said I don’t give social services enough information on a regular basis – I’ve been put down as uncooperative”

[mother] [Stanley et al., 2003]
When parents did seek support, they reported that professionals, especially social workers, started from the assumption that “women with severe mental illness are unlikely to be adequate mothers” (Diaz-Caneja & Johnson, 2004). One study analysing social workers’ diary entries found evidence of derogatory language to describe parents, their homes and lifestyles (Turesson, 2020) arguably confirming parents’ fears of negative judgement.

**Social service involvement exacerbating mental health difficulties.** The involvement of children's social services was described as triggering “a clock ticking” (Barbour et al., 2002), leading to pressure on parents, custody disputes and intrusive home visits. In one paper, a mother described her experience of attending a custody case conference as "being thrown to the wolves" (Ghaffar et al., 2011). Interactions with child protection workers were experienced as "daunting", "intimidating" and "traumatic", contributing to a worsening of mental health symptoms, reduced confidence and strained relationships with parents' wider support networks.

The threat of custody loss was a heavily destabilising factor at the very time parents were required to 'prove' their parenting abilities. Losing custody of children was described as a “universally traumatic”, “stigmatising” process which exacerbated mental health difficulties, undermined parents' motivation to engage with treatment and often led to suicidal thoughts:

"I’m stuffing myself with pills to help with anxiety...If I was feeling suicidal at the beginning, you know, when I left the hospital, now I feel four times more suicidal because of what [social services] are doing." [mother] (Lever Taylor et al., 2019)

Whilst mental health clinicians echoed the risk to parental wellbeing following child removal, child protection workers felt stuck between the decision to remove the child or not, knowing it would impact parents but feeling pressure to act in the child’s best interests. Child removal decisions were a common point of contention between professionals from different services.

**Mental health treatment making parenting difficult.** Both parents and professionals reported potential negative impacts of mental health difficulties on parenting, often in terms of disrupting parent-child bonding, reducing parents’ ability to emotionally regulate themselves and their children and making it difficult to provide appropriate support or set boundaries. However, treatment for mental health difficulties didn't always alleviate these problems. Some parents reported that medication side effects such as tiredness and concentration difficulties made parenting tasks "impossible", leaving them choosing between following their treatment plan or caring for their children:

"What comes first? Me sleeping or me being available for my child?" [mother] (Perera et al., 2014)

However, even if treatment wasn't perceived as helpful, parents felt they had to prove their engagement with services and comply with treatment plans to maintain or regain custody of children.
3.3.2. Working with parents, not against them

Many studies discussed how professionals from a range of services worked with and engaged parents and correspondingly how parents viewed professionals and the services they worked for. Professionals discussed various engagement techniques and examples of ‘good practice’. These often aligned with what parents wanted from professionals but not with the support they said they received.

Engaging parents through relationship building. From both parent and practitioner perspectives, relationships between parents and professionals were fraught. High levels of trauma in parents’ backgrounds, coupled with previous negative experiences with social services in some cases, led to parents beginning interactions with professionals from a place of mistrust, viewing social service intervention as "synonymous with the risk of their baby being taken into care" (Hanley & Long, 2006). In some cases, parents felt negative judgement and child removal was inevitable so they “shut down” and disengaged to protect themselves (Siverns & Morgan, 2021). Many parents felt professionals weren’t interested in their needs or background:

“No one wanted to hear about me. What I had been through did not matter to them.”
[mother] (Stephens, 2019)

However, there were examples of professionals taking steps to build positive relationships with parents through normalising their difficulties and being flexible with when and where they offered support. Generally, mental health clinicians reported making efforts in this regard more than social workers:

"I can have all these great interventions, but if I do not have a good rapport or relationship with the parent, it's not going to do anything." [mental health clinician] (Yoo et al., 2020).

Despite these efforts, both professionals and parents identified that some parents aren’t ready to engage with services and that "chasing" these parents was not a good use of resources nor therapeutically beneficial (Coates & Howe, 2015).

Some parents described how various sociodemographic factors, such as ethnicity and single parenthood impacted how professionals viewed them and consequently their engagement with services. One mother felt “condemned” for raising a child on her own, whilst another believed her race led to her being viewed by social workers as ‘the problem’. Both experiences led to further mistrust of services.

Working with trauma. A recurring theme was the prevalence of parents’ own experiences of childhood abuse or maltreatment as well as ongoing adversity in adulthood. Professionals from all services recognised this as an explanation for current parenting difficulties and reported using it to relinquish blame from parents:

"I never see a mom who comes in here as a bad mom. I just see that there’s been an unfortunate set of circumstances that got off track" [mental health clinician] (Yoo et al., 2022).
However, very few studies mentioned how acknowledging trauma influenced professional practice with only one study explicitly mentioning the use of trauma-informed care in child protection practices (Scott et al., 2018). At the same time, adopting a 'trauma-informed' label didn't necessarily indicate that parents' difficulties were grounded empathically within an understanding of their past experiences and wider circumstances. For example, the title of a study focused on trauma-informed care reads "They're not bad parents, they've just made bad choices" (Yoo et al., 2022) arguably suggesting these parents have 'chosen' to be in their difficult situations, rather than these choices themselves being understood also as rooted in a wider context of adversity and inequity.

Most parents found it useful to talk about their history of trauma with a trusted professional. However, some parents felt 'haunted' by their past, believing social workers based their judgements on past difficulties, even when parents had made positive changes. Many child protection professionals were doubtful about parents being able to make changes because of their upbringing:

"I don't think we can make the changes that we say we can make because these families have many generations of abuse and trauma behind them" [family worker] (Coates & Howe, 2015)

**Strengths-focused vs deficit-focused.** Parents felt that children's social workers focused heavily on 'failures' of parenting and risk assessments leading to parents losing confidence in their own abilities to care for their children. This aligned with some social workers' views of mental health difficulties as chronically impacting their ability to parent. The concept of mental health recovery was discussed in different ways by parents and professionals, with parents emphasising their parenting role, cultural identity and connection to others, whilst professionals across services focused on symptom management (Scott et al., 2018).

Despite this, there were examples of strengths-focused practice leading to positive outcomes, with practitioners recognising parents’ devotion to their children, resilience and determination. One mother described how social workers' "belief in her ability to change motivated her to seek help and focus on the needs of her children" (Ghaffar et al., 2011). Some innovative parenting interventions such as the Invisible Children's Project (Hinden et al., 2005) deliberately incorporated a 'strengths-based model' which led to improved parental engagement.

**The importance of transparency.** Parents described child protection services as "ultimately powerful but unpredictable" (Honey et al., 2021). They recognised that these professionals had power over their lives but felt “kept in the dark” with regards to decision-making (Ghaffar et al., 2011). Parents reported frustration that they weren't told what was expected of them by services and what consequences might follow. A lack of transparency contributed to parents' mistrust of services with one mother commenting: "If they’re not being straight with you, how can you be straight with them?" (Stanley et al., 2003). When parents were given information, they often struggled to understand the professional jargon, and therefore couldn’t “compete on equal terms” during child custody disputes (Ghaffar et al., 2011).
Forming a collaborative partnership facilitated parental engagement. Examples of this included involving the whole family in decision-making processes, regular communication with parents and transparency surrounding expectations for parenting. Even when difficult decisions were made e.g. child removal, seeking the involvement and agreement of parents first resulted in better outcomes for both parties.

3.3.3 Support wanted vs support provided

Studies described support provided by a range of services, enabling the identification of support considered most helpful by parents and most important by professionals. In many cases, the two perspectives did not align. The support provided was often manualised and rigid, contrasting to parents finding flexible care most helpful. Difficulties mentioned most often by parents, e.g. financial issues, tended not to be a focus of available interventions.

**Parenting support.** Parenting (particularly mothering) identity was central to parents’ strength, resilience and mental health recovery. Support with parenting was appreciated when delivered in a non-judgemental way by a trusted professional.

Parents reported that mental health interventions often neglected their parenting role and its impact on wellbeing, with one mother stating that her mental health team were unaware she had a child despite being greatly affected by losing custody of her daughter (Diaz-Caneja & Johnson, 2004). Ten studies mentioned parents making efforts to maintain contact or regain custody following child removal and parents appreciated support with this. However, parenting support was often withdrawn following child removal and parents received little support for managing the emotional and practical fallout of custody loss.

**Financial support.** Both parents and professionals recognised the detrimental impact of financial difficulties on emotional wellbeing and parenting. Financial deprivation, and related housing, legal and childcare difficulties, made service engagement difficult, with many parents struggling to make appointments. It also impacted parents’ ability to maintain custody, gain visitation rights and leave abusive partners.

Despite the centrality of financial issues in the literature, they were rarely a focus of service support. Parents felt shame over their struggles to meet their children’s basic needs, worsened by services’ inability to support them with this. Instead, mental health support was prioritised whilst basic needs remained unmet:

"They wanted to put me on medication. But I was depressed because I was homeless and I got five kids. I don’t take pills so I terminated that service. They never said nothing about helping me with housing" [mother] (Staudt & Massengale, 2015).

Services offering financial support described this as "essential" and "critically related to achieving and sustaining desired outcomes" such as retaining custody of children (Hinden et al., 2005).
**Mental health support.** Parents found the focus on mental health diagnosis confusing, often receiving inaccurate or conflicting diagnoses from different professionals. Certain diagnoses, such as 'personality disorder', typically led to social work professionals viewing these parents as 'high risk' and resistant to change. Conversely, those with postnatal depression more commonly felt their difficulties had been sanctioned by a diagnosis (Hanley & Long, 2006). Whilst some professionals found diagnostic labels useful (e.g. to externalise blame), others saw pitfalls to this practice: "we don’t see the person, we often just see the diagnosis" [mental health nurse] (Barbour et al., 2002). At times, an over-reliance on diagnoses led to the pathologisation of parenting difficulties and even experiences of domestic violence - with a tendency to “diagnose, medicate, discharge” [mental health clinician] (Humphreys et al., 2016).

Nevertheless, some parents were positive about the therapeutic relationships built with psychologists, therapists and mental health workers. Psychological therapy was generally perceived as helpful, particularly if parents were able to speak about a range of difficulties during therapy sessions. Therapy also helped parents cope with the stress of child protection involvement and improved engagement with these services. Parents were positive about group therapy and peer support as ways to normalise their difficulties and meet other parents in similar positions, but these services were rarely provided.

**Working with wider support networks.** Thirteen studies discussed the importance of family and friends as sources of support and stability for parents and their children. Despite familial relationship difficulties, extended family members often took on child-care responsibilities when parents couldn’t manage on their own.

“Those parents who had a strong social support network, whether it was family, friends, or church were able to cope with crises better than those who were more socially isolated”.

(Ackerson, 2003).

Professionals recognised the importance of parent’s support networks but also the tendency for family and couple relationships to become strained and "create stress" for parents (Yoo et al., 2022). Professionals across a variety of services primarily engaged with parents and rarely mentioned working with wider support networks. The peripheral role of fathers is reflected by participant demographics within the literature: 16 out of 25 parent cohorts were made up solely of mothers and mothers also comprised the great majority of participants in studies with mixed cohorts. Where discussion of fathers was included, fathers reported their parenting role as central aspects of their lives, but services tended to place pressure solely on mothers to care for children. There were mixed views on this among professionals yet a sense that attitudes were changing:

"The dad is a real asset, but he has not been allowed to participate...I have personally decided that the fathers should now be included, but I have really had to work on myself. We are not in complete agreement within the treatment group.” [social worker] (Turesson, 2020)
3.3.4. Constrained by service rigidity

Organisational constraints contributed to frustration among professionals across a range of services who felt powerless against, yet heavily impacted by, issues such as inadequate resources, rigid processes and service inaccessibility. Parents felt the impact of these constraints either directly via service accessibility or indirectly via its impact on professional practice.

**Fragmented services.** The involvement of professionals from separate services meant no one could take a holistic view of a parent's situation, family and intersecting needs. Children's social workers typically lacked understanding of parental mental health and were anxious about complex cases involving mental health needs. Some viewed parents' and children's needs as separate and conflicting, concluding that "it may not be possible to work on behalf of children while attending to their parents who have a serious mental illness" (Afzelius et al., 2017). Others understood parents' and children's perspectives were interdependent but felt they weren't trained to juggle both. Mental health clinicians felt parenting capacity assessments were beyond their role and were in turn described by social workers as "having little concern" for children (Mason et al., 2018).

Barriers to service collaboration included professional differences (conflicting priorities, different risk assessments, information sharing) and organisational barriers (lack of time, training and funding). Mental health professionals, particularly psychiatrists, were described as difficult to communicate with, which meant that social workers lacked sufficient information to be able to support families:

"I felt a lot of the time that [mental health professionals] weren't helping us...we came from two very different angles. They were very mum-focused, client-focused and we were very client-focused but on the child really, so I found they weren't giving us a lot of the best information" [child protection worker] (Darlington et al., 2005)

Some studies evaluated service efforts to improve collaboration, ranging from whole-family teams (Coates, 2017; McPherson et al., 2018) to the specialised training of individuals responsible for service integration (Davidson et al., 2012). In general, these services reported better outcomes such as reduced incidents of child removal.

The extent of separation between services differed between countries. A comparative study showed that professionals working in England reported less collaboration and knowledge outside of their field than those in other European countries (Hetherington & Baistow, 2001).

**A heavy focus on risk.** Child protection workers consistently discussed risk evaluation and found decisions surrounding parents with mental health difficulties "stressful, uncertain and complex" (Rouf et al., 2012). They felt they lacked sufficient information about a parent's mental health and subsequently relied on their intuition rather than concrete evidence in decision-making. They reported imagining the “worst case
scenario”, exacerbated by media reporting of cases where social services failed to protect a child. Some reported a shift from the traditional 'family maintenance' discourse to reduced risk tolerance among professionals:

"I would say that there is no risk-taking now. It’s about what will happen—what will the headlines say if I don’t remove this child?" [social work manager] (Barbour, 2003).

Parents reported that a sole focus on risk overshadowed hope for recovery and recognition of their strengths, feeling instead "reduced to a mental illness and its attributed risks" (Scott et al., 2018). Risk to parents was mentioned much less frequently than risk to children and mental health clinicians believed child protection services neglected risk to parents in their decision-making.

Professionals across services reported high caseloads and worried about their work outside of hours. There were several examples of how providing further support for professionals improved their practice. A range of professionals viewed opportunities to reflect on practice and engage in supervision as vital for making collaborative, good decisions. Service models designed to facilitate inter-agency cooperation allowed social service professionals to "work therapeutically whilst holding high levels of risk" (McPherson et al., 2018).

**Service inaccessibility.** Professionals and parents viewed mental health support as crisis-driven rather than preventative, contributing to parents feeling betrayed when services were unable to provide support. Once services were involved, the situation was likely to have reached 'crisis point', meaning actions to control risk were "inevitable" (Coates & Howe, 2015). Professional frustration and powerlessness over limited service resources mirrored that of parents, with one social worker recognising "you’ve got to fall before they’ll listen, and that’s that" (Darlington & Feeney, 2009). Working with constant crises also contributed to poor staff wellbeing, high staff turnover and burnout. Focus on crisis care over early intervention was shared by all European countries but was "most marked" in England (Hetherington & Baistow, 2001).

Another aspect of accessibility is understanding and meeting cultural needs. Culturally informed support was only discussed in one study (Caplan et al., 2020) yet Indigenous-Canadian parents in this study were reliant on culturally informed interventions to support their mental health and reconnect with their children following custody loss.

Regarding practical access to services, a lack of child-care facilities at mental health services and travel distances made appointments difficult to attend. Some professionals recognised parents’ efforts to engage despite these practical barriers:

"The whole thing may take four hours just to come to therapy, but [mothers] did it every week.” [mental health clinician] (Yoo et al., 2022).

Social workers viewed mental health services as inaccessible due to their "strict, hard boundaries" in terms of who is eligible for support (Darlington & Feeney, 2009).
4. DISCUSSION

This review provides a synthesis of experiences of support for parents with mental health needs and children's social services involvement. Our findings reveal that children's social services involvement tends to trigger a 'downward spiral' of stressful processes and pressure on parents, worsening their mental health and ability to cope. What begins as service 'support' can culminate in a traumatic process of intrusive intervention and even child removal, a result some professionals report as inevitable given the late stage at which support is offered. Parents tended to focus on the way in which professionals worked with them, discussing various approaches that made support easier to engage with, such as professionals prioritising practical support, relationship-building and transparency. Whilst professionals identified similar relational approaches as important in theory, organisational constraints such as a lack of funding and the crisis-driven nature of care limited their ability to provide therapeutic, collaborative and effective support to parents and their families. Fragmented service structures meant that professionals were rarely able to take a holistic view of parents' support needs.

Overall, parents were fearful of the consequences of service involvement and mistrustful of professionals. These findings align with previous research on parents at risk of custody loss, which suggests that mistrust of professionals, or low 'epistemic trust', leads to service disengagement and the commencement of child removal processes (Mason et al., 2020). The authors suggested that mistrust of professionals stems from adverse childhood experiences and intergenerational trauma, concluding that "acts of resistance or rejection of professional help can be seen as adaptive—given women's childhoods and relationship histories" (pg. 1). In our review, many parents reported a history of trauma, including child abuse and domestic violence. This suggests that adopting trauma-informed approaches, where professionals and the services they work under resist re-traumatisation, working collaboratively and openly with parents, is crucial to services becoming more trustworthy. Whilst child protection services in various countries incorporate trauma-informed care for young people (Conners-Burrow et al., 2013), this review argues for the extension of these practices to parental support.

A recent report from Child Protection England recognised that "multi-agency arrangements for protecting children are more fractured and fragmented than they should be" (Child Safeguarding Practice Review Panel, 2022, pg. 9) and our findings suggest this issue is common in other countries too. Our review found that multi-agency collaboration is heavily impacted by the separation of mental health and social care, and of child and adult care within these services. However, we found examples of local initiatives designed to facilitate collaboration between services, ranging from the creation of whole-family teams e.g. Coates (2017) to the specialised training of individuals responsible for service integration e.g. Davidson et al. (2012). Insights from these initiatives shed light on the mediators, and positive impact, of effective collaboration. A further barrier to interagency working is information-sharing, with child protection workers reporting frustration at mental health services not sharing information about parents, and vice
versa. This review provides supporting evidence for efforts to improve collaboration across services. For example, following the independent review of children's social care (MacAlistair, 2022), the UK government have announced plans to create "a decisive multi-agency child protection system" including social workers, family support workers and specialist workers e.g. mental health professionals to address barriers to inter-agency working and collaboration (UK Department for Education, 2023, pg. 5). Whilst this is a positive response with the potential to improve outcomes for families, our lived experience advisors raised concerns about information being shared ‘behind parents’ backs’ making it difficult for them to feel able to disclose concerns to anyone safely. Therefore, a move to more cooperative working must be mindful of respecting parents’ rights to confidentiality, particularly in mental health services.

Mental health and parenting difficulties do not occur in isolation, yet discussions of social and cultural factors were largely absent in the studies included in this review. Quantitative research reports a complex interaction between financial deprivation, ethnicity and child protection interventions, which requires accurate reporting to explore fully (Bywaters et al., 2016). Nevertheless, the present review finds that current qualitative evidence on child welfare and/or child protection do not explicitly adopt intersectional framework to expose potential inequities in child welfare processes and outcome. This made it difficult for us to understand the impact of structural factors such as class, ethnicity and financial hardship. Our review also raises concerns about potential widespread lack of understanding of these factors among professionals, with some parents reporting that child protection workers judged them based on aspects of their identity, including mental health diagnosis, single-parenthood and socioeconomic status. This was also emphasised by our lived experience advisors who felt families were treated differently by professionals based on their ethnicity and class, with families experiencing financial hardship and from ethnic minority backgrounds facing deep discrimination. Considering the person as a whole, their identities and complexities enable researchers to understand how the combination of these social identities affect how participants are viewed and treated by professionals and the institutions they worked in. For example, wider research has argued that racial patterns of deprivation best explain ethnic minority group overrepresentation in child protection (Bywaters et al., 2016). This suggests the intersection of ethnicity and financial hardship is crucial to incorporate into any approaches designed to address racial inequalities, yet interventions currently overlook this. For example, the UK government’s recent plan to address racial disparities in children’s social care fails to mention the role of financial deprivation (UK Department for Education, 2023).

The present review suggests that approaches to mental health treatment focusing on diagnostic pathways and medication offer only a partial response to parents’ difficulties. This was reflected by the disparity between the kinds of support parents wanted (financial, practical) and the support professionals typically discussed (medication, psychological therapy). Past research has identified complex links between financial hardship and both mental health (Kiely et al., 2015) and child neglect (Gupta, 2017), but studies rarely
mentioned financial support for parents, explained in part by the narrow, risk-focused and medicalised approaches mental health and children's services tend to adopt as well as a general lack of resources.

In line with previous literature (Antonopoulou et al., 2017; O'Connor et al., 2018), both social and mental health care professionals reported limited resources, high caseloads and burnout, difficulties also echoed in discussions with lived experience advisors and wider review team. The effects of under-resourced services permeated across all aspects of professional practice including relationship-building, collaboration and risk-management. A heavy focus on minimising risk and uncertainty also resulted in mechanisms and procedures that affected practitioners’ ability to provide therapeutic support and diverted attention from the complex, relational, political and moral contexts in which social work practice operates. Professionals, particularly those working in children's social services, were often aware of the negative impacts their actions may have on parents and children but felt powerless to do things differently in the face of these organisational constraints. This represents a high risk of 'moral injury', which occurs when staff are forced to comply with practices that they consider to be immoral and harmful (Reamer, 2021). This may explain the high number of staff choosing to leave social care roles, reflected by recent findings of a 50% increase in the number of vacant adult social care positions in England over the past year (Skills for Care, 2022). The reported detrimental impacts of public sector cuts and increased privatisation of social care as a way to reform children’s services (Jones, 2019) suggests a need to urgently target structural factors to protect staff from moral injury, reduce staff turnover and enable professionals to provide more effective support to parents and families.

As well as providing support to professionals, this review suggests ways in which current systems could be replanned to improve support for parents with mental health needs and children's social services involvement. Firstly, systemic changes to services enabling trauma-informed care would allow parents to engage parents earlier and more effectively in the child protection process, preventing an escalation of risk to children and parent-child separation. Secondly, mental health and social care is crisis-driven, making costly outcomes such as child removal more likely. A focus on early prevention could reduce the likelihood of these outcomes, freeing up professional time and money and ensuring better outcomes for families (Haynes et al., 2015). Finally, research literature demonstrates that investing in staff provides a range of benefits. For example, providing adequate training, supervision and reflection time reduces burnout and improves professional collaboration (e.g. Coates & Howe, 2015). Findings from this review suggest a target of training should be broadening practitioners’ approach to consider the interdependent needs of parents with mental health difficulties and their children. Crucially, improving professional practice in these ways is only possible in adequately funded services, where staff have a manageable workload. Therefore, this review suggests that individual factors such as professional practice should not be targeted independently of organisational constraints.
4.2. Strengths and Limitations

This review synthesised findings from a wide range of studies including a variety of participants, methodologies and service types. The involvement of a multi-disciplinary review team and lived experience advisors ensured data interpretations were firmly grounded in a range of experiences, including service-user experiences. Whilst we were able to present a broad overview of the existing research, synthesising a large evidence base inevitably leads to some loss of depth and nuance from the literature and readers are advised also to interrogate the individual studies reviewed.

There are also some important perspectives missing from this review. Most included studies were from high-income countries in the global north that adopt a western medical model of mental health. Therefore, the findings presented here cannot be extended to people and services in other cultural settings and countries. Furthermore, the fact that few studies reported the socio-demographic characteristics of participants means we were unable to explore the impact of racialisation and marginalisation, on how support was received. Further investigation into culturally informed parenting and mental health support is needed to determine its impact on engagement and outcomes for parents from diverse backgrounds and inform improvements to existing services.

Whilst the number of studies focusing on parents’ and professionals’ views of support was similar, the number of professionals’ perspectives included in this review was far greater than parents’ perspectives, meaning this review may represent a somewhat unbalanced view of support for parents. Furthermore, research into child protection staff wellbeing remains scarce and future work should unpack the impact of employee burnout on social service professional practice. As outlined, the majority of parent perspectives in this review are those of mothers and exploring fathers’ perspectives remains an important priority for future research. Future research should also consider how the paternal role interacts with mental health and children’s social services support and outcomes, rather than viewing mothers as the sole target of these interventions, especially as domestic violence, usually perpetrated by men against women, has been consistently shown to lead to maternal mental health difficulties and child protection involvement (Oram, 2017).

5. Conclusion

This review found that parents with both mental health needs and children’s social services involvement are often parenting in a context of trauma and financial hardship and want support to care for themselves and their children. Some aspects of mental health support, such as psychological therapy, can help parents develop confidence in their parenting and build strong bonds with their children, but the focus of current interventions tends to neglect key factors contributing to parents’ difficulties and mental distress, such as financial hardship and lack of practical parenting support. Often support also fails to address the
interdependence of parent stability and child welfare or to consider how child protection concerns may intersect with other aspects of mothers’ identities, resulting in the marginalisation or stigmatisation of particular groups. Services should provide support to parents earlier, preventing a downward spiral being triggered by stressful service intervention and child custody loss. Organisational constraints, such as the fragmentation of services, act as further barriers to good practice and recent local initiatives addressing these offer valuable learning points.

Acknowledgements

This project was funded by the Violence, Abuse and Mental Health Network (VAMHN). VAMHN is funded by UK Research and Innovation (UKRI) and their support is gratefully acknowledged (Grant reference: ES/S004424/1). The work was also supported by the Economic and Social Research Council (ESRC) Centre for Society and Mental Health at King’s College London [ES/S012567/1]. Angela Sweeney would also like to acknowledge the support of the National Institute for Health Research (NIHR) Maudsley Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King’s College London. Any views expressed here are those of the project investigators and do not necessarily represent the views of VAMHN, UKRI, ESRC, NHS, NIHR, Department of Health and Social Care or King’s College London.

The authors are very grateful for all the valuable contributions received from the Lived Experience Advisory Group.


Figure 1. PRISMA Flow Diagram (2020) showing search strategy

Records identified from search of Medline, CINAHL, Embase, Psycinfo, HMIC, Social Policy & Practice, SSA, SSCI, ProQuest and SCO (January 2000- present) (n=11,334)

- Duplicate records removed (n=5,906)

Records screened (n=5,428)

- Records excluded after title & abstract review (n=5,174)

Records sought for retrieval (n=254)

- Records not retrieved (n=12)

Records assessed for eligibility (n=242)

- Records excluded (n=204)
  - Reason for exclusion:
    - Population: Mental health criteria not met (67)
    - Population: No social services involvement (45)
    - Phenomenon of interest: Does not focus on experiences of support (26)
    - Perspective: Does not contain views of parents or practitioners (16)
    - Design: Does not have a qualitative design (25)
    - Wrong Publication type (25)

Papers included in review (n=41)
Table 1. Eligibility criteria for included papers

<table>
<thead>
<tr>
<th>SEARCH CONCEPT</th>
<th>INCLUSION CRITERIA</th>
<th>EXCLUSION CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONDITION/DOMAIN</td>
<td>• Studies with a focus on the views/ experiences of support for parents</td>
<td>• Studies without a primary focus on the views/experiences of support or interventions</td>
</tr>
<tr>
<td>BEING STUDIED</td>
<td>• Parents meeting formal diagnostic criteria for mental health difficulties, receiving high scores on screening tools, or self-reporting mental health difficulties AND with current or past children's social services involvement</td>
<td>• Studies where it is not possible to disentangle the views/experiences of different stakeholders</td>
</tr>
<tr>
<td>PERSPECTIVE</td>
<td>• Practitioners or professionals who support these parents</td>
<td>• Studies not including the views/experiences of eligible parents or practitioners</td>
</tr>
<tr>
<td></td>
<td>• Support or interventions not aimed at parents e.g. aimed at children or wider family members</td>
<td>• Studies that do not allow the differentiation of eligible parents/practitioner views from those of non-eligible participants</td>
</tr>
<tr>
<td>PHENOMENON OF</td>
<td>• Studies with an explicit focus on experiences of support or interventions for parents, where ‘support’ is taken as any professional support including mental health, social work, parenting or practical support.</td>
<td></td>
</tr>
<tr>
<td>INTEREST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TYPE OF STUDY</td>
<td>• Studies using a qualitative research design</td>
<td>• Studies not including analysis of data e.g. reflective/ commentary pieces</td>
</tr>
<tr>
<td></td>
<td>• Studies using a mixed methods design if qualitative data is reported separately</td>
<td>• Studies using a quantitative design</td>
</tr>
<tr>
<td></td>
<td>• Studies published in peer-reviewed journals or published articles or reports</td>
<td>• Alternative formats such as book chapters, conference papers, editorials, letters, blogs, websites, theses, general comment studies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Studies not published or available in English</td>
</tr>
<tr>
<td>First Author &amp; Title</td>
<td>Participants</td>
<td>Population characteristics (number, gender, ethnicity, profession, diagnosis)</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>(1) Ackerson (2003)</strong>&lt;br&gt;Coping With The Dual Demands of Severe Mental Illness and Parenting: The Parents' Perspective.</td>
<td>Parents&lt;br&gt;N=13</td>
<td>• Diagnosis: not specified&lt;br&gt;• Gender: 12 female (92%)&lt;br&gt;• Ethnicity: not reported&lt;br&gt;• Age: not reported</td>
</tr>
<tr>
<td><strong>(2) Afzelius (2017)</strong>&lt;br&gt;Children of Parents with Serious Mental Illness: The Perspective of Social Workers</td>
<td>Practitioners&lt;br&gt;N=13</td>
<td>• Profession: social service professionals (11 social workers, 1 trainee social worker, 1 treatment assistant)&lt;br&gt;• Gender: 12 female (92%)&lt;br&gt;• Age: M = 44 (29–57)</td>
</tr>
<tr>
<td><strong>(3) Barbour (2002)</strong>&lt;br&gt;Assessing risk: professional perspectives on work involving mental health and child care services</td>
<td>Practitioners&lt;br&gt;N=30-33 (not specified)</td>
<td>• Profession: mixed (mental health (MH) &amp; social services staff)&lt;br&gt;• Gender: not reported&lt;br&gt;• Age: not reported</td>
</tr>
<tr>
<td><strong>(4) Barrow (2014)</strong>&lt;br&gt;Context and opportunity: multiple perspectives on parenting by women with a severe mental illness.</td>
<td>Both&lt;br&gt;Practitioners (n=7)&lt;br&gt;Parents (n=7)</td>
<td>• Profession: housing shelters&lt;br&gt;• Gender: 4 female (57%)&lt;br&gt;• Age: not reported&lt;br&gt;• Diagnosis: not reported&lt;br&gt;• Gender: 100% female&lt;br&gt;• Ethnicity: 3 African American, 3 Latina, 1 other&lt;br&gt;• Age: M=36.7 (28–43)</td>
</tr>
<tr>
<td><strong>(5) Caplan (2020)</strong>&lt;br&gt;Indigenous and non-Indigenous parents separated from their children and experiencing homelessness and mental illness in Canada.</td>
<td>Parents&lt;br&gt;N=36</td>
<td>• Diagnosis: not reported&lt;br&gt;• Gender: 12 female (33%)&lt;br&gt;• Ethnicity: 21 Indigenous Canadian, 15 non-indigenous Canadian (White Canadian or White European)&lt;br&gt;• Age: M = 40</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Methods</td>
</tr>
<tr>
<td>-------</td>
<td>--------------</td>
<td>---------</td>
</tr>
<tr>
<td>(6) Coates (2015)</td>
<td>Both Practitioners (n=10):</td>
<td>Keep Them Safe Whole Family Team (KTS-WFT) Project - Central Coast Local Health District Outreach Service</td>
</tr>
<tr>
<td></td>
<td>Parents (n=20):</td>
<td>New South Wales, Australia</td>
</tr>
<tr>
<td>(7) Coates (2017)</td>
<td>Practitioners N=10</td>
<td>Northern Sydney Local Health District (NSLHD) Sydney, Australia</td>
</tr>
<tr>
<td></td>
<td>Practitioners N=232</td>
<td>Department of Families and Queensland Health Australia</td>
</tr>
<tr>
<td>(8) Darlington (2004)</td>
<td>Practitioners N=36</td>
<td>Department of Families and Queensland Health Australia</td>
</tr>
<tr>
<td>(9) Darlington (2005)</td>
<td>Practitioners N=36</td>
<td>Department of Families and Queensland Health Australia</td>
</tr>
<tr>
<td>(10) Darlington (2008)</td>
<td>Practitioners (See: Darlington, 2004)</td>
<td>Department of Families and Queensland Health Australia</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Method</td>
</tr>
<tr>
<td>-------</td>
<td>--------------</td>
<td>--------</td>
</tr>
<tr>
<td>(11) Darlington (2009)</td>
<td>Both Practitioners (n=4): • Profession: child protection caseworkers (1 family support worker, 2 child protection worker, 1 MH social worker) • Gender: 100% female • Age: M=36.5 (26-50) Parents (n=4): • Diagnosis: 2 X Psychosis, 1 X PTSD, 1 X depression • Gender: 100% female • Ethnicity: not reported • Age: M=31 (19-36)</td>
<td>Department of Families and Queensland Health Australia</td>
</tr>
<tr>
<td>(12) Davidson (2010)</td>
<td>Practitioners N=109 • Profession: 12 ‘Champions’ in MH, 59 MH team members, 12 ‘Champions’ in childcare, 26 children’s social workers • Gender: 84% female • Age: not reported</td>
<td>Northern Health and Social Care Trust (NHSCT) Northern Ireland, UK</td>
</tr>
<tr>
<td>(13) Diaz-Caneja (2004)</td>
<td>Parents N=22 • Diagnosis: 8 X schizophrenia delusional, 4 X bipolar disorder, 4 X severe depression with psychotic symptoms • Gender: 100% female • Ethnicity: 13 White British, 3 White other, 1 Black British, 1 Black Caribbean, 1 Black African, 2 Asian, 1 mixed • Age: &gt;20</td>
<td>Camden and Islington Community Mental Health Team London, UK</td>
</tr>
<tr>
<td>(14) Ghaffar (2011)</td>
<td>Parents N=47 • Diagnosis: not reported • Gender: 39 female (83%) • Ethnicity: 36 White British, 5 X British Asian 6 X not specified • Age: &lt;20 (n=2), 20-29 (n=20), 30-29 (n=12), 40-49 (n=7), &gt;50 (n=1)</td>
<td>Local Authorities in Northern England UK</td>
</tr>
<tr>
<td>Study</td>
<td>Authors</td>
<td>Sample</td>
</tr>
<tr>
<td>-------</td>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td>(16) Hetherington (2001)</td>
<td>Supporting families with a mentally ill parent: European perspectives on interagency cooperation</td>
<td>Practitioners: N= not reported</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parents (n=9):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis: 5X Major Depressive Disorder, 1X schizoaffective, 1X substance abuse, 1X adjustment disorder, 1X bipolar disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Gender: not reported</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ethnicity: 6 Caucasian, 3 African American</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Age: 26-40</td>
</tr>
<tr>
<td>(18) Hollingsworth (2013)</td>
<td>The role of positive and negative social interactions in child custody outcomes: Voices of US women with serious mental illness.</td>
<td>Parents: N=3</td>
</tr>
<tr>
<td>(19) Honey (2021)</td>
<td>Parents: N=8</td>
<td>Setting not reported</td>
</tr>
</tbody>
</table>
### Living with mental illness and child removal

- **Diagnoses:** 3X depression, 3X bipolar, 3X psychotic disorder, 2X anxiety disorder, 1X post-traumatic stress disorder
- **Gender:** 100% female
- **Ethnicity:** not reported
- **Age:** Not reported

#### Practitioners

- **N=28**
- **Profession:** senior practitioners working in child protection, family support, specialist domestic violence, MH and substance misuse
- **Gender:** not reported
- **Age:** Not reported

#### Research

- **University of Sydney, Australia**
- **Interpretive Phenomenological Approach**

#### Findings

1. Protecting myself
2. Constrained mothering.

---

### Humphreys (2021)

Beyond co-occurrence: Addressing the intersections of domestic violence, mental health and substance misuse

#### Practitioners

- **N=28**
- **Profession:** child welfare social workers
- **Gender:** 6 female (75%)
- **Age:** M=50.8 (42-60).

#### Research

- **Research for child welfare department, Japan**
- **Semi-structured interviews**
- **Qualitative descriptive analysis**

#### Findings

1. Partnering with non-offending parent
2. Addressing the intersection of domestic violence with mental health
3. Pivot to the perpetrator
4. Differing frameworks across services

---

### Kageyama (2018)

Social Workers’ Support Skills for Parents with Mental Disorders: A Qualitative Descriptive Study in Child-Welfare Social Workers

#### Practitioners

- **N=8**
- **Profession:** child welfare social workers
- **Gender:** 6 female (75%)
- **Age:** Not reported

#### Research

- **Research for child welfare department, Japan**
- **Semi-structured interviews**
- **Qualitative descriptive analysis**

#### Findings

1. Identification of goals social workers supported parents in
2. Support skills used by social workers

---

### Keddell (2016)


#### Both

- **Practitioners (n=22):**
  - **Profession:** social workers
  - **Gender:** 19 female (86%)
  - **Age:** not reported

#### Parents

- **n=8**
  - **Diagnosis:** not specified (majority depression)
  - **Gender:** 7 Female (88%)
  - **Ethnicity:** not reported
  - **Age:** not reported

#### Research

- **Child-welfare NGO, Aoteatora, New Zealand**
- **Secondary discourse analysis of paired social worker and service user narratives**

#### Findings

1. Dominance of a family maintenance discourse that framed decision making
2. Defining children’s best interests as relational needs and rights
3. The use of mental illness and lack of support to construct non-culpable causes of original family problems
4) 'Safety' in addition to risk
5) Strong commitment to ‘respect for persons’

---

### Lever Taylor (2019)

Experiences of social work intervention among mothers with perinatal mental health needs.

#### Parents

- **N=18**
  - **Gender:** 100% female
  - **Diagnosis:** 4 X depression, 1 X anxiety, 9 X personality disorder, 4 X bipolar disorder/ psychosis/ schizophrenia
  - **Ethnicity:** 12 White British, 1 White other, 4 Black Caribbean, 1 Black African
  - **Age:** M = 28.7

#### Research

- **NHS Mental healthcare Services, UK**
- **Semi-structured interviews**
- **Thematic Analysis**

#### Findings

1. Labelled as ‘bad mothers’
2. Set up to fail
3. Turning points
### (24) Marziali (2006)
Supportive group therapy for parents who chronically neglect their children

<table>
<thead>
<tr>
<th>Parents</th>
<th>N=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnosis: complex emotional needs</td>
<td></td>
</tr>
<tr>
<td>• Gender: not reported</td>
<td></td>
</tr>
<tr>
<td>• Ethnicity: not reported</td>
<td></td>
</tr>
<tr>
<td>• Age: not reported</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personality Disorder Group Therapy Service Evaluation Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analytical process not reported</td>
</tr>
</tbody>
</table>

1) The search for boundaries  
2) Attack and despair  
3) Mourning and repair  
4) Integration of self-control.

### (25) Mason (2018)
Experiences of child protection workers in collaborating with adult mental health providers: An exploratory study from Ontario, Canada.

<table>
<thead>
<tr>
<th>Practitioners</th>
<th>N=339</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Profession: family service workers (31.2%), children’s service workers (13.3%), intake workers (10.0%), investigation workers (9.1%), other (36.4%)</td>
<td></td>
</tr>
<tr>
<td>• Gender: not reported</td>
<td></td>
</tr>
<tr>
<td>• Age: 52.1% between the ages of 25 to 44 years</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children’s Aid Societies Ontario, Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey Data (Open-ended questions)</td>
</tr>
<tr>
<td>Thematic qualitative analytic procedures (Crabtree and Miller, 1999)</td>
</tr>
</tbody>
</table>

1) Collaborative strategies  
2) Barriers and facilitators to collaboration  
3) Ideas to improve collaboration between child welfare and adult mental health services

### (26) McPherson (2018)
Evaluating integrative services in edge-of-care work

<table>
<thead>
<tr>
<th>Practitioners</th>
<th>N=24</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Profession: MH practitioners, enhanced therapists, PIMHAP lead, trainee clinical psychologists, children’s services managers, children’s services social workers, children’s centre managers, midwives, allied project consultants and administrators</td>
<td></td>
</tr>
<tr>
<td>• Gender: not reported</td>
<td></td>
</tr>
<tr>
<td>• Age: not reported</td>
<td></td>
</tr>
</tbody>
</table>

| Norfolk Parent Infant Mental Health Attachment Project (PIMHAP) Service Evaluation UK |
| Focus Groups |
| Thematic Analysis |

1) A safe place to leave professional defences behind  
2) Working within financial and professional constraints  
3) Creating solutions to long-standing dilemmas  
4) Holding really tough stuff without switching off.

### (27) Mind (2005)
A right to know, a right to be involved: a survey of the views of people with mental health problems who were parents experiencing Local Authority Statutory Children’s Services

<table>
<thead>
<tr>
<th>Both Practitioners (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Profession: child &amp; family social workers, independent Reviewing Officer, family resilience workers, community MH workers, solicitors</td>
</tr>
<tr>
<td>• Gender: not reported</td>
</tr>
<tr>
<td>• Age: not reported</td>
</tr>
</tbody>
</table>

| Mind’s Parenting Advocacy Service Croydon, UK |
| Survey data (open questions) and 1:1 telephone interviews |
| Not reported |

<table>
<thead>
<tr>
<th>Parents (n=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnosis: not reported</td>
</tr>
<tr>
<td>• Gender: not reported</td>
</tr>
<tr>
<td>• Age: not reported</td>
</tr>
<tr>
<td>• Ethnicity: not reported</td>
</tr>
</tbody>
</table>

Service evaluation - themes not reported
<table>
<thead>
<tr>
<th>Study</th>
<th>Parents</th>
<th>Practitioners</th>
<th>Setting</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>(29) Pause (2021)</td>
<td>Both</td>
<td>Practitioners (n=9)</td>
<td>Maternal Mental Health Service Cheshire &amp; Merseyside, UK</td>
<td>Virtual focus group, individual conversations, and an online survey Analysis not reported</td>
<td>1) Women who have experienced the removal of children are currently not routinely offered maternal mental health services 2) Women will be feeling overwhelmed and may be fearful of services. 3) Maternal mental health services should offer support early, build trusting relationships, work collaboratively with other services, and be open and honest with women. 4) Services should understand the impact of trauma, ask and listen to womens preferences</td>
</tr>
<tr>
<td>(30) Perera (2014)</td>
<td>Both</td>
<td>Practitioners (n=11)</td>
<td>Adult public mental health service Melbourne, Australia</td>
<td>Semi-structured interviews Constructivist grounded theory</td>
<td>1) Positive aspects of motherhood for women living with mental illness 2) Challenging aspects of motherhood</td>
</tr>
<tr>
<td>(31) Powell (2020)</td>
<td>Parents</td>
<td></td>
<td>Setting not reported USA</td>
<td>Semi-structured telephone interviews Content Analysis</td>
<td>1) Types of supports parents reported as useful for their well-being 2) Chronic economic hardships and material deprivation</td>
</tr>
<tr>
<td>Study</td>
<td>Practitioners</td>
<td>Community Mental Health Team Staff.</td>
<td>Both Practitioners</td>
<td>Both Parents</td>
<td>Mental Health Services (NHS and private healthcare providers)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Scott (2018)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siverns (2021)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mental Health Services (NHS and private healthcare providers)</td>
</tr>
<tr>
<td>Stanley (2003)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Participants</td>
<td>Procedure</td>
<td>Methodology</td>
<td>Key Findings</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
<td>--------------</td>
<td>-----------</td>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td>(37) Stephens (2019)</td>
<td>Parents</td>
<td>N=20</td>
<td>CW-affiliated community-based organizations e.g. social service providers, mental health centres</td>
<td>Semi-structured interviews</td>
<td>1) Chronic and compound exposure to Potentially Traumatic Events (PTEs) 2) Interpersonal violations of trust 3) Pervasive mistrust of others 4) Revictimization 5) The absence of appropriate MH treatment 6) Grown while living with complex trauma</td>
</tr>
<tr>
<td>(40) Yoo (2020)</td>
<td>Both</td>
<td>Practitioners (see Yoo, 2022)</td>
<td>Child welfare agencies</td>
<td>Semi-structured interviews</td>
<td>1) Psychotherapy as a place for safety and empathy 2) Psychotherapy as a place for challenge 3) Psychotherapy as a place for problem resolution.</td>
</tr>
<tr>
<td>(41) Yoo (2022)</td>
<td>Practitioners</td>
<td>N=10</td>
<td>Child welfare agencies</td>
<td>Semi-structured interviews</td>
<td>1) Parents strengths: potential and capacity for care</td>
</tr>
</tbody>
</table>
They're not bad parents. They've just made bad choices.

Mental health clinicians’ perspectives of parents involved with child protective services

- Profession: 3 family therapists, 3 counsellors, 3 social workers, 1 clinical psychologist
- Gender: 9 female (90%)
- Age: $M = 43.5$

Illinois, USA

Thematic analysis

2) Parents challenges: Reasons behind maltreatment
<table>
<thead>
<tr>
<th>First Author</th>
<th>Aims</th>
<th>Appropriateness</th>
<th>Design</th>
<th>Recruitment</th>
<th>Data collection</th>
<th>Research relationships</th>
<th>Ethics</th>
<th>Data analysis</th>
<th>Findings</th>
<th>Value</th>
<th>Intersectionality</th>
<th>Service user involvement</th>
<th>Positionality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ackerson (2003)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Azfelius (2017)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Barbour (2002)</td>
<td>Can’t tell</td>
<td>Can’t tell</td>
<td>Can’t tell</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Barrow (2014)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Can’t tell</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Caplan (2020)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Can’t tell</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Coates (2015)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Coates (2017)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Darlington (2004)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Darlington (2005)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Darlington (2008)</td>
<td>Yes</td>
<td>Yes</td>
<td>Can’t tell</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Can’t tell</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Darlington (2009)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Can’t tell</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Davidson (2010)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Can’t tell</td>
<td>Can’t tell</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Diaz-Caneja (2004)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Can’t tell</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Ghaffar (2011)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Hanley (2006)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Hetherington (2001)</td>
<td>Yes</td>
<td>Yes</td>
<td>Can’t tell</td>
<td>Can’t tell</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Hinden (2005)</td>
<td>Yes</td>
<td>Yes</td>
<td>Can’t tell</td>
<td>Yes</td>
<td>Yes</td>
<td>Can’t tell</td>
<td>Can’t tell</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Hollingsworth (2013)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Can’t tell</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Honey (2021)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Humphreys (2021)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Can’t tell</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Kageyama (2018)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Can’t tell</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Keddell (2016)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Lever Taylor (2019)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Study</td>
<td>Yes</td>
<td>Yes</td>
<td>Can't tell</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----</td>
<td>-----</td>
<td>------------</td>
<td>-----</td>
<td>-----</td>
<td>----</td>
<td>----</td>
<td>-----</td>
<td>-----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Marziali (2006)</td>
<td>Yes</td>
<td>Yes</td>
<td>Can't tell</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Mason (2018)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>McPherson (2018)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Can't tell</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Mind (2005)</td>
<td>Yes</td>
<td>Yes</td>
<td>Can't tell</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Can't tell</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Ostler (2015)</td>
<td>Yes</td>
<td>Yes</td>
<td>Can't tell</td>
<td>Can't tell</td>
<td>Yes</td>
<td>No</td>
<td>Can't tell</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Pause (2021)</td>
<td>Yes</td>
<td>Yes</td>
<td>Can't tell</td>
<td>Yes</td>
<td>Can't tell</td>
<td>No</td>
<td>Can't tell</td>
<td>Can't tell</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Can't tell</td>
<td>No</td>
</tr>
<tr>
<td>Perera (2014)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Can't tell</td>
<td>Can't tell</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Powell (2020)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Can't tell</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Rouf (2012)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Scott (2018)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Sivers (2021)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Stanley (2003)</td>
<td>Yes</td>
<td>Yes</td>
<td>Can't tell</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>?</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Staudt (2015)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Stephens (2019)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Can't tell</td>
<td></td>
</tr>
<tr>
<td>Tcherneoganyevski (2018)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Turesson (2020)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Can't tell</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Yoo (2020)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Can't tell</td>
<td>Can't tell</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Yoo (2022)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Can't tell</td>
<td>Can't tell</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Theme/Sub-Theme

**THEME 1: A DOWNWARD SPIRAL OF SERVICE INTERVENTION**

<table>
<thead>
<tr>
<th>Theme/Sub-Theme</th>
<th>Illustrative Quotes</th>
</tr>
</thead>
</table>
| **Needing support but fearing the consequences.** | 'All mothers discussed feeling ‘scared’ or ‘frightened’ or having a fear of losing care of their child once CPS became involved. As a result this caused some mothers to be reluctant in seeking mental health services for the fear that their child may be taken away' (Perera et al., 2014)  

> “Every mother’s fear is that her children will be taken into care...If I did anything that made them think I was going crazy then they’d take my daughter away.” [mother] (Diaz-Caneja & Johnson, 2004)  

> "The first social worker used to look at me like I was an alien...I don’t know if they have a full understanding... that even if someone’s got a mental illness, they can still be a good parent." [mother] (Lever Taylor et al., 2019)  

> “When I asked for help from services, they just wrote down, ‘Mum can’t cope, mum is saying this, mum is doing this.’ And they use it against you.” [mother] (Pause, 2021) |
| **Social services involvement exacerbating mental health difficulties** | "My daughter got taken away...that was probably the worst time for me. Cause she had been with me for seven years... she had always been in my care... and then she was gone and I couldn’t talk to her. And I felt really bad. I just wanted to die, you know. It was really bad." [mother] (Caplan et al., 2020)  

> "It’s like you’re at the worst time of your life and they want you to be at your best, to show them that you are the, you know, and put these runs on the board...you’re at your absolute worst, and they’re expecting you to be the best you’ve ever been." [mother] (Honey et al., 2021)  

> “Because there is a stigma when you are not looking after your children. People are looking at you and because you are washed and dressed and presentable and they can’t see a reason why you can’t look after your child, other than you must be a drug addict, you must be a dreg of society. So I feel stigmatised.” [mother] (Diaz-Caneja & Johnson, 2004) |
| **Mental health treatment making parenting difficult** | 'Some mothers and staff members spoke about mothers refraining from taking their medication in order to take adequate care and meet the needs of their children. Staff members reported that this was often due to the side effects of medication (e.g. drowsiness) which greatly added to the challenges of parenting. (Perera et al., 2014)  

> 'Symptom management and engagement with mental health professionals and services are not in themselves indicative of recovery. Indeed, for many parents, having to engage with services was seen to be an indication of a setback, a lack of personal resources to cope, or a challenge to their recovery, rather than a support of it' (Scott et al., 2018)
## Theme 2: Working with Parents, Not against Them

| Engagement parents through relationship building | "In the end, Social Services will take [the children], because they'll have no choice, quite honestly. I won’t work with them, I won’t engage, I won’t do absolutely anything that they tell me to and... I will get what I want in the end [referring to the children being removed], because it was the only way I saw out of it." [mother] (Siverns & Morgan, 2021)  
One mother described how she and social workers learnt to know and understand each other better. She attributed this to shifts in communication styles on both sides that resulted in social workers seeing her as a mother in need of support, rather than a risk: "I didn’t feel like anybody was listening to me...When they finally did listen everybody just kind of clicked..." [mother] (Lever Taylor et al., 2019)  
"There’s nothing they could have done differently to engage me more, so in some ways, perhaps chasing me was a waste of time really" [father] (Coates & Howe, 2015) |
| Working with trauma | There were repeated failures in caregiver and CWS responsiveness to the needs that mothers presented with. Sixteen of the 20 mothers stated that they had not even been asked about their histories or their trauma when interfacing with CWS workers. One mother stated, "No one wanted to hear about me. What I had been through did not matter to them." (Stephens, 2019)  
"We take those individuals who already carry the shame and guilt of their own childhood. And then they’re parents, and they’re wanting something different [for their children]. I don’t believe that parents go into parenting wanting to mess up, wanting to ineffectively parent and harm their children." [mental health clinician] (Yoo et al., 2022)  
"It’s still following me. It’s like they see these things of who I used to be and they’re not talking to who I am now. They’re not looking at what I’m doing now. Like I changed my life when I had children, I’m a completely different person." [father] (Scott et al., 2018) |
| Strengths-focused vs deficit-focused | 'One mother, who had had a negative experience of professionals previously, spoke eloquently about how social workers' belief in her ability to change motivated her to seek help and focus on the needs of her children: "They told me...I've got the potential to do it. I've just got to get my mind in the right place".' (Ghaffar et al., 2011)  
"How many sacrifices that those moms make to come to therapy is amazing. Some of them could leave hours before coming to therapy because they have to get a bus [and] wait for the next bus. The whole thing may take four hours just to come to therapy, but they did it every week...I’ve had people come in [when] there’re horrible rainstorms, waiting outside for the bus or having to walk to get to therapy, because they want to get their child back." [mental health clinician] (Yoo et al., 2022)  
Statements such as 'We're not going to change the borderline personality disorder and we're not going to change the bipolar' (Mary: OT social worker) construct the problem as intractable and undercut any faith in clients' ability to recover and eventually regain care of their children.' (Scott et al., 2018) |
| The importance of transparency | ‘Some felt decisions were made before meetings started. One couple felt they could not contribute to decisions being made. They said “from her coming home ... we were kept in the dark”. Another mother said: "They always asked us, but our view. They said "We still want to know your views", but it never made a difference".' (Ghaffar et al., 2011) |
"I never in my wildest imagination dreamed that my children would be took for the period of time that they were took. I thought it was temporary – maybe a week or two until I got back up on my feet, got us another house, moved out of the area, moved away from the person that was causing us direct danger – and then my kids would be back. They told me to give up custody and you would get your kids back; so I am like – how long? He was like, maybe a month or two. But [that] turned into almost two years.” [mother] (Hollingsworth et al., 2013)

"It’s important that we, together with [child protection], are open to families about the concerns... .They need to be told, and we need to be told, so it’s clear to everyone and we’re all on the same page. It’s our job to help parents understand the decisions child protection makes, but we can’t do that unless we understand them as well... It’s very important that families don’t receive conflicting information, but unless we work closely, this happens and families get confused... . They need to know clearly what’s expected of them.” [child protection worker] (Coates, 2017)

**THEME 3: SUPPORT WANTED VS SUPPORT PROVIDED**

<table>
<thead>
<tr>
<th>Parenting support</th>
<th>'Five of the women did describe feeling able to talk about their experiences and difficulties as mothers to their keyworkers. Each of these had had a consistent keyworker with whom she had felt able to establish a trusting relationship. This was seen as a substantial support in parenting.' (Diaz-Caneja &amp; Johnson, 2004)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial support</td>
<td>'As far as the neglect and leaving [children] alone, many say “I had no other options. I have no help.” I had one [mother] who would leave her children locked in her apartment because she had to go work midnights because she had no options, no childcare” ’ [mental health clinician] (Yoo et al., 2022)</td>
</tr>
<tr>
<td>Mental health treatment</td>
<td>'Several participants recognized that medication, and mental health treatment and support are helpful in managing symptoms. However, they also stressed that medication and attending appointments can interfere with parenting and the level of interaction mothers have with their children.’ (Perera et al., 2014)</td>
</tr>
</tbody>
</table>

'It was also clear that for the majority of these parents their acute symptoms abated with proper diagnosis and treatment. However, they continued to struggle with the handicap of being labelled mentally ill.’ (Ackerson, 2003)

[It] is just the temptation to pathologise the victim's experience of domestic violence and put a diagnosis on it and focus specifically from a mental health point of view: diagnose, medicate, discharge - which doesn't hold the perpetrator accountable whatsoever?" [mental health clinician] (Humphreys et al., 2016)
"I’ve been diagnosed everything.… One said I was a paranoid schizophrenic and the other one said no I wasn’t.… You know, when you get a different doctor, they see what they think they see, and do the best they can, you know … and some of them want to medicate you to death, and, you know, not deal with your problems and not talk to you.” [Parent] (Ackerson, 2003)

<table>
<thead>
<tr>
<th>Working with wider support networks</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;They [family] did step in and help me out, but sometimes their good intentions were the worse thing for me. Sometimes they tended to take over and they had the children a lot … also they got on me a lot … [and told me to] snap out of it.&quot; [mother] (Ackerson, 2003)</td>
</tr>
<tr>
<td>&quot;The dad is a real asset, but he has not been allowed to participate…I have personally decided that the fathers should now be included, but I have really had to work on myself. We are not in complete agreement within the treatment group.&quot; [Social worker] (Turesson, 2020).</td>
</tr>
<tr>
<td>‘Women told us how important it is to include their partners and/or the children’s fathers in any services offered, noting that it is “not just women. I know that there are men going through traumatic times”.’ (Pause, 2021)</td>
</tr>
</tbody>
</table>

**THEME 4: CONSTRAINED BY SERVICE RIGIDITY**

### Fragmented services

"Making contact [with mental health professionals] is a poor experience the majority of the time. I cannot recall any mental health provider who initiates and who is responsible for collaborative communication” [child protection worker] (Mason et al., 2018)

“They [social services] are only here for [the baby], you know...If you want [my baby] to do well, we need to be well as well. Well, I need to be well.” [mother] (Lever Taylor et al., 2019)

"I try to understand where child protection are coming from in their decision making. . . But I’m not sure that they fully appreciate the impact of depression or anxiety on someone. I think they are extremely child focussed and that’s their job but there isn’t much room for an understanding of what’s actually driving the distress in the family." [mental health clinician] (Coates, 2017)

“I can only do the mental health stuff—I cannot do the child care and I am finding more and more social workers who can only do one or the other” [social worker] (Barbour et al., 2002)

### A heavy focus on risk

"You worry that you’re [pause] reacting too strongly to a situation. You are misjudging it. You know, you think you are seeing something that you are not. I suppose the other fear is that you’re missing something, and you’ll get blamed for it. That sort of thing.” [Psychiatrist] (Rouf et al., 2012)

‘A salient example of risk eclipsing other considerations is the experience McKayla recounts of being reduced to her mental illness and its attributed risks. “Nobody was taking any of that into consideration, they were just, this is who she is, these things what she is doing is who she is and she’s a risk. I was at risk, yes.” [parent’]. (Scott et al., 2018)

‘Clinicians explain that both individual and group supervision is critical in terms of enhancing objectivity and assisting them to tolerate the uncertainty and complexity of the work.’ (Coates & Howe, 2015)
<table>
<thead>
<tr>
<th>Service inaccessibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I kind of feel betrayed by [child protection services] because I had already asked them for help prior to [the removal]. And they didn’t care. I’d asked a mental health worker to help and she didn’t care.” [mother] (Honey, 2021)</td>
</tr>
<tr>
<td>‘All the women who cared for their children identified difficulties in attending appointments or using day care services as there were no crèche facilities and mental health service premises were not appropriate environments for children.’ (Diaz-Caneja &amp; Johnson, 2004)</td>
</tr>
<tr>
<td>‘The majority of clinicians comment that families should be referred ‘much earlier, not when it’s at the pointy end’ (Alex). Clinicians argue that working with families earlier, before they have reached such high levels of risk, will impact positively on client outcomes as well as staff wellbeing.’ (Coates &amp; Howe, 2015)</td>
</tr>
<tr>
<td>“I’m trying to think about mental health, but they really feel quite distant and not—I really very rarely consider them, I guess…. It just seems that they have really, really strict, hard boundaries and that they’re very clear about that, and so I just don’t find them approachable.” [children’s social worker] (Darlington &amp; Feeney, 2009)</td>
</tr>
<tr>
<td>“Mental Health can only cover so much because of government funding now, so if you’re not in that category or criteria, you’ve got to go to general practitioners who are not trained on mental health issues, and they’ll quickly write you out a script, and you’re not getting the help you need. And there’s a really big failing in the mental health system at the moment….I feel you’ve got to fall before they’ll listen, and that’s that.” [social worker] (Darlington &amp; Feeney, 2009)</td>
</tr>
</tbody>
</table>
Description of Supplementary Material

S1. Search Strategy for electronic databases
A full list of search terms used to search the electronic databases including free-text and MeSH terms.

S1. Adapted Critical Appraisal Skills Programme
An adapted version of the Critical Appraisal Skills Programme (2018) used to evaluate study quality in this review. This method includes three additional areas of evaluation: intersectionality, service user involvement and positionality.